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 Statewide Quality Assurance Program. AHCA maintains review/revision oversight of this document. This document is considered current until otherwise notified by the Contractor.

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.

Delmarva Foundation

Table of Contents

List of Acronyms.. 4
Policies and Procedures 7
Confidentiality.. 7
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 12
- Notification to WSC 12
- Selecting the Sample for PCRs 12
- Scheduling the face-to-face interview/a confirmation call..13
- Pre-Interview Information Gathering for the Interview......13
- Review of Information from APD...13
- Scheduling Support Coordinator/Consultant and Provider participation in the PCR...... 13
- Confirmation call to the Support Coordinator and Provider(s).................... 13
- Requesting Records...13
- Claims Data Pull..14

Interview Activities.. 14
- Face-to-Face Interviews (NCI, Health Summary, and Individual Interview)....................15
- Observation of the Service Delivery Locations (group home or day program)....17
- Support Coordination/Consultant Interview................................17
- Support Coordinator/Consultant Central Record Review.................................18
- Medicaid Claims Data Analysis...18
- The Medical Peer Review (MPR) Process..19
- NCI Interview Validation by HSRI 22

Provider Discovery Reviews 22
Types of Services to be Reviewed 22
Procedures and Methods for Reviews 23
Pre-Onsite Activities.. 25
- Scheduling the PDR...26
- Confirming the Review with the Provider...27
- Medicaid Claims...30
- Sample Selection for Record Reviews...27
- Gathering Information from APD...24

Onsite Activities 24
- Confirming Documents for Review..24
- Informal Individual Interviews 31

Observation of Service Delivery Locations……………………………………32
Administrative Record Review…………………………………………………33
Individual Record Review……………………………………………………34
Provider/Direct Care Staff Interviews………………………………………34
Alert Reporting…………………………………………………………………35
Preliminary Findings…………………………………………………………36
Post Onsite Review Activity 36
Reconsideration Procedures 38

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.

Regional Office – APD's Regional office responsible for managing one of APD's six service Regions.

CDC+ – Consumer Directed Care Plus Program is a permanent Medicaid State Plan Option under 1915j of the Social Security Act 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) 1915 (c) 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 the Florida HCBS waiver or participating in the CDC+ program.

NCI – National Core Indicator Survey - 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 day training facilities).

PCR – Person Centered Review is a process of discovery beginning with the person and reviewing the services and supports provided to the person by the support coordinator.

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 Waiver program and renders services to Medicaid Waiver recipients and bills for Medicaid Waiver 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 standards related to identified potential billing discrepancies.

SSRR – Service Specific Record Review - The SSRR is a review of the person's service record maintained by the provider. It is used to evaluate the extent to which providers incorporate a person centered approach in their service delivery systems, and maintain compliance and accountability to applicable laws, APD expectations, and standards.

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

Policies and Procedures

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 is 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 Regions, 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 the toll free number (866-254-2075) or by fax at (813-977-0027).

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 QARs 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 Regional Manager;
- If you are still not satisfied with the resolution please ask to speak with the Project Director;
- 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 is 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 an annual Provider Discovery Review or individual record review, the Delmarva QAR notifies Regional APD staff of the difficulty scheduling the review with the provider/CDC+ representative. This is in the form of a phone call followed up with an email. The

provider/CDC+ representative is given three business days to respond to APD Regional staff. If Regional staff succeeds in getting the provider/CDC+ representative to comply, the review is scheduled and conducted accordingly. If there continues to be non-compliance from the provider/CDC+ representative despite efforts from APD staff, the provider/CDC+ representative is scored "Not Met" in all areas of the discovery tool.

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

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

Procedure for providers who are a "no-show" after a review has been scheduled:

Should a provider fail to appear at the scheduled time and location for a Provider Discovery Review or individual record review, the provider/CDC+ representative is scored "Not Met" for all elements pertaining to the record review. The QAR notifies Regional APD staff by phone.

Discovery Review Procedures

Quality Framework

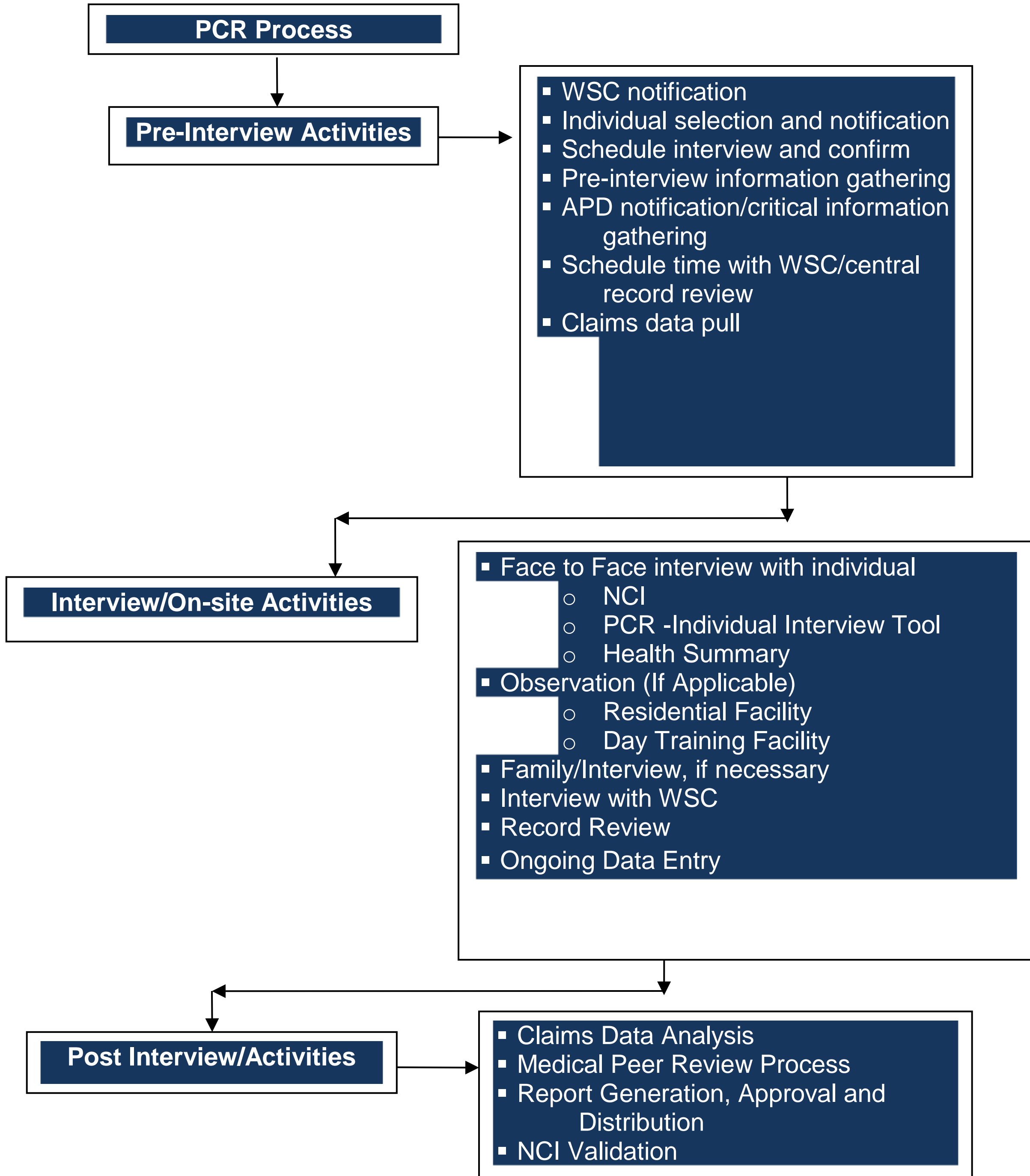
The Quality Assurance System developed by Delmarva, in collaboration with the Agency for Health Care Administration (AHCA) and the Agency for Persons with Disabilities (APD), is used to determine whether current systems to support individuals are efficient, effective, and rendered to their satisfaction. 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 Waiver Support Coordinator 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 Region 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 from the individual's perspective. PCRs begin with a face to face interview with individuals receiving services and include a review of the supports and services rendered by the Support Coordinators specific to that individual, including a review of the support plan. 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, service authorizations, progress notes, medical information, and provider information (implementation plans, quarterly summaries etc.).

Selecting the Sample for PCRs

Support coordinators and consultants who rendered and billed for services over the previous 6 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. The names of two individuals served by each support coordinator are randomly selected. For consultants serving people through the CDC+ program at least one individual receiving service through CDC+ may be selected for a PCR; however Consultants may get 1 CDC, 2 CDC or none if people served have already been sampled. The Delmarva QAR calls the WSC and/or CDC+ consultant and notifies 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 it is provided the WSC onsite if needed. 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 is 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, reiterates the purpose of the interview, and confirms 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. 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 application. 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. If the interview replaces a last minute cancellation a letter will not be sent.

Information covered by the QAR during the initial phone call with WSC will include the following at a minimum:

- Sharing names of persons sampled for PCR.
- Coordinating with WSC to assist with contacting and scheduling PCR.
- Confirming with Agency the number of WSC's, hire dates, gather caseload information, sample PCRs for any WSC's not in original sample.

Pre-Interview Information Gathering for the Interview

Prior to conducting the NCI Adult Consumer survey, PCR Interview and the Health Summary it is important for the QAR to collect information from the WSC 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 associated with the WSC. This information is discussed with the WSC during the interview if applicable.

Scheduling Support Coordinator/Consultant participation in the PCR

Prior 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). Typically, the interview with the support coordinator, and central record review occurs after the individual interview has been completed.

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

Confirmation with Support Coordinator

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. Subsequent calls to the WSC will be initiated by the QAR to:

- Finalize and confirm PCR times and locations
- Gather background information for NCI
- Schedule WSC interview
- Schedule WSC PDR review to include Administrative and Service Specific Record Review (SSRR)

Claims Data Pull

QARs access Medicaid claims data prior to the face-to-face interview. Claims data are used to compare the WSC documentation of services rendered to the person with actual billed claims to demonstrate whether the documentation matches what the WSC billed with what was paid. The comparison will also show whether the WSC 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 WSC to review the individual's records.

Interview/Record Review Activities

Face-to-Face Interviews (NCI, PCR Interview Tool and Health Summary)

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. For those who choose to participate, the PCR consists of the National Core Indicators Adult Consumer Survey, individual interview and Health Summary.

The QAR explains the two distinct components of the interview: 1) gathering information for the NCI; 2) gathering additional information using the PCR Interview Tool and Health Summary. 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.

NCI - 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 rights
- 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 PCR Interview Tool and Health Summary. The QAR also gives to the person a feedback survey and self-addressed/stamped envelope to complete at their leisure.

PCR Interview Tool - Data specific to the individual's desired goals and outcomes, are collected through the PCR Interview Tool. The Interview Tool covers for four key areas:

- **Person Centered Supports**: Individuals needs are identified and met through Person Centered Practices.
- **Community**: Individuals have opportunities for integration in all aspects of their lives including where they live, work, and gain access to community services and activities and opportunities for new relationships.
- **Health**: Individuals are in best possible health.
- **Safety**: Individuals are safe.

The interview consists of open-ended questions such as:

- What services and supports are you receiving?
- How did you have input into deciding which services you receive?
- How are you offered options of services and supports?
- Who is providing your supports and services?
- How did you have input into choosing who provides your services?
- How were your service providers selected?
- What do you know about your rights as a citizen?
- How does your WSC provide you with information about your rights?
- What rights are most important to you?

The QAR ultimately determines within each area if certain findings need to be reported as applicable for each person interviewed. The actual questions asked may vary from interview to interview depending on the needs of the person being interviewed and the person's communication style. In addition, where a person lives will drive what areas are reviewed and questions asked.

Health Summary - Data specific to the individual's health and safety in all settings are collected using the Health Summary tool. The Health Summary is incorporated into the interview tool and 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 Health Summary is used to assist in identifying any health and behavioral issues/concerns. Discoveries are generated when applicable, and these are shared with the WSC and APD via the PCR Report.

If the face-to-face PCR interview occurs 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 may be announced or unannounced. If it is announced, it 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. Although observations may be conducted following the interview with the person, the information attaches to the providers PDR report.

Support Coordinator/Consultant Interview

Following the face to face interview with the person, the reviewer uses the WSC Interview Tool to conduct 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;
- Ensure the protection of individual rights and fair treatment
- Ensuring appropriate preventative medical services and treatment are obtained

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.

Support Coordinator/Consultant Central Record Review

The final component of the PCR is a review of the individual's record maintained by the support coordinator using the Support Coordinator or CDC+ Consultant service specific record review tool. In addition to the two PCR records, the QAR will select one

unannounced record for inclusion in the WSC's Provider Discovery Review (PDR). Review of records covers the prior 12 month period preceding the review and determines whether:

- Support plans are based on identified needs and preferences of the individual;
- The individual's preferences were taken into consideration;
- The individual is supported to choose services;
- The individual is supported to choose service providers
- The individual is supported to drive service delivery including when and where services are rendered;
- The individual's satisfaction with supports and services is addressed.
- The individual's health and safety needs were addressed;
- There is collaboration between service provider and the support coordinator;

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;
- Services are delivered in accordance with the individual's Cost Plan
- Billing requirements are met;
- Incident report requirements are met;
- Provider documentation is in the central record.

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 billing discrepancy 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 PCR Individual Interview Tool.
3. Documentation Review – stable and precise review of the individual's Central File, Medical Information, Health Summary, 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 Summary 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 Summary 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 Regional Medical Case Manager or the Regional Behavior Analyst. If during the time of the Person Centered Review, either based on information gathered from the WSC 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 Urgent Care Visits in the past 12 months
- 4 or more antiepileptic medications
- 4 or more psychotherapeutic medications
- 4 or more medications for chronic conditions
- 3 or more injuries requiring medical care within 6 months
- 2 or more Baker Acts
- 2 or more falls in the past 12 months
- Skin breakdown
- Weight gain or loss of more than 10 pounds in the last 12 months

- Medications known to cause Tardive Dyskinesia (TD)
- 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 Managers approve 100% of reports prior to dissemination.

Reports are mailed to the WSC, 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 WSC 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 (PDR) 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 accountability to Medicaid, Medicaid Waiver, AHCA and APD standards. The PDR process uses a well-rounded approach where information is gathered from interviews with individuals receiving services, interviews with provider/staff, review of agency policies and procedures if applicable, review of general provider practices, review of individual service records and observations of licensed residential and day training facilities. The PDR process:

- ✓ Centers around the provider's service delivery system
- ✓ Evaluates performance in delivering appropriate services and supports to assist the person in achieving personal goals/outcomes and meeting identified needs
- ✓ Assesses quality, billing and compliance with Waiver Handbook, Florida Administrative Code, and other state requirements, rules, and policy

This holistic approach ensures information is gathered directly from individuals receiving services while allowing providers the opportunity to demonstrate their adherence to person-centered planning and compliance with standards as set forth by CMS and the DD Waiver Services Coverage and Limitations Handbook.

Eligibility Criteria

Each provider identified as meeting eligibility criteria is required to participate in an annual Provider Discovery review at least once each contract year. However with the exception of Support Coordinators those providers whose overall PDR score in the previous year meets "deemed status" criteria may skip a year of review. The contract year is defined as the period from January to December. Deemed status criteria are determined on an annual

basis by AHCA and APD and can be revoked statewide or for a given provider at the discretion of either entity. It should be noted the annual PDR schedule is driven by the volume of providers eligible for a PDR review each year. Annual PDRs may not always be exactly 12 months apart.

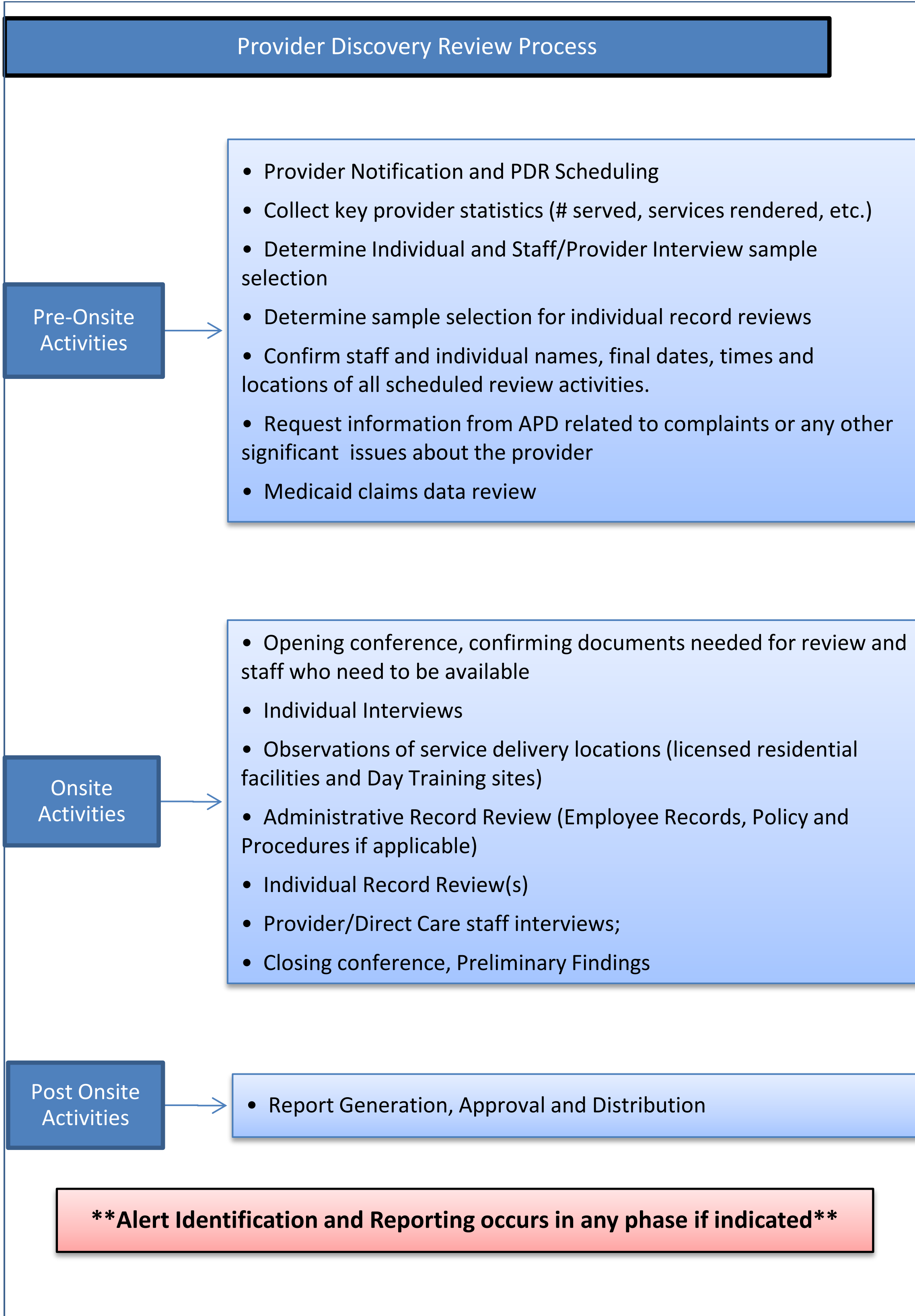
A provider becomes eligible for a Provider Discovery Review when services have been rendered and billed for at least 6 months for one or more of the following services:

- Behavior Analysis Services
- Behavior Assistant Services
- Residential Habilitation Standard
- Residential Habilitation Behavior Focus
- Residential Habilitation Intensive Behavioral
- Life Skills Development 1 (Companion)
- Life Skills Development 2 (Supported Employment)
- Life Skills Development 3 (Adult Day Training)
- Personal Supports (In-Home Supports, Personal Care Assistance, Companion)
- Respite Care (under 21)
- Supported Living Coaching Services
- Specialized Medical Home Care
- Waiver Support Coordination/CDC+ Consultant
- CDC+ Representative

The provider becomes eligible for review once this criterion is met for one service. At the time of the review, all eligible services provided within the previous 12 month review period will be included in the PDR.

Procedures and Methods for Reviews

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


Provider Discovery Review Process
Pre-Onsite Activities
• Provider Notification and PDR Scheduling
• Collect key provider statistics (# served, services rendered, etc.)
• Determine Individual and Staff/Provider Interview sample selection
• Determine sample selection for individual record reviews
• Confirm staff and individual names, final dates, times and locations of all scheduled review activities.
• Request information from APD related to complaints or any other significant issues about the provider
• Medicaid claims data review
Onsite Activities
• Opening conference, confirming documents needed for review and staff who need to be available
• Individual Interviews
• Observations of service delivery locations (licensed residential facilities and Day Training sites)
• Administrative Record Review (Employee Records, Policy and Procedures if applicable)
• Individual Record Review(s)
• Provider/Direct Care staff interviews;
• Closing conference, Preliminary Findings
Post Onsite Activities
• Report Generation, Approval and Distribution
Alert Identification and Reporting occurs in any phase if indicated

Pre-Onsite Activities

Provider Notification and Scheduling

Prior to November 15th of each year Delmarva Regional Managers develop annual PDR and PCR schedules for the following contract year, identifying the quarter a provider will receive an onsite visit. All providers meeting eligibility criteria will receive an onsite visit unless otherwise requested by APD and AHCA.

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. Additionally this letter informs the provider that a QAR will contact the provider up to 30 days prior to the date of the review. 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 will also direct the provider to the FSQAP website location to access this procedure manual and the current review tools. Providers who do not have internet access are directed to contact our customer service department. The relevant sections of the manual will be mailed to providers at their request. The QAR documents all calls/contact efforts to the provider in a contact log.

Collect key provider statistics (# served, services rendered, etc.)

During this initial phone call the QAR describes the process to the provider, including the provider's role in scheduling individual/staff interviews, and takes the opportunity to answer any questions the provider may have. The following is a list of discussion topics the QAR will cover during the initial contact with the provider:

- QAR introduces themselves, and explains the purpose of the call
- Inform provider there will be a short opening and closing meeting component to the review process
- Does provider operate in any other APD Area(s)?
- When applicable how many licensed residential facilities and/or day program locations does provider have?
- Request a list of individuals served by service
- Request a list of employees by service (including date of hire)
- Inform provider information will be used to determine individual/staff interview selections
- Select a PDR review date that falls sometime within the next 30 days
- Provide a link to our website and refers the provider to the tools on our website
- Provide a link to this Operational Policies and Procedure Manual and Discovery Review tools

- Explain a person may decline to participate in a PDR interview; another name will be randomly selected.
- Discuss provider role and responsibility with scheduling interviews.
- Explain based on number of people served and number of services rendered individuals and staff will be randomly selected to be interviewed
- Confirm primary provider contact information and make ensures the provider has QAR contact information
- Answer any initial additional provider questions

Subsequent QAR calls to the provider will be made in order to:

- Provide individual and staff names sampled to be interviewed
- Enlist Provider assistance with scheduling interviews
- Inform provider the individual may decline to participate in a PDR interview. If this happens another name will be randomly selected. Providers/Staff however may not decline and must participate in the interview process.
- Finalize and confirm individual interview times and locations.
- Finalize and confirm Provider/staff interview times and locations
- When applicable confirm dates and times for day training and/or licensed residential facility observations
- Confirm PDR review date and time to include Administrative and Service Record Reviews

This information also allows for planning on the part of the provider to ensure staff availability during the review timeframes, including agencies making other staff available to assist in the review process if the administrator/owner is not available.

Individual Interview, Staff/Provider Interview and Record review sample selection

Individual Interview sample selection

The PDR includes face-to-face interviews with individuals receiving services to capture the individual's perspective regarding the effectiveness of supports and services in meeting stated goals and needs. In keeping with the expectations of the Centers for Medicare and Medicaid Services (CMS) interviews with individuals are designed to assess the efficiency and quality of supports, services, planning and delivery—the support delivery system—from the individual's perspective. The number of individuals sampled per provider is based on the number of individuals served by the provider and the number of services the provider renders. Using a combination of names of individual's served and services provided gathered from the provider along with claims data the QAR will randomly select the names.

See “PDR Individual Interview Sample Matrix” below. If necessary, when an individual’s communication style limits information the QAR can gather form the person, proxies may be used to gather necessary information. If proxies are used, this information will be captured in the application for purposes of data analysis.

PDR Individual Interview Sample Matrix	
Individuals Served Per Provider	Number Individuals Sampled
1 - 9	At least 1 per eligible service, minimum of 1 per provider
10 - 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	At least 1 per eligible service, 5% of total served/max of 10

Provider/Staff Interview sample selection

As a component of each PDR a sample of provider/staff rendering services to individuals will receive a PDR staff interview. The table below describes the sampling selection for provider/staff interviews. While the provider organization will be tasked with providing a list of all staff rendering each service, the QAR will decide which staff will be interviewed.

PDR Provider/Staff Interview Sample Matrix	
Individuals Served Per Provider	Number Provider/Staff Sampled
1 - 9	At least 1 per eligible service, minimum of 1 per provider
10 - 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	At least 1 per eligible service, 5% of total served/max of 10

Individual record review sample selection

Based upon claims data, individual records are selected to ensure all eligible services rendered in the previous 12 months are represented in the sample. The individual’s records

are chosen from the eligible services and the sample size is based on the total number of people receiving eligible services and the total number of individuals served by the provider. Individuals that are sampled to be interviewed will have a full file review. An individual receiving more than one service counts for those services. Additional records will be reviewed as needed to cover all services and meet the unannounced record requirement. The matrix below describes sample selection for PDR individual record reviews.

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

The matrices above do not apply to Waiver Support Coordinators (WSC). Each WSC will have two individuals sampled from their caseload to be interviewed. The WSC is the provider interviewed related to each of the two individuals. And a third unannounced record will be selected once onsite.

For Waiver Support Coordinators, two record reviews will be completed as part of the PCR process. 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 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.
- Individuals 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.

Request information from APD related to complaints or any other significant issues about the provider

Current PDR and PCR schedules are sent to each APD Region on a weekly basis. Specific APD Regional staff has access to current schedules via the FSQAP reporting system for authorized viewers. This serves as formal notification and 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.

Medicaid Claims Data Review

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.

Onsite Activities

The PDR takes place where the records are maintained. This could be an office, group home or the provider's home. Any deviation from the provider's office location has to be approved through AHCA.

Unannounced records will be sampled once onsite.

Opening conference, confirming documents needed for review and staff who need to be available

Once onsite, the QAR will conduct a brief opening conference with the provider. The purpose of the opening conference is to establish the framework for the PDR process and outline expectations for both Delmarva and the provider. This initial meeting includes introductions and an opportunity to confirm:

- The name of the primary contact identified by the provider for all aspects of the PDR process and staff who need to be available

- PDR Individual Interview schedules including names, address, times, location, contact numbers
- PDR staff interview schedules including names, address, times, location, contact numbers
- Lists of all staff rendering services eligible for review
- Documents needed for review

PDR – Individual Interviews

A PDR Interview Tool is used to gather information as part of face to face interviews with individuals receiving services. The purpose of this interview is to gather information specific to the person's desired goals, outcomes and satisfaction with services from the individual's perspective.

The interviews also help the QAR determine whether services are effectively implemented in accordance with the person's unique needs, expressed preferences and decisions concerning his/her life.

If family members or others close to the person are present during the individual interview, the QAR, with the permission of the person, may gather additional information related to service delivery and satisfaction. This information may be needed to corroborate information if there are significant gaps in information provided by the person.

The Interview will cover four key Quality Areas…

- **Person Centered Supports**: Individuals needs are identified and met through Person Centered Practices
- **Community**: Individuals have opportunities for integration in all aspects of their lives including where they live and work. Access to community services and activities and opportunities for new relationships
- **Health**: Individuals are in best possible health
- **Safety**: Individuals are safe

Quality Areas reviewed and questions asked will be driven by the specific service(s) the provider renders to the person being interviewed. For example questions related to where a person lives will be asked only if provider renders Residential Habilitation, Supported Living or possibly Personal Supports if rendered in a Supported Living setting. Additional detail outlining what questions will be asked based on service(s) rendered is written into the header of each Quality Area within the tool.

Provider/ Staff Interviews

The QAR will conduct Provider/staff interviews with staff identified by the QAR. Information will be gathered using the Provider/Staff Interview Tool. This process ensures providers have a voice in the process and an opportunity to describe their practices in service delivery.

Keys areas covered will include, but not be limited to:

- Person Centered Practices: Individual's needs are identified and met through Person Centered Planning.
- Community: Individuals have opportunities for integration in all aspects of their lives including where they live, work, access to community services and activities, and opportunities for new relationships
- Individuals are in best possible health
- Individuals are safe

Observations of service delivery locations (licensed residential facilities and Day Training sites)

Observations are conducted by the QAR at licensed residential and day training service locations. The focus of these observations is used to make determinations in the following key areas:

- Autonomy and Independence
- Community Opportunity
- Privacy Dignity and Respect
- Physical Environment
- Medication Management
- Restrictive Interventions
- Abuse, Neglect and Exploitation

During the observation component of the PDR, individuals who agree to participate are informally engaged in conversation to determine how supports and services are being provided and to determine their level of satisfaction with the provider. Provider/Staff on the premises are also included in conversations related to any of the key focus areas.

An Observation Review Checklist is used as a guide and reporting mechanism for the QAR to document any findings. Observations may be announced or unannounced and occur at all day program facilities and up to a maximum of 10 licensed residential facilities per provider. All licensed facilities receiving funding for any level of Residential habilitation are required to have onsite observations as part of the annual PDR. Observations can occur anytime during the year prior to the annual PDR as either announced or unannounced. Sometimes the observation may be done when an individual chooses to be interviewed at the home.

Any facility observation conducted prior to the annual PDR will count in that year and will not need to be cone again during the formal scheduled review. However, if the provider has more than 10 licensed residential facilities, a maximum of 10 sites are observed per contract year (January – December). The homes not seen in one year are slotted to participate in an observation the next year until all facilities have been reviewed.

The numbers of licensed residential facility locations are selected as follows:

Number of Licensed Residential Facilities	Number of Licensed Residential Facilities receiving an Observation
1 to 10	1 per home
11 or more	A maximum of 10 different homes

Administrative Review

Policy, Procedure and General Practice

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. 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 and are reviewed as applicable.

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 incident tracking, and grievances.

Solo providers not required to have formal policies and procedures at this time; however they are expected to make available all incident reports, related follow-up, grievances, etc. at the time of the review. The PDR Administrative Process is an opportunity for the provider, whether agency or solo, to discuss or demonstrate any processes and procedures and their overall approach to service delivery.

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 Waiver Coverage and Limitations Handbook is also included as part of this record review. Evidence of employee qualifications and completion of background screening requirements is 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, to include a minimum of three employee records, where available. For support coordination agencies, a maximum of three staff records are reviewed.

PDR Employee Record Sample
Minimum of 3 per provider, at least 1 per eligible service

Individual Record Reviews

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 relevant Medicaid Developmental Disabilities Waiver Coverage and Limitations Handbook standards.

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 potential billing discrepancies. At a minimum documentation review includes a review of Support 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.

Provider Discovery Reviews (PDRs) CDC+ Representatives

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 the individual's file.
  - Monthly spending procedures and corrective actions are followed.
  - Current Employee job descriptions are maintained in the 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 the regional APD office 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 regional APD within two business days of the incident. Delmarva QA Supervisors take the lead on reporting alerts.

Closing Conference, Preliminary Findings

At the conclusion of the PDR the QAR meets briefly with the provider and/or staff identified by the administrator/owner to provide a brief overview of the findings associated with the PDR.

The provider is given a Preliminary Findings worksheet which enables the provider to address areas requiring improvement in preparation for remediation activities with APD

and to confirm SSRR standards cited by the reviewer. The Preliminary Findings worksheet identifies SSRR service standards reviewed at the time of the onsite visit including the identification of potential billing discrepancy items and alerts that are scored Not Met. . It is important to note this information should not come as a surprise to the provider due to interactive sharing and feedback provided throughout the PDR. Both the QAR and the provider sign the Preliminary Findings worksheet and a copy is given to the provider to help ensure all participants have a clear understanding of review findings. 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 (if applicable) and training and qualifications of staff.

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 founded complaints or grievances against the provider, if available.

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.

Delmarva 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 applicable to standards of performance related to noted billing discrepancies. These standards are identified on the Provider Discovery Review report under the heading **Billing Discrepancies 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 **Billing Discrepancy Detail**.

- **Important Note:** Documentation not made available at the time of the initial review will not be accepted for a Reconsideration Review. All documents pertinent to the reconsideration request must be sent at the same time. Only one request for reconsideration per PDR will be processed.

If you disagree with the findings related to the documented billing discrepancies in your Provider Discovery Review (PDR) report, you may request a Reconsideration Review. The Reconsideration Request must be made in writing and received within 30 days of your receipt of the annual PDR report. If the request is not submitted in the 30 days, it will not be accepted and the request will be deemed ineligible. You have the option of submitting the Reconsideration Request by hand delivery, mail or by fax to the Tampa or Tallahassee address/Right Fax number located below. Upon receipt, your Reconsideration Request will be entered into a tracking system to ensure Delmarva completes the Reconsideration Report within 30 days of receipt of your request.

To submit a Reconsideration Request you **must** fill out the Reconsideration Request form located on our website at 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
- Billing discrepancy 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
(888) 877-5993 Fax

Tallahassee Office
2039 Centre Pointe Blvd.
Suite 202
Tallahassee, FL 32308
(850) 671-5044
(888) 877-5993 Fax

A review of the Reconsideration Request will be processed and a report generated within 30 days. If you do not receive your Reconsideration Report shortly after the 30 days, please contact our Customer Service Representative at 1-866-254-2075.

Final Note: Reconsideration Request submissions should only include documentation related to the request. Please forward other documents related to APD remediation plans, corrective action plans or corrected documentation to your Regional APD office if and when requested.

Revision Date	Change Description/Purpose
2015- 0119	**Revised procedures per contract amendment**
2014_0131	Changed “recoupment” to “billing discrepancy” throughout document; Added the updated Reconsideration Procedures.
2013_0328	Revised Cover page to include statement **“**The Contractor maintains review/revision oversight of this document. This document is considered current until otherwise notified by the Contractor.”
2011_0905	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
2010_1001	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. 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: • Support Coordinators who work in multiple Areas will have 2 PCRs sampled for each Area they serve in. • 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. **Removed Said Sanchez’s name – page 7**

2011_0601	Revised - DD Handbook was added to Explanation of Terms, page 4 Corrected - 'Centers for Medicaid & 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 Revised- Observation of Interview Environment to Observation of the Service Delivery Locations, page 15 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 billing discrepancies', pages 7 and 29. Revision – description of confirmation letter to CDC+ participants, page 29.
2010_0201	New procedure
2017_0130	Updated Medical Record Request Criteria