# Provider Performance Reviews

# Desk Review Procedures

**November 2006**

# Developmental Disabilities and Family and Supported Living Home and Community-Based Services Waiver Programs

**Florida Statewide Quality Assurance Program**
**Delmarva Foundation**

**A project funded by the**
**Florida Agency for Health Care Administration in cooperation with the**
**Agency for Persons with Disabilities**

# Provider Performance Review Process Overview

## PROVIDER DESK REVIEWS

The provider desk review process is limited in scope to basic compliance monitoring of providers of the Developmental Disabilities and the Family and Supported Living Home and Community Based Medicaid Waivers. Excluded from Desk Reviews are the eight primary on-site reviewed services (Adult Day Training, In Home Supports, Non-Residential Supports and Services, Residential Habilitation, Support Coordination, Supported Employment, Supported Living Coaching, and Special Medical Home Care).

The services subject to a desk review if they meet the above criteria include:

- Non-Licensed Services
  - Behavior Analysis and Assessment
  - Behavioral Assistant
  - Chore
  - Companion
  - Homemaker
  - Personal Care Assistance
  - Respite Care
  - Transportation

- Licensed Services
  - Dietitian
  - Medication Review
  - Occupational Therapy and Assessment
  - Physical Therapy and Assessment
  - Private Duty Nursing
  - Psychological Assessment
  - Residential Nursing (if not site-visited)
  - Respiratory Therapy and Assessment
  - Skilled Nursing
  - Specialized Mental Health Services
  - Speech Therapy and Assessment
  - Therapeutic Massage and Assessment

## Eligibility

Desk reviews are conducted only for providers of desk review eligible services who have delivered services or supports for at least six to twelve months, and have served at least one individual during the most recent three month period in which claims data are available through FMMIS.

Based upon the agreed sample size for each year the following guidelines are used to identify providers who render at least one of the services listed on the prior page and who are eligible to receive a request to submit documentation to complete a desk review:

1) Any provider who had an "Alert" (includes Level II Background Screening non-compliance, identification of a threatening health, safety or abuse situation) on his/her last review.
2) Any provider who has a "Recoupment" on his/her last review.
3) Any provider last reviewed prior to two years ago.
4) Any provider who had discontinued the provision of all services which require an onsite consultation.
5) All new providers.

If these criteria do not account for the sample size for the year, the remaining sample will be chosen randomly.

## Requested Information

The desk review entails a review of provider-specific information available from the Agency for Persons with Disabilities Area Offices, the provider, Delmarva Foundation and phone interviews with individuals or their families/guardians. Information considered in the provider desk review and the sources are as follows:

Developmental Disabilities Area Offices will be asked to supply:

- Access to provider enrollment files
- Complaints and incident reports relating to the provider
- List of mandatory Area Office training sessions
- Any other pertinent information

The Delmarva Foundation will supply:

- Claims data from FMMIS specific to the provider

Solo (individual) providers are requested to supply the following information for the desk review:

- Copies of records, logs, progress notes, remittance vouchers and other documentation required for reimbursement and monitoring for a maximum of three (3) individuals, per service, who have been identified by Delmarva Foundation.
- Copies of service authorizations.
- Copies of provider training records (per service-specific requirements).

- Copies of proof of education, experience, résumé and/or licenses.
- Copies of proof of attendance at mandatory Area Office meetings/training.
- When applicable to the service, copies of maintenance logs for vehicles, copies of current drivers license, insurance policy, and vehicle registration.
- Proof of Level II background screening.
- Any other documentation demonstrating compliance with other elements in the service specific checklists

Agency providers are requested to supply:

- Copies of records, logs, progress notes, remittance vouchers and other documentation required for reimbursement and monitoring for a maximum of three (3) individuals, per service, who have been identified by Delmarva Foundation. However, providers of a single service, serving more than thirty (30) individuals, will supply information for five (5) individuals who have been identified by Delmarva Foundation.
- Copies of service authorizations.
- Copies of qualifications and training information for a maximum of three (3) staff members per service. Staff member selection criteria are: one (1) Recently hired employee, one (1) Long-term employee, and one (1) Supervisor. Only one of these employees should work with an individual selected for this review. Qualifications and training information should include:
    - Employment application, resumé, licenses/registrations or certifications as applicable or other documentation that demonstrates the employee meets the qualifications outlined for the specific service.
    - Proof of Level II background screening for those staff having direct service contact with DD and/or FSL waiver individuals.
    - Staff Training records.
    - Proof of attendance at mandatory Area Office meetings/training.
- If agency staff provides transportation services, copies of employee's current driver's license, vehicle registration(s), and proof of insurance.
- When applicable to the service, maintenance logs for vehicles will also be required.
- Any other documentation demonstrating compliance with other elements in the service specific checklists.
- Proof of the Provider Performance Review Core Assurance policies on rights, choice, abuse reporting, abuse education, grievance procedure, and health and safety respectively.
- Results of the last Self-Assessment performed, to include information gathered from individual satisfaction surveys and any quality improvement plan or corrective action measures that have been made as a result of the self-assessment, referring to the Provider Performance Review Core Assurance tool.

The review is related to service-specific requirements contained in the applicable Provider Performance Review monitoring checklists, as well as the Provider Performance Review Core Assurance elements listed above. Service-specific monitoring checklists are utilized to review providers of the above noted services.

## Program Standards

Standards being used to conduct Provider Performance Reviews are based on the Core Assurances and Service Specific requirements for providers found in the Developmental Disabilities Home and Community-Based Services Waiver Services Florida Medicaid Coverage and Limitations handbook, the Medicaid Waiver Services Agreement and Family and Supported Living Waiver Services Directory. These standards identify expectations for service delivery based on regulations and agreement requirements. The standards form the basis for uniform monitoring tools that will be applied on a statewide basis.

Review tools for services other than the eight primary services have been organized by category headings followed by elements of performance. The elements of performance are weighted (have a designated point value) in tools for all services to emphasize the significance of the element requirement. The basic weight (point value) of any element is one (or 1 point). Elements with a weight greater than one have the weight or point value identified in the Cite # column next to the element in the review tools. Elements of performance may have a weight or point value of two (or 2 points). All alert element designations have a weight or point value of 4 (or 4 points).

Information to determine compliance with the standards and elements of performance is gathered through the desk reviews. Methods of evaluation include document review, claims review, and interview.

**Service Specific Monitoring Checklists and Protocol**
Medicaid DD and FSL Waiver providers must comply with requirements identified for the specific services in their corresponding Florida Medicaid Coverage and Limitations handbooks when they have been enrolled to offer the service.

The service specific Monitoring Checklist should be completed for each enrolled Medicaid waiver service being furnished by the provider. For each standard found Not Met, the standard must be referenced with an explanation on the Comment Page in the final Summary of Findings report.

The Service Specific Monitoring Protocol provides guidelines to be used by the Quality Improvement Consultant (QIC) in the evaluation process.

After all of the information required to score the Service Specific Checklists has been gathered, the QIC should review each Checklist and corresponding Protocol to determine any remaining questions, or additional information which may be needed to clarify a compliance determination.

The QIC makes note of any elements of performance not being met, which may require recoupment. The Area Office is provided with sufficient details to support the findings for recoupment, which may include copies of relevant materials. Details should include:

- A record identifier (individual‘s first name and first letter of the last name) to facilitate Area Office follow up;
- Indication of type of documentation required, but missing;
- Narrative description of deficiency;
- And, hard copies of documentation, and the relevant dates or review period, when available.

These elements of performance are associated with documentation of services and supports required for reimbursement and/or monitoring, (referred to as “reimbursement documentation” or “monitoring documentation” in the Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook and the Family and Supported Living Waiver Services Directory). If a provider does not meet reimbursement or monitoring documentation requirements the QIC flags the report identifying to the Area Office that recoupment of funds may be warranted and that follow-up is needed.

The QIC keeps a record of the sample used for each review. The record will be kept for both individuals and staff. The QIC will note the individuals’ first name and the first initial of their last name.

**Summarizing Results**

Any standards found to be **Not Met** on the Checklist must have a corresponding comment indicating the reason. Each comment should reference the element of performance (by number) and clearly describe the findings that resulted in the requirement being judged as **Not Met**.

When completing the checklist and making compliance determinations the QIC will make every effort to cite a deficiency under the single most appropriate element of performance. It is not necessary to “domino” deficiency results unless conditions clearly warrant this level of citation.

When the QIC has completed this phase of the evaluation process, he/she finalizes compliance determinations and summarizes findings using the laptop computer and software application.

In the laptop application, consultants will also identify whether there are compliance issues that may result in an alert or recoupment. If for those elements where recoupment or an alert is applicable, when the QIC marks the element “not met,” the application will show that this element is an alert or where potential recoupment may apply. The report will identify if the provider is required to submit a Documentation Submission. While all deficiencies noted are expected to be corrected by a provider, submission of a Documentation Submission is dictated by a provider’s overall score for the review. See Follow Up Documentation Review Procedures section for further details.

If the provider is cited for a background screening alert, the QIC must contact the designated APD Area Office person and provide them with the name of the person who is not in compliance and why. The QIC will document in the report at the element level that the APD Area Office was notified.

The QIC completes the Narrative Summary containing information including but not limited to; service score influences, statements about service and support provision, billing issues, Individual/Family contact results, and incidents, complaints/grievances obtained from Area Offices, etc.

**Conciliation and Scoring**

The following table represents the general rules for making a determination of provider compliance with the Developmental Disabilities and the Family and Supported Living Home and Community Based Medicaid Waiver elements of performance.

**SCORING MATRIX**

| | **MET** | **NOT MET** |
|---|---|---|
| Records Review – as assessed for any single element of performance, (other than elements re: rights, health & safety) | No record is missing the required element of performance | A record is missing the required element of performance. |
| Rights, Health & Safety | No evidence of individual rights, health or safety violations | Any evidence of individual rights, health or safety violations |
| Alert Items | Any element designated with a bell indicates an alert. No evidence of alert items. | Any evidence of an alert item. |
| Staff Qualifications | Evidence that the provider/staff meet the required qualifications of the service(s) rendered | Any evidence of the provider/staff not qualified to render the services. |
| Staff specific training requirements | Evidence that the provider/staff have the specific required training identified in the element. | Any evidence of the provider/staff not having the specific required training identified in the element. |
| Recoupment Items | No evidence of recoupable items | Any evidence of recoupable items |

| | | |
|---|---|---|
| Qualitative Standards (for example, elements of performance that address progress on or achievement of individual goals, receipt of services in the least restrictive most normalized manner, community inclusion activities, active solicitation by the provider of individual opinions and choices, and/or elements of performance that are more subjective in nature) | The quality of services provided presents no risk to the individual, enhances the individual's quality of life and/or the individuals' skills and abilities. | Any instance where the quality of the services provided have the potential to place the individual at risk, are unnecessarily restrictive, fail to enhance the individual's quality of life, do not present opportunities for growth and skill development, and/or fail to address individual's goals. |

***Note: The software application will perform the following steps for the QIC upon completion of the applicable checklists. The following procedures identify how the software will calculate the Summary of Findings report:***

1. Final results of the evaluation are entered on a Service Specific Summary of Findings page.
2. Each service monitored is listed on the Summary of Findings form under the "Service Specific" or section heading. Section totals and a total score per service are calculated. Calculations to determine the "Number of Standards Met" and the resulting "Percent of Standards Met" are completed in the same manner as noted above.

**Note: Findings related to all services provided will be included in one report.**

3. The overall score is determined by adding the Service Specific totals. Dividing the grand total of standards met by the grand total of available standards and multiplying by 100 determines the grand total of percentages. The resulting percent is noted in the appropriate space under "Percent of Standards Met."

**Delmarva will notify the appropriate Area Office designee of any alerts identified prior to the report generation. They will identify the provider or agency staff to whom the alert applies.**

**Final Report**

The completed Summary of Findings Report is considered the final report for the monitoring review. The report contains:

- Provider Information
- Reviewer Name
- Numerical results of scores for the service(s) specific review including the percent of standards met.

- Service Specific Comment Page(s) indicating areas requiring improvement
- Notation when a documentation submission is required and the timeframe in which it is due
- Notation when recoupment issues have been identified
- Notation when alert(s) have been identified

If a Level II Background screening alert was scored as "not met" at the element level, the QIC will identify the provider/staff first name and last initial and the specific reason for the deficiency. Also, included in this section, the QIC will identify the notification of the APD Area Office designee.

Within 30 days of the review date, Delmarva headquarters will send a copy of the final report to the provider, the appropriate APD Area Office, and have the report made available through the FSQAP website to AHCA and the APD Central Program Office.

**Reconsideration Process**

Upon receipt of the Summary of Findings report, the provider has an opportunity to request a review or reconsideration of those findings. If the provider believes the documentation originally submitted meets the requirements of the element marked as Not Met, the provider must request a reconsideration of findings within 30 days of receipt of the final Summary of Findings report from Delmarva. The provider's request for reconsideration must be in writing to:

**Delmarva Foundation**
8875 Hidden River Parkway, Suite 275
Tampa, FL 33637

The written request must reference **Reconsideration Request** and include the following information:

- Provider Medicaid ID Number
- Provider name and address
- Review date
- Consultant's name
- Element(s) of performance for which reconsideration is being requested
- Reason for reconsideration request, by element(s) of performance
- Documentation to support reconsideration
- Person to contact and phone number

The appropriate person will review the Reconsideration Request and consult the final Summary of Findings report for the provider. If necessary, the QIC who performed the review will be consulted to clarify the determination made, to review the subject of the Reconsideration, and to make a determination if a request can be granted immediately or if it requires more intensive review. Regional Managers, PPR Coordinator and selected consultants may review Reconsideration Requests.

All Reconsideration Requests will be resolved within 60 days of the receipt of the Reconsideration Request. All Reconsideration Requests will be tracked to their resolution. Follow-up on the elements of performance that are the subject of the Reconsideration Request will be delayed until the reconsideration process is complete.

Whenever reconsideration results in a change in the Summary of Findings for a provider a report with an amended score will be submitted to the provider, the Area Office and made available to AHCA, and the APD Central Program Office within 30 days of the final reconsideration resolution. If the element of performance determination stands as originally noted by the reviewer, the provider will have 30 days from receipt of the reconsideration resolution before follow-up activity is initiated.

Use of the Reconsideration process does not eliminate the provider's right to appeal. Providers may contact their local Area Office for more information regarding fair hearings and formal appeals procedures.

## Recommended Action for Failure to Correct Deficiencies

It is the desire of AHCA and APD that the Florida Statewide Quality Assurance Program (FSQAP) encourage providers to improve and enhance services to individuals by embracing a person-centered approach and adequately supporting individuals in their personal goals while maintaining and remaining compliant with all rules and regulations identified.

In the event a provider subject to a Desk Review fails to submit the requested documentation after receiving two written requests, the FSQAP will notify the AHCA and APD to pursue further action as deemed necessary.

## Follow Up Documentation Review Procedures

The follow-up documentation review is prompted when a completed desk review of the Developmental Disabilities or the Family and Supported Living Home and Community-Based Waiver provider scores below 90% or has alert items scored "not met." The table below identifies eligibility for a Follow Up Documentation Review and the provider's required actions for responding to their Desk Review results.

| **Desk Review Results** | **Follow-up Documentation Review Requirements** |
|---|---|
| 89% or below with no alerts | Documentation submission addressing all not-met elements to DF within 30 days of report receipt. |
| Any score with an alert | Documentation submission addressing all alert elements to their designated Area Office within 10 days of notification by the Area Office. |

| | |
|---|---|
| | This documentation also should accompany the documentation submission within 30 days of report receipt. |

This type of review can also be utilized for the minimum service requirement elements scored "not met" on an onsite Collaborative Outcomes Review and Enhancement (CORE) consultation scoring at "Achieving" or "Implementing" with no alerts. Please note this review does not require a quality improvement plan (QIP). The review of required documentation eliminates the need for a QIP in the situations outlined above.

The follow-up documentation review entails a review of documentation specific to the correction of elements scored "not met" on a desk review. Due to the nature of the desk review covering only requirements that can be documented, this process offers a clear, concise means of determining compliance with Medicaid Waiver standards. The follow-up documentation review is an ideal choice for determining compliance with elements scored "not met" on an onsite CORE consult that can be reviewed via documentation (e.g.- training certificates, service authorizations, etc.). This method allows the reviewer to determine compliance without traveling to the provider's location, and provides a follow-up determination without further interference in the provider's service delivery schedule.

The follow-up documentation review is processed in a centralized location at Delmarva Foundation's regional office in Tampa. The PPR Coordinator conducts these reviews by reviewing the original PPR report and determining if the documentation submitted meets the requirements of each element cited as "not met."

The PPR application will be utilized to develop a review report based on corrected elements. In the Summary of Findings section, the report will identify those elements originally scored as Not Met and whether the documentation submitted is in compliance with the standard. Supporting documentation as to whether the element is scored as Met or remaining Not Met will be included. The percentage of the elements corrected will be identified on the report. The report will also indicate if the local Area Office needs to provide technical support to the provider.

The report will be sent to the provider indicating acceptance or denial of their documentation and the reasons for denials. Copies of the report will be sent to the provider, and the APD Area Office and made available to the Agency for Health Care Administration (AHCA) and the APD Central Office.

The PPR Coordinator will track provider compliance with these reviews and log in the date of receipt of documentation into the tracking system database. Delmarva will in turn report any incidents of non-compliance to AHCA, with copies going to APD and the provider. Non-compliance is defined as not responding **within required timeframes** of receipt of the PPR report. Reviews that identify extreme cases of non-compliance can result in more intensive follow-up with a provider. Selected providers may receive an

onsite follow-up review or a technical assistance follow-up review as defined in criteria developed for these follow-up procedures.