

Frequently Asked Questions for Provider Compliance Reviews

The Review Process

Q. When is a Provider Compliance Review done?

A. All Individual Options Waiver and Level One Waiver Providers must undergo a regular compliance review at least once every 5 years for each county that they provide services in. Special reviews can be done more often if there is a need. This process will not review those Individual Options Waiver, Level One Waiver, and Residential Facility Waiver services provided in a licensed setting. Services in a licensed setting are reviewed in accordance with licensure rules by the department only.

Q. What types of Provider Compliance reviews are there?

A. There are three types of Provider Compliance Reviews:

- 1) A Regular Provider Compliance Review that is conducted by ODMRDD or the county board once every five years in each county that the provider provides services in.
- 2) A Special Provider Compliance Review that is done as a result of an MUI, a complaint or other circumstances that call into question the provider's failure to maintain provider certification standards. The need to conduct a special review needs to be based on credible information or allegations.
- 3) A Look-Behind Review is conducted by ODMRDD and is conducted on a sample of the reviews that have been completed by a county board during the calendar year. This review is to assure conformance with the rule requirements outlined in 5123:2-9-08 of the Administrative Code. The department will schedule these reviews but a provider or county board can request ODMRDD to conduct a Look-Behind Review.

Q. Where are the reviews conducted?

A. Provider Compliance reviews can be conducted in an On-Site Review Format or a Desk Review Format. The On-Site Reviews should be conducted at the location where the majority of the information required for the review is located. A Desk Review would require information to be mailed or faxed and done in cases that do not involve a significant amount of information to verify compliance.

Q. Are all Provider Compliance reviews announced and conducted on-site at the provider's office location?

A: Regular compliance reviews are coordinated with the provider and surveyors in terms of location and time. Special reviews may be unannounced. Additionally, compliance reviews may be desk reviews, depending on the service to be reviewed.

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- Q.** Do surveyors conduct reviews in the homes of individual providers?
- A.** Only if the provider wants to have the review at his/her home and it is agreeable to the surveyor. The surveyor and provider should agree upon the location.
- Q.** Who decides what the schedule and type of review will be used for a provider compliance review?
- A.** The regular review schedule will be developed by ODMRDD in collaboration with county boards.
- Q.** Who can conduct a Provider Compliance Review?
- A.** Only employees or agents of ODMRDD, a county board, or COG who have completed the training by ODMRDD may conduct a Provider Compliance reviews.
- Q.** Can the CB conduct a regular review using only portions of the tool?
- A.** When conducting a regular review, (meaning one that is conducted as part of the 5-year review process) a county board must use all of the tools that apply to the provider being reviewed. If conducting a special review, a county board may only use that portion of the review tool that pertains to the reason the special review is being conducted. For example, if an MUI occurs due to a staff person giving an individual the wrong medication, a review may only be conducted on the medication administration section of the review tool. Your citations, report and required plan of correction from the provider would then also be limited to what was reviewed.
- Q.** Can regular compliance reviews be conducted more often than one time every 5 years? If the answer is yes, they can be done more often than one time every five years, explain the circumstances under which this would be permissible.
- A.** The rule indicates that “special reviews” can be conducted whenever the county board or department have reason to believe the provider is not in compliance with continuing certification standards. This could be as a result of a complaint from an individual, family member, neighbor, or any other person, or could be the result of an MUI or UI. Special Reviews would also need to follow the rule protocol and process

Personnel Information

- Q.** Is there a standard method for choosing which employee’s personnel information will be reviewed during a Provider Compliance Review?
- A:** No, There is no standard method for selection of personnel files. Selection process is up to the surveyor on a Provider Compliance only review. It may, for example, consist of a random selection of personnel files or the personnel files of those staff most recently hired.

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Q. How many employee personnel files are required to be reviewed during a Provider Compliance review?

A: The Provider Compliance Protocol establishes the minimum number of files to be reviewed. The Protocol guidelines are to be followed.

Q. What information is to be checked during the provider employee review?

A: It depends on the waiver and type of provider being reviewed. Reference the Agency Personnel Review form for information related to agency IO and Level 1 providers. The file review information for Level 1 and IO individual providers is found in the corresponding review tools. Please note that ODMRDD reviews the BCII checks of **individual** providers at the time of initial certification, therefore it is not necessary to review the BCII during the compliance review. However, the reviewer will need to check the MRDD Abuser Registry and the Nurse Aide registry for the individual providers at the time of the compliance review.

Q. What type of criminal background check is required to be done on all employees providing direct services to individuals?

A: All employees providing direct services must have a report from the Ohio Bureau of Criminal Identification and Investigation, also known as a BCII report. Both a BCII check and a FBI check are required if the employee has not lived in the state of Ohio for the 5 years previous to employment.

Q. Is a BCII report still required if an FBI report is on file?

A: Yes. A FBI check alone is not sufficient for employees who have lived out of state during the five years prior to employment.

Q. How do I recognize a FBI Check?

A: An FBI report is a report of a request of information from the Ohio Bureau of Criminal Identification and Investigation the FBI. BCII will issue the report in the same format as a BCII but it will state that information has been obtained from the FBI. FBI records with charges will state, "May not meet the qualifications for employment". The employer is responsible to follow-up on any questionable BCII responses to determine whether the applicant meets the qualifications for employment.

Q. What follow-up should be present for a BCII that states the prints are unclassifiable?

A: Additional attempts should be made to get classifiable fingerprints. After three attempts to run fingerprints through BCII you can request that a report be run using the name and SSN. This BCII report will look the same and state it was run using

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Name and SSN. You should document all attempts to submit fingerprints and responses from BCII.

Q. Can agencies use WebCheck for BCII checks?

A: Yes, WebCheck is a program developed and implemented by the Ohio Bureau of Criminal Identification and Investigation (BCI&I). WebCheck is a quick way to obtain a BCII criminal background check.

Q. Should local police reports be ignored if they are provided during the review?

A: No. A BCII Report is required by rule and no other type of police report covers this rule requirement. Any information regarding criminal charges/offences must be followed up on as if it was on the BCII report regardless of the source of the information. The important thing to remember in this situation is the local background check cannot be substituted for a BCII report.

Q. How do I know a person has a clear BCII record?

A: The BCII report will state “No Record” and be in a standard BCII letter format.

Q. How will I know if the BCII lists criminal charges?

A: If charges are listed on the BCII report it will not be in a letter format and it will list the charges with arrest dates and ORC number that corresponds to the charge. The report may also include information regarding the disposition of the criminal case resulting from the charges. A Sealed Record will have a table type format with the charge listed but it will not list the date that the record was run.

Q. Do Sealed Records still have to have the same follow-up as other charges?

A: Yes, 5123:2-1-05.1(M) states “This rule is applicable to records of convictions that have been sealed pursuant to sections 2953.32 of the Revised Code because the information contained in those sealed records bears a direct and substantial relationship to any position with a contracting entity that involves providing direct services to persons with mental retardation or developmental disability.”

Q. How do I know if the charges are disqualifying or not?

A: A specific list (J)(1) of disqualifying offenses is found in the Background Check Rule 5123:2-1-05.1. Disqualifying offenses can also be other felonies that are not on the list but that “Bears a direct and substantial relationship to the duties and responsibilities of the position being filled” or “A violation of an existing or former law of this state, any other state, or the United States, if the offense is substantially equivalent to any of the offenses described in (5123:2-1-05) (J)(2)(3)(4).

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Q. What type of follow-up should I see for criminal charges listed in the personnel information?

A: A Journal Entry that is certified by the Clerk of Courts for the court where the case addressing the charges was heard. Certification should be in stamp or embossed seal form. The Journal Entry needs to list the final disposition of the case along with any other sentence information.

Q. How do I determine if the person meets the qualifications for rehabilitation?

A: Refer to 5123:2-1-05.1 (N)-(P) for information on rehabilitation for the purpose of employment.

Q. What registry checks are required as part of the background investigation for direct service professionals?

A: A background investigation for direct service professionals must include documentation that the prospective employee information has been checked with the Abuser Registry and the Nurse Aide Registry. In addition, there must be a certified driver's abstract for any staff providing transportation services. If you have specific questions related to a BCII report or how the results may affect hiring or certification call the PC/IQA unit at (614) 466-7508, not the ODMRDD legal dept.

Q. Is there a timeline for completion of the Abuser Registry check?

A: Yes, it must be completed prior to hiring the employee. The Abuser Registry rule 5123:2-17-03(F)(3) states: "Any person or government entity seeking to hire, contract with, or employ a person as an MR/DD employee shall make an inquiry to the department regarding whether the person's name is on the registry. If the subject of the inquiry is on the registry, the inquiring party shall not hire, contract with, or employ the person as an MR/DD employee."

Q. What documentation verifies that the Abuser Registry was checked?

A: A printout of the registry check screen showing the result of the search for the individual's SSN and Name or documentation from ODMRDD that the employee is not on the Abuser Registry. The registry may be accessed online at odmrdd.state.oh.us/includes/abuserregistrydoc/abuser_registry.htm.

Q. Is there a timeline for completion of the Nurse Aide Registry check?

A: Yes, it must be completed prior to hire for all Level One staff and prior to hire for IO staff hired after 7/1/05. For IO staff hired prior to 7/1/05, the Nurse Aide Registry must be checked but the rule did not state that it had to be completed prior to hire.

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Q. What documentation verifies that the Nurse Aide Registry was checked?

A: A printout from the website showing results of a search for staff's name or some form or statement from the entity that states that it contacted ODH and inquired about the status of the potential employee in regard to the registry. The Nurse Aide Registry may be checked on line at:
https://odhlogin.odh.ohio.gov/nar/nar_registry_search.aspx

Q. Who is required to have a driver's abstract as a part of the background check process?

A: Employees whose job description requires them to provide transportation services.

Q. Is any type of drivers abstract acceptable?

A: The information in the driver's abstract must come from the Bureau of Motor Vehicles. This could be an abstract from BMV or another source as long as the information comes directly from the Bureau of Motor Vehicles.

Q. If a staff person provides transportation, are they required to have CPR certification?

A: At least one staff person who is certified in CPR must be present while transporting individuals.

Q. Does the Provider Compliance Review team want to see the personnel evaluations?

A. No.

Q. What type of CPR and First Aid training is acceptable for staff covered under ODMRDD rules?

A. In this era of technology, there are many entities that offer web based training for CPR and First –Aid certification. Although, these entities have credentials, their performance measures may differ significantly. The standards of performance the department recognizes follow the prescribed format equivalent to the American Red Cross. **A prescribed format is defined as lecture, demonstrations via video or conferencing and hands-on-training in a practice while you watch format. To obtain CPR/First Aid certification, the web based testing is permissible when followed with an actual skills competency in person demonstration.**

Applicants that prefer to obtain CPR/First Aid web based training in lieu of classroom training for initial certification must submit with their application written verification that the entity's curriculum is equivalent to the American Red Cross prescribed format. Individuals certified as an EMT are required to submit their EMT

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certification as evidence of completion of CPR/First Aid. Applicants currently certified must maintain written verification of the entity's curriculum in the event of a compliance review.

- Q.** If CEO or the person who is responsible for Supported Living Administration is the same person who had the experience required for the agency's initial certification, does the Provider Compliance Review team want to see the CEO's resume, BCII, and credentials on the day of the review?

A: No.

- Q.** If the CEO or person who is responsible for Supported Living Administration is not the same as when the agency was certified, does the Provider Compliance Review team want to see the resume, BCII, and credentials of the Person who is responsible for Supported Living Administration on the day of the review?

A: Yes. The Supported Living Certification rule 5123:2-12-02(J)(1) requires the agency provider to employ a chief executive officer or an individual responsible for supported living administration who has specific qualifications listed in the rule.

Policies

- Q.** Does a policy or procedure have to be in writing for the policy or procedure to be considered in compliance with rule?

A: Yes, policies and procedures must be in writing. However, there is no requirement in rule for policies/procedures to be dated.

- Q.** Can a policy or procedure be created or revised during the on-site review process?

A: Yes, but the surveyor will still make a citation. The revised policies/procedure should be submitted with the POC.

Incidents Adversely Affecting Health and Safety

- Q.** Who is required to receive initial and annual training on the requirements of the rule Incidents Adversely Affecting Health and Safety?

A: All provider and county board staff shall receive training on the requirements of this rule prior to unsupervised contact with individuals and no later than 30 calendar days after employment and during each calendar year thereafter. Annual training must include a review of health and safety alerts released since the previous calendar year's training.

- Q.** Is it required that training on Incidents Adversely Affecting Health and Safety be documented?

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A: Documentation must include the training topic, date of training, who provided the training, length of training, a brief description of the training content, and the name of the attendee.

Q. Do citations regarding training on the Incidents Affecting Health and Safety rule not being completed have to be reported to the MUI Unit?

A: No.

Q. Is a provider required to have a policy/procedure for internal review of all Major Unusual Incidents?

A: Yes, AGENCY providers must implement a written procedure for the internal review of MUIs. Rule 5123:2-17-02 Incidents Adversely Affecting Health and Safety outlines the requirements for the internal review of MUIs. Individual providers are not required to have a written policy or procedure.

Medication Administration

Q. If the individual utilizes assistance with self-administration of medications do the staff supporting the individual need Medication Administration training?

A: Direct Care Professionals do not require training in Medication Administration when the ISP states that the individual can safely self-administer medications, with or without assistance.

Q. When does a Direct Care Professional require Medication Administration training?

A: Direct Care Professionals do require training in Medication Administration when the ISP states that the individual is unable to self-administer medication with or without assistance. (Not required in rule for ISP to indicate self-administration)

Q. What is the difference between Medication Administration and Delegated Nursing?

A: Medication Administration is the actual procedure of passing meds that staff must be trained for if required by the situation. Delegated Nursing is the RN oversight that is needed in certain situations.

Q. Can families delegate medication administration to providers?

A: Medication administration can be delegated by a family member to an Individual Provider if the individual lives with the family member and the family member is the primary caregiver. The family member is then responsible for training and supervising the Individual Provider, and no proof of training or certification is required. The family of the individual cannot delegate the administration of medications to staff of agency providers.

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Q. What is acceptable proof of training in Medication Administration?

A: As of 12/29/03 a current, valid Medication Administration certificate issued by ODMRDD will be the only proof accepted. Other documentation, as specified in 5123:2-6-06(C)(3) may be acceptable before that date if the direct care provider was grand fathered in before 12/29/03.

Q. When is Delegated Nursing required?

A: For sites with 5 or less beds Delegated Nursing is required only for G-Tubes, J-Tubes, and insulin injections. For sites with 6-16 beds Delegated Nursing is required for Medication Administration, G-Tubes, J-Tubes (for sites with 6-16 beds a nurse is required to provide direct nursing for insulin injections). Sites with 17 beds or more Delegated Nursing can be utilized only when the individuals are on field trips (direct nursing services must be provided on-site). Be sure to check for any additional requirements in the individual's ISP. All the rules pertaining to medication administration are found in Chapter 5123:2-6 for the Administrative Code.

Transportation

Q. Can homemaker personal care and transportation be billed as one service on the waiver?

A: No, transportation and homemaker personal care are two separate waiver services and must be billed as such. This is specified in the CMS waiver document.

Q. Do providers of transportation have to have an Ohio driver's license?

A. No. Transportation providers must have a driver's license that is valid in Ohio.

Individual Providers

Q. Can an individual provider subcontract the provision of services to another provider?

A: No. This is prohibited by rule and waiver standards and assurances.

Review Information

Q. What should be done when the provider cannot produce the information that is requested by the surveyor during a compliance review?

A: It is important the providers are given the every opportunity during the review day to provide the requested information. However, no additional survey information will be accepted by the reviewer after the end of the survey exit conference. After the exit conference, information will only be accepted with the Plan of Compliance.

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The surveyor should mark the appropriate box on the survey tool as “not met” and document who told the surveyors that the information was not available, as well as the date and time the information was requested.

Q. If the county board determines an individual is subject to abuse, neglect, misappropriation, or exploitation, due to a provider’s failure to meet continuing certification standards, what can the county board do?

A. The county board can do any or all of the following:

- File a complaint in the Probate Court in accordance with 5126.30 of 5126.333 of the Revised Code.
- Obtain consent form the individual/guardian to seek another provider.
- Make a recommendation to the department for a suspension or revocation of the provider’s certification.

Q. Will surveyors ask to see ISPs or service delivery documentation?

A. Yes. ISPs and service delivery documentation is needed to verify ISP compliance.

Q. Can the county board require the provider to obtain county specific training prior to the provider being permitted to serve individuals in that county?

A: No. The only trainings required of providers are those trainings specified in rule, statute, waiver assurances, the ISP, or agency policy.

Q. Can the county board add additional review items to the survey protocol as long as the provider agrees to it?

A: No. The same survey protocol must be followed statewide.

Q. Are computer logs that identify training acceptable as verification the employee received training?

A: Yes. Documentation of training must include the following:

- (a) The name of the person receiving the training
- (b) Date(s) of training
- (c) Training topic
- (d) Instructor's name, if applicable
- (e) Brief description of the content of the training
- (f) Length of training

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Q. What does “annual” mean when it refers to training that needs to be completed on an “annual “basis?

A. “Annual” means any consecutive 365-day period unless specified otherwise in rule. Annual training is considered compliant when it is completed within 365 days of the annual training in question plus an additional 30-day buffer period as provided by rule. This would mean that annual training must be completed within 395 days from the last training date on the required material. Please note that employees must receive annual MUI training during each calendar year following the initial training. For example, an employee who received initial training on 3/1/07 and annual training on 10/1/08 would be in compliance with the MUI training requirement.

Q. Every time a compliance review is conducted, must the sample selection process be utilized, specifically the selection of sample records, or could all records for a provider agency be reviewed?

A. The protocol must be followed for regular compliance reviews, including the record selection table outlined in the protocol. The only time the surveyor (reviewer) should expand what is within the protocol sample selection process is when there are identified patterns in the sample number that may warrant an expanded selection of additional records. Reviewers should not go into a provider’s records and, without reason, pull all personnel records each time there is a review. This would not lend itself to a fair process/protocol that is applied equally across the state for all providers regardless of who is doing the review.

For a special review, the sample selection process may or may not be applicable, depending on the circumstances of the review.

Q. A county board or COG currently conducts waiver-billing reviews during every QA review (review units of service documented versus units of service billed). Will this still be permissible since it is not addressed in the compliance rule?

A. A review of provider billings is not a component of this provider compliance review process. The department’s Divisions of Audits conducts those types of reviews. However, if irregularities in billing are identified, they may indicate issues with ISP compliance, which is part of the provider compliance review process. A county board may not require a provider to pay back or otherwise adjust future billings or payments unilaterally. Doing so could jeopardize the ability of the department of ODJFS to recover funds from the provider in the future.

Q. CBs currently provide monitoring of services, as per the SSA rule. This might include reviewing the provider’s documentation, which is a portion of the compliance rule. Does the compliance rule narrow the scope of the CB’s monitoring practices, or will they be able to continue without using the tool?

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A. CBs (SSAs), as required in rule, must monitor services to assure delivery. However, if monitoring reveals a provider compliance issue that requires any type of plan of correction, the provider compliance process must be used. Separate the individual's QA from the provider's compliance processes.

Q. A county board or COG currently conducts Annual Agency Reviews. Can we continue to conduct those reviews, which cover many of the same components as the Compliance tool, as long as we point out issues, make recommendations, and do not require follow-up? If yes, can the Annual Agency Review be done in licensed facilities?

A. The process described in rule 5123:2-9-08 (and its accompanying Protocol) is the only review process duly authorized to evaluate if a certified waiver provider is in compliance with continuing certification standards. A county board and/or COG should discontinue using any other review process or tool to evaluate a provider's compliance as it carries no authority and results in no consequences for the provider should violations be discovered.

The intent of the rule was to establish a single review process and criteria and to establish consistent standards for evaluating provider compliance throughout the state. As the rule states, a review must be completed at least once every five years, and more frequently if needed.

For licensed providers, the rule indicates that those reviews are conducted in accordance with licensure rules, not a county board review process. A county board, through their normal SSA activities or through an MUI investigation, may refer a licensed provider to the department for its review of compliance with licensure standards.

Q. It is understood that if during a Quality Assurance Review, a Compliance issue is uncovered that is covered in your Compliance Tool, we must use your tool to address it. However, if a QA issue (outcome for an individual) is uncovered, can a request for follow-up be made on the issue? For example, should an individual say he/she doesn't like the direct care staff working with them, can a referral be sent to the team for follow-up?

A. Making the team aware of an issue that may need further discussion and follow-up is not the same as requiring the provider to respond with a plan of correction. If you require the provider to supply a response back to you, then it may be necessary to use the PC process. Issues that you have noted above should go to the SSA to first carry through with the individual for further discussion, not the provider directly.

Q. If compliance issues are found during a Quality Assurance Review, can the county board or COG decide to just make recommendations and not always do a Compliance Review? It seems that the county board or COG should have some discretion as to

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whether or not to do a Compliance Review depending on the severity of the issue. For example, should the county board or COG find that a provider has otherwise good documentation but has missed the frequency of a support that is not a health and safety issue, couldn't the county board or COG just recommend that the service be provided and documented according to the ISP and not require any follow-up?

A. It is not necessary to use the PC review process every time a potential compliance issue comes up. However, if a provider compliance issue is impacting the health, safety, or outcomes of the individual, it is advised to use the compliance process. It is important to use the Provider Compliance process for any situation that is identified in rule and is part of the PC compliance review process. The individual's QA review for outcomes and satisfaction is different than a provider's compliance to requirements to continue certification. It is necessary to separate the individual's QA from the provider's compliance.

POC

Q. What method is acceptable for submitting a Plan of Compliance to the department?

A: **E-mail** - remember that corresponding evidence must be submitted with the POC
Fax- remember that corresponding evidence must be submitted with the POC
Hard copy - remember that corresponding evidence must be submitted with the POC

The date that all documentation necessary to determine whether the POC is acceptable is the date the POC is considered received.