agency for persons with disabilities
State of Florida

SUBJECT	YEAR	PROCEDURE NUMBER
PROVIDER RECOUPMENT AND OVERPAYMENT FOR SERVICES FUNDED BY THE HOME AND COMMUNITY-BASED SERVICES WAIVERS	2007	APD 18-002

PROCEDURE MAINTENANCE ADMINISTRATOR: Community Development

PURPOSE: The Developmental Disabilities Waiver Services Florida Medicaid Coverage and Limitation handbook (the handbook) and the Family and Supported Living Waiver Services Directory furnish regulations and procedures relating to documentation required for reimbursement and monitoring; as well as service activities and requirements necessary to receive payment for services provided under the Medicaid Home and Community-Based Services waivers. Service providers are required to implement requirements of the handbook and Services Directory (the Directory) for each service for which they are claiming reimbursement and are authorized to perform. When a provider fails to implement services in accordance with handbook or Directory requirements, or does not have documentation required for reimbursement or monitoring purposes, funds paid to the provider for the service may be recouped through Medicaid. The handbook identifies those requirements that must be met in order to avoid recoupment.

Providers who were reimbursed for services that were not performed, or that were performed in excess of what was authorized, or services and activities that were performed outside the limitations of the handbook or Directory, are subject to recoupment of funds as overpayment.

Providers suspected of fraud and/or abuse of Medicaid funding will be referred through the APD Central Office to the Agency for Health Care Administration Medicaid Program Integrity Unit and/or the Department of Legal Affairs Medicaid Fraud Control Unit using the procedures identified in this policy.

1. SCOPE:

These procedures outline responsibilities and activities that each APD Area must implement for recoupment or overpayment of funds from an identified provider related to services funded through the Home and Community-Based Services Waivers (HCBS waivers). These procedures will be uniformly applied statewide. For the purpose of implementing this operating procedure, APD will target recoupment for violations identified beginning in 2007. This does not limit the ability of APD or other agencies to recoup for violations defined as overpayment in prior years, nor limit recoupment activities due to fraud.

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2. AUTHORITY:

Chapter 59G, Florida Administrative Code

3. DEFINITIONS:

The following definitions are provided to clarify activities associated with implementation of this operating procedure.

Agency for Persons with Disabilities (APD) is the Agency responsible for services to eligible individuals with Developmental Disabilities. APD is responsible for the operation of the HCBS waivers within the State.

Agency for Health Care Administration (AHCA) is the Medicaid Agency for the State of Florida. AHCA administers the Developmental Disabilities and Family and Supported Living waivers and the Medicaid claims process.

Contracted Quality Assurance Provider – an organization under contract with the Agency for Health Care Administration to provider statewide quality assurance for the Developmental Disabilities and Family and Supported Living waivers. The current contractor is the Delmarva Foundation.

Delmarva Foundation (Delmarva) – Also referred to as the "contracted quality assurance provider," Delmarva is a quality improvement organization recognized by the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services as a Quality Improvement Organization (QIO). Delmarva has been awarded a contract to implement quality assurance oversight statewide for all services for persons with developmental disabilities that are funded through Florida's Developmental Disabilities and Family and Supported Living Home and Community-Based Services Waivers.

Family and Supported Living Waiver Services Directory – The Family and Supported Living Waiver (FSL) is a Medicaid program which provides funding for home and community-based supports and services to eligible persons living in their own home or family home. This includes both children and adults. FSL offers twelve services with funding cap limits. The FSL Waiver Services Directory provides a description of services available, limits, provider enrollment qualifications and enrollment procedures.

Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook – The Developmental Disabilities (DD) Waiver is a Medicaid program that provides home and community-based supports and services to eligible persons with developmental disabilities who live in their own home, family home, or some residential facilities. The Coverage and Limitations Handbook explains covered services, their limits, provider enrollment procedures, qualifications, responsibilities and place of service delivery.

Medicaid 081 form or Non-Institutional Other 081 Form – An electronic or paper Medicaid form which may be used to file an adjustment or void for billing errors. Adjustments and voids replace the original claim. Adjustments may be processed electronically through WINASAP electronic billing software. The printed 081 forms may be ordered from ACS and instructions for completion are available on the internet at www.Floridamedicaid.acs-inc.com. Go to Provider Support, click on Medicaid Forms, then link to order forms.

Overpayment – For the purpose of this operating procedure, overpayment is considered (a) Provider payment for services that were not delivered or for which there is no documented evidence of delivery; (b) Payment for services that were not authorized, or were performed and paid in excess of the authorization for service; or (c) Payment for services that were not performed in accordance with handbook requirements/limitations. All confirmed overpayments require repayment.

Provider Reviews– Medicaid Waiver Providers – Quality assurance or investigative reviews conducted by the contracted quality assurance provider (Delmarva), the APD Area office, AHCA, or a designated representative for APD or AHCA. The reviews to determine a provider's success in meeting outcomes for an individual and/or the provider's ability to meet minimum

service and rule requirements, as stipulated in the Medicaid Waiver Handbook. For information on types of reviews performed by the contracted quality assurance provider, refer to Delmarva procedures listed on their web site www.dfmc-florida.org.

Quality Assurance or quality assurance reviews – The process used by the Agency for Persons with Disabilities or its designated representative(s), for determining the level of performance and compliance with program requirements for contracted service providers, and the perception of consumers of services on their quality of life as impacted by those supports and services. Information from this process is used by APD Area offices and the central office of the Agency for Persons with Disabilities to improve the quality of both services and quality of life outcomes for people with developmental disabilities and their families.

Quality Improvement Plan (QIP), or Quality Enhancement Plan (QEP) – Based on the results of quality assurance reviews, a quality improvement or enhancement plan may be required of a provider to address improvements necessary to meet individual outcomes, rule and billing requirements, or service delivery expectations.

Recoupment – A collection or reimbursement of disbursed Medicaid funds from a provider due to findings of quality assurance reviews, investigations or audits that indicate a payback of funding received by the provider.

Recoupment Finding – A recommended finding of quality assurance reviews, investigations or audits indicating that required documentation was not found to justify expenditure of waiver funding for a specific service, or that services were billed in excess of what was authorized for an individual(s), or that a provider billed and was paid for activities that are beyond the limitations of the handbook. APD Areas are responsible to follow up on such findings to determine whether recoupment is warranted, and the amount of the recoupment a provider must repay to the state in reimbursement.

Trend – Confirmed findings or recoupment citations that are repetitive which shall lead to further evaluation of overall potential level of recoupment impact (refer to the Recoupment Chart).

4. Area Responsibilities

The following procedures will be implemented when recoupment or overpayment is identified. Recoupment or overpayment may be recommended by the contracted quality assurance provider as a result of a provider performance review, or may be identified by the APD Area or the Central Office for the Agency for Persons with Disabilities, the Agency for Health Care Administration, the Office of the Attorney General/Department of Legal Affairs or an agent of these agencies through investigations or provider audits.

A. General Instructions:

1. Area staff will review reports received from the contracted quality assurance provider or other investigative sources to determine whether recoupment deficiencies are noted and recoupment warranted, whether due to error or falsification. Recoupment must be in accordance with Medicaid rule. Each Area will determine, based on the detail provided in the report and in this policy, the amount of the recoupment to be pursued. Recoupment/overpayment shall be pursued for findings of quality assurance reviews, investigations or audits that indicate:

   (a) A trend or pattern denoting required documentation was not found to justify expenditure of waiver funding for a specific service; or

   (b) that services were billed and paid in excess of what was authorized for an individual(s); or

   (c) that a provider billed and was paid for activities that are beyond the scope and/or limitations of the handbook or Directory,

   (d) that there is evidence of possible falsification of records, or

   (e) an overpayment was received.

2. Reports of provider annual or follow-up reviews conducted by the contracted quality assurance provider will identify deficiencies found in minimum service requirements and whether there are recommendations for recoupment. Investigations or audits from other sources resulting in recommended recoupment or overpayment activities shall also be reduced to written summary, and, as appropriate, referred to the APD Area office for review and further action.

   (a) Desk Reviews: If the provider was reviewed by the contracted quality assurance provider under the desk review procedures, no final decision on recoupment or overpayment should be made until Area receipt of the contracted quality assurance provider follow-up report or documentation review needed to close the review. The provider as part of the follow-up documentation review process may supply missing or mistakes in documentation resulting in a recoupment deficiency at the time of the desk review.

   (b) CORE and WiSSC Reviews: Area staff should proceed with recoupment activities if there is a recommendation for recoupment contained in the annual report. If a follow-up review is performed by the contracted quality assurance provider, reviewers will examine

records to determine whether documentation and other practices have been improved or corrected, however, the finding for the annual review still stands as a deficiency.

(c) If no follow up is due, then recoupment process is to begin at the close of the review.

(d) No final decision on recoupment or overpayment should be made by the Area on recoupment or overpayment deficiencies that have specifically been submitted to the contracted quality assurance provider as part of a reconsideration request until results of the reconsideration are received by the Area.

3. Upon receipt of a report or finding indicating potential recoupment or overpayment, the Area will research the extent of the findings to determine if action is warranted. For documentation issues, recoupment should be implemented only if (a) the required activity or documentation was missing for billing or (b) there are confirmed findings that are repetitive. The Area may, based upon initial findings or recommendations, perform a further review of provider records to determine the extent of the provider's non-compliance with rule requirements.

4. The Area will review appropriate ABC or FMMIS screens to assure that the provider received payment for the service(s) at the time the deficiency occurred. If the provider did not bill and receive payment, recoupment actions should not be taken.

5. When a decision is made by the APD Area that funds should be repaid by the provider for recoupment or overpayment, the Area will use guidelines in this procedure and the handbook to determine the amount of funds to be repaid. Individual and provider specific rate information, along with report detail provided by the contracted quality assurance provider or other investigative sources should supply adequate information for the Area to make repayment decisions.

6. The Area office shall have authority to implement recoupment activities if the amount of repayment is under $2,500. The Area shall also track the recoupment action through completion and submit quarterly updates to the APD Central Office (see Attachment 1 for tracking form). These actions will be reported to the Central office monthly.

7. If the amount is above the $2,500 threshold the Area office will provide a copy of the recoupment or overpayment information to the APD Central Office Quality Management unit for review and approval by the APD Deputy Director of Operations or designee prior to initiating any recoupment or overpayment activities (See Attachment 2 – Recoupment Decision Memo Template).

8. When initiating recoupment activities, the Area will:

(a) notify the provider in writing that funds are to be recouped based on review results, the specific reasons for the recoupment and of the specific amount to be repaid. (See Attachment 3 – Notification Letter to Providers Template and Sample Letter)

(b) invite the provider to meet with Area staff to plan for repayment of funds.

(c) review the financial impact of the payback with the provider and, as appropriate, agree on a payback plan not to exceed one year.

9. Recoupment may be accomplished through WINASAP electronic billing software or using the Non-Institutional Other 081 form to "reverse payments" by withholding funds from future payments.

   (a) The funds may be repaid in one billing cycle, or repaid overtime based on a plan agreed to by the provider and Area, but no longer than 12 months.

   (b) The provider must supply evidence that reverse payment has occurred through copies of the WINASAP SCREEN or an 081(s) to adjust the payments. A copy of the remittance voucher indicating successful payback will be submitted to the Area. (The Area may also verify that the adjustment was made through FMMIS.)

   (c) The Area may request assistance from the APD Central Office Quality Management unit when completing the recoupment process.

   (d) The Area may request assistance of the APD Area Provider Relations Liaisons to help in the identification of recoupment or repayment amount and relevant information.

10. For providers refusing to meet with the Area and/or to cooperate with the repayment process, the Area will contact APD Central Office Quality Management for assistance from ACHA to initiate a "Gross Adjustment Request" form. The Quality Management Unit at the APD Central Office may request information relating to the recoupment before initiating a "Gross Adjustment Request."

11. APD Central Office will notify the AHCA Medicaid Program Integrity Unit and the Office of the Attorney General/Department of Legal Affairs Medicaid Fraud Control Unit of any action being taken relative to a given service provider with regard to this policy and request the same. This action is intended as a means of ensuring open communication and minimizing duplication of effort across agencies with similar responsibilities.

B. <u>Referral of Recoupment or Overpayment to the Agency for Health Care Administration</u>

1. Circumstances meeting the criteria below are appropriate for referral to the Agency for Health Care Administration's Medicaid Services Program for transmittal to the Medicaid Program Integrity Unit for review and possible action. When referral to Medicaid Program Integrity is warranted, recoupment/overpayment citation information should be forwarded to the APD Central office Quality Management Unit, with a full description of the issue(s), detailed provider identifying information, other evidence, as well as contact information for all potential informants, as appropriate (See Attachment 4 Referral to Medicaid Program Integrity Template). The criteria for referral includes:

   - A determination by the APD Area that potential exists for a full-scale audit of the provider's receipt of Medicaid funds, or potential fraud or abuse is suspected. (e.g., the Area suspects that overbilling is a prevalent practice and may have existed for years, not just an error.)
   - If proof and/or indication of potential fraud or abuse is discovered, or
   - If other irregularities are found which suggest potential fraud or abuse;

- If chronic non-compliance or failure to cooperate by the provider is an issue; and
- If recoupment through use of WINASAP or an 081 form does not appear to be appropriate (i.e., provider has been or is being terminated, with future payments not expected to be sufficient to recoup funds).

2. Upon receipt of information submitted by the area, the APD central office Quality Management staff will review information with appropriate operational staff and make recommendations regarding appropriate action needed. If the Area referral meets criteria, the information will be referred to MPI using the Medicaid Program Integrity Intake Form.

3. Medicaid Program Integrity (MPI) will review the referral according to internal processes and take appropriate action per internal policies and practices. AHCA will notify the Agency for Persons with Disabilities of additional information needs, actions taken and any recoupment resulting from a referral.

General Guidelines for Recoupment

1. Initial Annual Review: There will typically be no recoupment for a deficiency found on the first annual quality assurance review on a new waiver provider, or on the first annual review of a new service(s) added by a provider, unless the provider is subject to overpayment, or Medicaid potential fraud and abuse is determined (refer to Recoupment Chart). The provider will receive technical assistance from the contracted quality assurance provider and/or the Area on how to appropriately correct the deficiency and will be required to complete a Quality Improvement/Enhancement Plan identifying actions that will be taken to improve and maintain compliance with service and rule requirements.

2. Subsequent reviews: If subsequent reviews identify the same or a different deficiency that indicates recoupment, then full recoupment will be pursued (refer to Recoupment Chart for guidance).

3. Each decision for recoupment will be documented by a decision memo prepared by Area staff that details the reason for the recoupment, the action to be taken, the results of the Area meeting with the provider, if appropriate, the amount to be recouped and how recoupment will occur. The memo will also indicate the impact of the recoupment on the provider's ability to continue to operate. The APD Area Administrator will conduct final review and approval of each decision memorandum and will forward to the Quality Management unit and the Deputy Director of Operations or designee as appropriate to the amount of the recoupment. A copy of the WINASAP screen(s) or 081 form(s), remittance voucher(s) verifying repayment, the gross payment form, and other appropriate documentation will be kept on file with the decision memo.

4. The Area Office will maintain a permanent file of all recoupment referrals or actions.

Note: Refer also to General Guidelines for Overpayment on page 17 (section D.)

Recoupment Chart (Based on the October 2003 Handbook, implemented June 23, 2005)

Documentation	Requirement and Recoupment Guidelines	New Provider/New Service(s) 1st or Initial Annual Review	Subsequent Reviews Resulting in Deficiency(s)
Implementation Plan ADT NRSS (if applicable) Res Hab SE SL	When an Implementation plan is required, but not present: an amount equal to the daily rate, or a pro-rated daily portion of a monthly rate for each day after the 30 calendar day time frame that a final implementation plan is not available. If Plan is present, but elements of the Implementation Plan are not present (e.g., supporting data, strategies, does not address goal), provide TA. Recoupment not recommended. (Trend: Absence of an Implementation Plan, or Plans not developed within timeframes.)	Technical Assistance Quality Improvement plan (QIP/QEP)	Full recoupment for the number of days and number of individuals determined out of compliance. QIP/QEP Consider termination of Waiver Services Agreement. And/or referral to AHCA or MFCU for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.

Recoupment Chart (Based on the October 2003 Handbook, implemented June 23, 2005)

Documentation	Requirement and Recoupment Guidelines	New Provider/New Service(s) 1st or Initial Annual Review	Subsequent Reviews Resulting in Deficiency(s)
Monthly Summary (Also applies to Monthly Summary Notes in Non-Core Services) ADT IHSS NRSS (if applicable) Res Hab SE SL (progress notes)	A summary note of the month's activities indicating the individual's progress toward achieving support plan goals. An amount equal to a daily rate or a pro-rated daily portion of a monthly rate for each month that a monthly summary (monthly service log and progress notes for Supported Living) was not available (Trend: Absence of monthly summary(s), or Monthly Summary Notes. This includes situations where the Monthly Summary(s) is present, but no description of progress is contained in the summary and is required.)	Technical Assistance QIP/QEP	An amount equal to a daily rate for each month and each individual determined out of compliance (e.g.: 3 individuals missing summaries for 6 months = daily rate X 3 individuals X 6 months.) QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA or MFCU investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.
Annual Report ADT NRSS (if applicable) Res Hab SE SL	A written report documenting the individual's progress toward support plan goals(s) for the year. Submitted to the support coordinator no later than 30 days prior to the support plan year-end. (Trend: Absence of annual reports. This includes situations where the Annual Report(s) is present, but no description of progress is contained in the report and is required.)	Technical Assistance QIP/QEP	An amount equal to a daily rate for each month and for each individual that the documentation was not available. (e.g.: 3 individuals missing summaries for 6 months = daily rate X 3 individuals X 6 months.) QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA or MFCU for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.
Quarterly reviews of health and safety	(Note: No recoupment is recommended if the initial	Technical Assistance	An amount equal to a monthly rate for each quarter and for each individual

Recoupment Chart (Based on the October 2003 Handbook, implemented June 23, 2005)

Documentation	Requirement and Recoupment Guidelines	New Provider/New Service(s) 1st or Initial Annual Review	Subsequent Reviews Resulting in Deficiency(s)
Supported Living Coaching Only	Housing Survey was not performed, but the document is now available and is updated quarterly for health and safety.) Trend: Absence of Housing Surveys, or health and safety is not updated quarterly on an existing survey.	QIP/QEP	when the update was required and was absent. The monthly payback is applicable to the month when the update was scheduled to occur. QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA or MFCU for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.
Service Log; Trip Log Daily Progress Note	An amount equal to the daily rate or a pro-rated daily portion of a monthly rate for each day that the service log, daily attendance log or daily progress note does not document that the service was provided as billed. (Absence of the document, or absence of an entry for the date(s) billed.) Note: If the documentation is present, however, an element required for the document is cited as a deficiency (e.g., time, date, activities), recoupment is not recommended. TA should be provided.	Technical Assistance QIP/QEP	An amount equal to a daily rate for each day and each individual that the documentation was not available. QIP/QEP Note: If there is no supporting documentation that the service was provided as billed, this cite is subject to overpayment procedures. Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.
Dietary Management Plan;	(Viewed as similar to Implementation Plan for Core	Technical Assistance	Full recoupment for the number of days and number of individuals determined

Recoupment Chart (Based on the October 2003 Handbook, implemented June 23, 2005)

Documentation	Requirement and Recoupment Guidelines	New Provider/New Service(s) 1st or Initial Annual Review	Subsequent Reviews Resulting in Deficiency(s)
Nursing Care Plan, Treatment Plan (SMHS)	Services.) When a plan is required, but not present: an amount equal to the daily rate, or a pro-rated daily portion of a monthly rate for each day after the initial claim submission that a plan is not available. If Plan is present, but elements of the Plan are not present, provide TA. Recoupment not recommended. (Trend: Absence of a Plan, or Plans not developed within timeframes.)	QIP/QEP	out of compliance. QIP/QEP Consider termination of Waiver Services Agreement. And/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.
Behavior Analysis Service Plan	(Viewed as similar to Implementation Plan for Core Services.) An amount equal to the daily rate, or a pro-rated daily portion of a monthly rate for each day after a 90 calendar day time frame that a final plan was not available after the effective date of the service authorization. (Note: Requirement modified since a Behavior Services Plan may take longer than the 30 days to develop.) (Absence of a plan.)	Technical Assistance QIP/QEP	Full recoupment for the number of days and number of individuals determined out of compliance. QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.

Recoupment Chart (Based on the October 2003 Handbook, implemented June 23, 2005)

Documentation	Requirement and Recoupment Guidelines	New Provider/New Service(s) 1st or Initial Annual Review	Subsequent Reviews Resulting in Deficiency(s)
Reports and Assessments: (Medication Review, PT, OT, Speech, Respiratory Therapy, Psychology Assmt.[if applicable], Specialized Mental Health Assmt., Therapeutic Message [if applicable])	One Time payment for Assessment or report production. (One Deliverable for Fee Paid.) Recoup funds if assessment or report was paid, but no assessment or report was delivered.	Technical Assistance QIP/QEP	Full recoupment of the amount paid for the assessment or report for each individual determined out of compliance. QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.
Support Plan and/or Cost Plan not available by the effective date	An amount equal to a daily rate or a pro-rated portion of a monthly rate is subject to recoupment for each day after the effective date of the support and/or cost plan that these plans are not available Note: Support and Cost plan should be available within 20 days of the effective date of the plan. Cost Plan may not be approved due to approval process.	**Solo Provider:** Technical Assistance QIP/QEP **Agency Providers** If new agency, treat as solo above. If review of a new treating provider in an agency that has undergone previous reviews see recommendation under "Subsequent Review" column, as appropriate.	Full recoupment for the number of days and number of individuals determined out of compliance. QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.

Recoupment Chart (Based on the October 2003 Handbook, implemented June 23, 2005)

Documentation	Requirement and Recoupment Guidelines	New Provider/New Service(s) 1st or Initial Annual Review	Subsequent Reviews Resulting in Deficiency(s)
Required face-to face contacts: Support Coordination – Full: No monthly face-to-face contact with an individual living in a licensed residential facility or supported living OR No face-to-face contact every three months for individuals living in their family home. Support Coordination – Limited: No evidence of at least two face-to-face contacts per year with a minimum of one contact in the resident's home.	An amount equal to a monthly rate is to be reimbursed for each month and for each individual that the service was billed whenever a face-to-face contact was required, but did not occur. For the quarterly face-to-face, the payback is applicable to the month the quarterly visit was scheduled to occur.	**Solo Provider:** Technical Assistance QIP/QEP **Agency Providers** If new agency, treat as solo above. If review of a new treating provider in an agency that has undergone previous reviews see recommendation under "Subsequent Review" column, as appropriate.	Full recoupment for the number of days and number of individuals determined out of compliance. QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.
Support Coordination – Full: No face-to-face contact every three months <u>in the place of residence</u> made with an individual living in a licensed facility or supported living.	An amount equal to a monthly rate is to be reimbursed for each quarter and for each individual that the service was billed when a face-to-face contact was required and did not occur. For the quarterly face-to-face, the payback is applicable to the month when the quarterly visit	**Solo Provider:** Technical Assistance QIP/QEP **Agency Providers** If new agency, treat as solo above. If review of a new treating provider in an agency that has undergone previous reviews see recommendation under "Subsequent Review"	Full recoupment for the number of occurrences and number of individuals determined out of compliance. QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may

Recoupment Chart (Based on the October 2003 Handbook, implemented June 23, 2005)

Documentation	Requirement and Recoupment Guidelines	New Provider/New Service(s) 1st or Initial Annual Review	Subsequent Reviews Resulting in Deficiency(s)
Support Coordination – Limited: No face-to-face contact in the place of residence in the last year.	was scheduled to occur.	column, as appropriate.	occur at any time, if justified.
Support Coordination – Full: No face-to-face contact in the place of residence made at least every six months with an individual living with their family. Support Coordination – Limited: No face-to-face contact in the place of residence at least once per year.	An amount equal to a monthly rate is to be reimbursed for each six-month period and for each individual that the service was billed when a face-to-face contact was required and did not occur. For the quarterly face-to-face, the monthly payback is applicable to the month when the visit was scheduled to occur.	**Solo Provider:** Technical Assistance QIP/QEP **Agency Providers** If new agency, treat as solo above. If review of a new treating provider in an agency that has undergone previous reviews see recommendation under "Subsequent Review" column, as appropriate.	Full recoupment for the number of occurrences and number of individuals determined out of compliance. QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.
Support Coordination – Full: No "other" contact made in a month when a face-to-face contact was required, or The monthly payback is applicable to the month when the contact(s) was scheduled to occur.	If support coordinator failed to make the face-to-face, refer to recoupment guide above for no face-to face contact. No other action necessary. If the face-to face was made, but not the second contact, an amount equal to one half the monthly rate is to be reimbursed for each individual that the service was billed and the second contact was required and did not occur.	**Solo Provider:** Technical Assistance QIP/QEP **Agency Providers** If new agency, treat as solo above. If review of a new treating provider in an agency that has undergone previous reviews see recommendation under "Subsequent Review" column, as appropriate.	One half the monthly amount for the number of months and number of individuals determined out of compliance. QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.

Recoupment Chart (Based on the October 2003 Handbook, implemented June 23, 2005)

Documentation	Requirement and Recoupment Guidelines	New Provider/New Service(s) 1st or Initial Annual Review	Subsequent Reviews Resulting in Deficiency(s)
Support Coordination – Full: There were not two "other" activities made on behalf of the individual in a month when no face-to-face occurred. Support Coordination – Limited: No monthly contact with or activities on behalf of recipients when no face-to-face occurred..	An amount equal to a monthly rate is to be reimbursed for each month and for each individual that the service was billed and the required contacts did not occur.	**Solo Provider:** Technical Assistance QIP/QEP **Agency Providers** If new agency, treat as solo above. If review of a new treating provider in an agency that has undergone previous reviews see recommendation under "Subsequent Review" column, as appropriate.	Full recoupment for the number of occurrences and number of individuals determined out of compliance. QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.

Recoupment Chart (Based on the October 2003 Handbook, implemented June 23, 2005)

Documentation	Requirement and Recoupment Guidelines	New Provider/New Service(s) 1st or Initial Annual Review	Subsequent Reviews Resulting in Deficiency(s)
For transitional services: No weekly face-to-face contacts during the first 30 days from discharge from an institution.	An amount equal to a weekly rate is to be reimbursed for each week and for each individual that the service was billed when a face-to-face contact was required and did not occur.	Full recoupment for the week(s) billed when the requirement was not met. QIP/QEP	Full recoupment for the week(s) billed when the requirement was not met. QIP/QEP Consider termination of Waiver Services Agreement. And/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.
Lack of progress notes that adequately detail support to individual/family	Progress notes are absent, or lack the detail necessary to determine support and actions taken by the WSC on behalf of the individual to warrant reimbursement.	**Solo Provider:** Technical Assistance QIP/QEP **Agency Providers** See recommendation under Second Review Existing Provider, or Subsequent Review, as appropriate	If the two contacts required for full support coordination or one contact for limited support coordination billing have been met, recoupment for lack of progress notes will be made at ¼ of the month's billing and reimbursement for each individual and each month where notes are missing. If verification of the 2 contacts required for full support coordination or one contact for limited support coordination cannot be made based on progress note detail, recoupment will be made based on the lack of required contacts above. QIP/QEP Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Referral to AHCA for investigation may occur at any time, if justified.

D. General Guidelines for Overpayment

1. For purposes of this policy, Overpayment is considered:

   - Provider payment for services that were not delivered or for which there is no documented evidence of delivery;

   - Payment for services that were not authorized, or were performed and paid in excess of the authorization for service; or

   - Payment for services that were not performed in accordance with handbook requirements/limitations (e.g., did not meet service definition, required ratios).

   - Payment for services that the provider is not enrolled to provide. (Service not approved by the Area office.)

2. Overpayment may be discovered through monitoring and review by the contracted quality assurance provider or may be found through investigation or audit of the service provider by APD or ACHA staff, or agents of either.

3. Typically, funds are to be recouped in full for overpayment. The provider must have billed and received payment for the service during the period of the deficiency or error in order for overpayment activities to be initiated. The Area will review appropriate ABC and/or FMMIS screens to assure that the provider was paid for the service(s) during the time the deficiency occurred. If the provider did not receive payment, actions other than overpayment or recoupment may be taken.

4. The Area office shall have authority to implement overpayment activities if the amount of repayment is under $2,500 (see Attachment 3 for template and sample letter). The Area shall also track the overpayment action through completion and submit quarterly updates to the APD Central Office (see Attachment 1 for tracking form). These actions will be reported to the Central office monthly.

5. If the amount is above the $2,500 threshold the Area office will provide a copy of the overpayment information to the APD Central Office Quality Management unit for review and approval by the APD Deputy Director of Operations or designee prior to initiating any recoupment or overpayment activities (See Attachment 2 – Recoupment Decision Memo Template).

6. Based on the severity of the provider billing practices, information concerning the overpayment will be referred to the Agency for Health Care Administration for possible audit of the provider and/or investigation by the Medicaid Program Integrity Unit and/or the Department of Legal Affairs Medicaid Fraud Control Unit. Refer to Section I.B of this policy.

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1. Examples of Overpayment and Recommended Actions:

Example	Action	Recommendation
No service authorization	Area staff will review the cost plan and/or ABC to determine whether the service was approved. If approved, the provider and the support coordinator will be contacted and requested to furnish a copy of the service authorization to the Area.	If the service was approved, but no copy of the authorization was furnished at the time of the provider review or audit: • A QIP/QEP should be required of the provider, and if the authorization was not furnished to the provider by the support coordinator, a QIP should also be required from the support coordinator. If the Area review indicates that the service was not approved: • All providers regardless of tenure: Full recoupment of the amount paid for the service for each individual determined to be out of compliance. • Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse.
Service billed at a frequency, or at a rate, higher than that approved on the cost plan or indicated on the service authorization	Area staff to review ABC cost plan to verify frequency and/or rate approved and/or authorized.	All providers regardless of tenure: • Full recoupment of the amount paid over that which was approved and authorized for each individual determined to be out of compliance. • A QIP/QEP will be required from the provider. • Consider termination of Waiver Services Agreement. And/or referral to AHCA for investigation of possible fraud/abuse. If the frequency/rate was not approved on the cost plan, but was authorized by the support coordinator: • No funds will be recouped from the provider. The support coordinator will be penalized an amount equal to the full overpayment for the service in excess of that which was approved in the cost plan for each individual determined to be out of compliance. • A QIP/QEP will be required from the support coordinator. Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse.

Example	Action	Recommendation
Service not provided according to handbook requirements.	Area to review cite and service requirements to verify noncompliance. Examples include, but are not limited to: Companion service not performed on a 1 – 1 basis NRSS (if applicable) performed in a group larger than 3 with no area approval. PCA service billed concurrently with ADT. Transportation billed as a separate service when transportation is included in the rate for the service.	If the service was approved in the cost plan and authorized by the support coordinator: • No funds will be recouped from the provider. • Working with the individual to identify service options, the WSC will alter the cost plan to reflect appropriate services that are in compliance with rule requirements. • Service(s), or delivery of service(s), that is in violation of the rule will be terminated immediately. • A QIP/QEP will be required from the provider and/or the support coordinator. If the service(s) , was not approved on the cost plan, but was authorized by the support coordinator: • No funds will be recouped from the provider. • The support coordinator will be penalized an amount equal to the full overpayment paid for the service(s) for each individual determined to be out of compliance. • A QIP/QEP will be required from the support coordinator. • Working with the individual to identify service options, the WSC will alter the cost plan to reflect appropriate services that are in compliance with rule requirements. • Service(s), or delivery of services, in violation will be terminated immediately. • Consider termination of Waiver Services Agreement. And/or referral to AHCA for investigation of possible fraud/abuse. If the service(s), or service(s) as delivered, was not approved by the area and not authorized by the support coordinator: • Full recoupment of the amount paid for the unauthorized service(s) will be recouped from the provider for each individual determined to be out of compliance. • QIP/QEP will be required of provider. Consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse.

Example	Action	Recommendation
Service billed when there is no documentation that individual was in attendance.	Area to review cite and service requirements to verify noncompliance.	• Full recoupment of the amount paid for the period when the individual(s) was not present. • QIP/QEP required of the provider if practice appears to be prevalent (not incidental error). • Consider termination of Waiver Services Agreement. And/or referral to AHCA for investigation of possible fraud/abuse.
Service not provided as defined by the rule.	This is a serious determination that indicates an overall lack of performance and compliance for key service requirements by the provider. The determination is backed by a general lack of documentation and ability of the reviewer/auditor to verify compliance to rule requirements through other means. Deficits in this area are not indicated by incidental deficiencies. Examples of this include: A Residential Habilitation, ADT, NRSS (if applicable), Supported Living or Supported Employment provider that does no training or support with an individual(s) in order to meet the individuals goals/outcomes. (This is not sloppy or missing paperwork, or a lack of understanding of programmatic approaches. This represents an intentional action – or lack of action – by the provider.) A support coordinator who has little or no documentation that supports were sought for an individual(s) and that face-to-face contacts were made. Progress notes (or lack thereof) indicate little to no effort made to support the individual and to coordinate service delivery designed to meet individual goals.	The provider should be given an opportunity to improve service delivery through execution of a QIP/QEP and receipt of technical assistance from the Area, the contractor quality assurance provider, or other entity as appropriate. Follow-up on corrective action should be no later than 60 days from the review and should result in significant improvement of service delivery methods. If little or no improvement is seen in performance, consider termination of Waiver Services Agreement and/or referral to AHCA for investigation of possible fraud/abuse. Full recoupment of the amount paid for the period under review is warranted. The Area may allow the provider an opportunity for improvement prior to full recoupment and possible disenrollment being initiated.

Example	Action	Recommendation
Provider not enrolled to provide service by Area office.	Even if authorized for the service, the provider is subject to recoupment if the provider has not been enrolled by the Area to provide the service(s) (determination of meeting qualifications, etc.). If the provider was sent the authorization by the WSC and the WSC has an Area developed resource for identifying provider enrollment for both type of waiver and services in addition to ABC, then the WSC may be subject to a fine. Contact the Quality Management Unit in the Central APD office processing.	• Full recoupment of the amount paid or an amount negotiated by the Area office. • QIP/QEP required of the provider if practice appears to be prevalent (not incidental error). • Consider termination of Waiver Services Agreement. And/or referral to AHCA for investigation of possible fraud/abuse.

TRACKED CHANGES

This is a newly established operating procedure, established on July 31, 2007.

AREA RECOPMENT TRACKING LOG

Provider Name	Provider Number	Service Category	Number of Consumers	Review Type	Score/ Level	Alerts	Recoupments	Type of Recoupment	Date of Follow Up	Action Taken	Recoupment Status	Amount Calculated for Recoupment	Dates of Recoupment	Final RcoupmentAAmount	Explanation
John Q. Provider		(ADT, Res Hab, In Home, WSC, etc.)		CORE, WiSCC, Desk	Percent met, Achieving, Implementing etc.	(number)	(number)	see code	Follow-up activity date	Describe action taken	1. New Provider 2. New Service 3. 1st Review 4. Subsequent Reviews				
Type of Recoupmnent code:															
1= Required Billing Documentation															
2= Monitoring Deficiency															
3= Overpayment															
4= Other - explain															

Sample Letter
Attachment 2

RECOUPMENT DECISION MEMO
(Area requests for over$2,500)

Date:
To: Lorena Fulcher
From: Area 51
Subject: John Q. Provider Recoupment

Based on a Desk Review conducted by Delmarva, recoupment of funds in the amount of $2,500 or greater is requested for the following provider:

Provider Name:
Address:
Provider #:
Agency or Independent

History:

- Description of services provided by the provider.
- Total number of consumers supported.
- Indicate if this is the result of an initial review or subsequent review.
- Indicate the process used (Desk, CORE, WiSCC, Area initiated audit, etc) to discover the need for a recoupment.
- The date of the review.
- Provide a summary of the review findings and reasons for recoupment including dates, names, amounts, etc.
- Provide verification through FMIS that billing occurred for dates and consumers in question.
- Indicate the total dollar amount to be recouped. (must be $2,500 and over)
- Indicate any follow up technical assistance offered by Delmarva or the Area subesquent to the review.
- Summary of any provider meetings held to develop plan (if none indicate so)

Area Decision

- Indicate the total amount recommended to be recouped.
- The time period for the recoupment (one time or spread out over time).
- Indicate the impact anticipated on the providers ability to continue to operate.
- Submit a draft electronic copy of the Area notification letter to be sent to the provider.

Attachment 3

Letter to Providers Notifying Them of Recopument

(ON LETTERHEAD)
Date

John Q. Provider
123 Appleblossom Lane
Anywhere, Florida 32333

Provider No.(s):

Dear Mr. Provider:

In accordance with the (Choose one or both) Developmental Disabilities Waiver Services Florida Medicaid Coverage and Limitation handbook (the handbook) and/or the Family and Supported Living Waiver Services Director, APD is exercising its option to recoup funds for failure to implement requirements of the Medicaid Waiver program, and/or for overpayment of funds to you or your agency. The following identifies findings in violation of the Medicaid waiver requirements:

NEED TO BE SPECIFIC AND LIST e.g. Section (specify page/section) of the handbook requires that the support coordinator will submit to the Area office no later than 20 calendar days prior to the support plan effective date, a new annual support plan and cost plan with supporting documentation and allows for recoupment of funds equal to a prorated daily amount of your monthly billing for every day that the support plan is beyond the effective date. Client (name) support plan should have been effective on 9/1/06, yet the plan was not submitted for review until 9/15/06, etc. The calculated amount of this recoupment is $……..

NOTE: The provider has no due process rights. They may protest and eventually take to a hearing, but we don't have to notice them of this option.

Please contact (Area staff member and phone number) in the APD Area office to discuss the recoupment and to initiate a payback for the funds identified above. Should you elect not to meet with representatives of the Area office, the recoupment will be pursued with the Agency for Health Care Administration. If you have any questions, please call *(insert name of area contact)* at phone number *(insert phone number of area contact*).

Sincerely,
Area Administrator

Cc: Mac McCoy, Deputy Director for Operations, Agency for Persons with Disabilities
Linda Mabile, Quality Management Unit, Agency for Persons with Disabilities
Other ccs as needed in Area

Attachment 3

Letter to Providers Notifying Them of Recopument

- Provide explanation of the review results that identified the need for recoupment and enclose a copy of the document.
- Identify the amount of funds requested to be recouped.
- Invite the provider to meet with Area staff to plan for repayment of funds.
- Provide instructions on how to complete the Form 081 or notify them where to locate the instructions and the form.
- Provide deadline to complete the action.

Provide instructions to the provider on documentation to be provided to the Area office that indicates recoupment action complete. (copy of provider remittance voucher)

Attachment 4

Referral to Medicaid Program Integrity

This document is to be used for referrals to MPI. The information should be forwarded to MPI through the APD Central Office in accordance with Operating Procedure requirements.

<<Date>>

Horace Dozier
Program Administrator
Medicaid Program Integrity – Intake Unit
2727 Mahan Drive, M.S. #6
Tallahassee, Florida 323908

RE: <<Provider Name>>
<<Medicaid ID# >>

Dear Mr. Dozier

The Agency for Persons with Disabilities (APD) is forwarding information to you on the above-referenced provider for investigation by your office. Preliminary review of this matter indicates << describe APD findings here >>.

Please be advised that APD has <<< describe APD actions here: contact with provider, Termination Recommendation, other referrals; if the action hasn't yet taken place indicate that it is in process or will be put in place within the next several days/weeks, etc.>> Attach any pertinent documents, including the last Delmarva review results

If you have questions or need further information, please contact <<administrator>>, APD Administrator, at xxx-xxxx.

Sincerely,

Name
Title
Agency for Persons with Disabilities

cc/enc:

CASE REFERRAL INFORMATION

1. **PROVIDER NAME/NUMBER/ADDRESS:**

2. **SERVICES CERTIFIED TO PROVIDE**:

3. **STATEMENT OF ALLEGATION WITH SUPPORTING REFERENCES (STATUTE, RULE, POLICY, ETC.)**:

4. **EVIDENCE CURRENTLY AVAILABLE TO SUPPORT ALLEGATION**: (Copies should be submitted with the referral or provide a name and phone number of contact where they may be obtained.)

5. **SUMMARY OF ACTION TAKEN BY APD, INCLUDING OTHER REFERRALS**:

6. **APD CONTACTS and PHONE #**:
   Administrator:
   Investigator:

Attach any pertinent documents, including the last Delmarva review results