CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of care and services paid by Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

COMPLIANCE REVIEWS

The Department of Medical Assistance Services and its contractors routinely conduct compliance reviews to ensure that the services provided to Medicaid enrolled individuals are medically necessary and appropriate and are provided by the appropriate provider. Managed Care Organizations (MCOs) conduct audits for services provided to Members enrolled in Managed Care. These reviews are mandated by Title 42 C.F.R., Part 455. Providers and individuals are subject to periodic and unannounced utilization reviews, as well as identified for review by system- generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider’s peer group.

To ensure a thorough and fair review, trained professionals employed by DMAS or its contractors review all cases using available resources, and make on-site reviews of medical records, as necessary.

Statistical sampling may be used in a review. The Department or its contractor will use a random sample of paid claims for the audit period to calculate any excess payment. Overpayments will also be calculated based upon review of all claims submitted during

a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, DMAS may restrict or terminate the provider's participation in the program.

PSYCHIATRIC SERVICES MEDICAL RECORD REQUIREMENTS

Documentation for each psychiatric service must be written at the time the service is rendered and must include the dated signature of the professional rendering the service. Medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author.

A required physician signature for DMAS purposes may include signatures, computer entry, or rubber-stamped signature initialed by the physician. These methods only apply to DMAS requirements. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the provider's administration with a signed statement to the effect that he or she is the only person who has the stamp and he or she is the only person who will use it. The physician must initial and completely date all rubber-stamped signatures at the time the rubber stamp is used. For additional information on physician signatures, refer to the Medicaid *Physician Manual*.

When plans of care and psychotherapy or counseling services are provided by one of the following: "Residents" under supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10) or licensed substance abuse treatment practitioner (18VAC115-60-10) approved by the Virginia Board of Counseling; "Residents in psychology" under supervision of a licensed clinical psychologist approved by the Virginia Board of Psychology (18VAC125-20-10); "Supervisees in social work" under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work (18VAC140-20-10), to support the billing of these services, the licensed supervisor must ensure that:

- Therapy or counseling sessions rendered by a Resident or Supervisee must be provided under the direct, personal supervision of a qualified, Medicaid enrolled provider.
- The therapy session must contain at a minimum the dated signature of the Resident or Supervisee rendering the service but also include the dated signature of the qualified, Medicaid enrolled, licensed supervising provider.
- Each therapy session must contain the dated co-signature of the supervising provider within one business day from the date the service was rendered indicating that he or she has reviewed the note. The direct supervisor can be the licensed program supervisor/manager for the agency.

INPATIENT ACUTE CARE

General Acute Care Hospital Audits

The audits for General Acute Care Hospitals for psychiatric stays shall consist of a review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in 42 CFR §§ 456.100 through 456.145.

2. List of current Utilization Management Committee members and physician advisors to determine that the Committee's composition is as prescribed in the 42 CFR §§ 456.105 through 456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and lists of attendees to determine that the Committee is meeting according to its utilization management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR §§ 456.141 through 456.145.

5. Topic of one ongoing Medical Care Evaluation Study to determine if the hospital is in compliance with the 42 CFR § 456.145.

6. From a list of randomly selected paid claims, the hospital must provide a copy of the physician admission certification, recertification if applicable, and written plan of care for each selected stay to determine the hospital's compliance with 42 CFR §§ 456.60 and 456.80. If any of the required documentation does not meet the requirements found in the 42 CFR §§ 456.60 through 456.80, reimbursement may be retracted.

7. The hospital may appeal in accordance with the *Administrative Process Act* (§§ 2.2- 4000 et seq., of the Code of Virginia) and the provider appeal regulations (12VAC 30–20–500 et. seq.) any adverse decision resulting from such audits, which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.

All medical record entries must also include the time of the entry, as well as the dated signature of the provider of any service or intervention. All patient medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This includes, but is not limited to, orders, progress notes, procedure notes, patient assessments, H&Ps, treatment interventions, and any other service or treatment provided.

Free-Standing Psychiatric Hospital Audits

Absence of any of the required documentation may result in denial or retraction of any reimbursement. In each case for which payment for freestanding psychiatric hospital services is made under the State Plan:

1. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a free-standing psychiatric hospital consistent with 42 CFR Section 456.160.
2. The physician, or physician assistant, or nurse practitioner, acting within the scope of practice as defined by state law and under the supervision of a physician, must recertify, at least every 60 days that the individual continues to require inpatient services in a psychiatric hospital.
3. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician must perform a medical evaluation of the individual and appropriate professional personnel must make a psychiatric and social evaluation as cited in 42CFR 456.170.
4. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each individual as cited in 42CFR 441.155 and 456.180. The plan shall also include a list of services provided under written contractual arrangement with the freestanding psychiatric hospital that will be furnished to the individual through the freestanding psychiatric hospital's referral to an employed or contracted provider, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought.

The audits for freestanding psychiatric facilities shall consist of a review of the following:

a. Copy of the freestanding psychiatric facility's Utilization Management Plan to determine compliance with the regulations found in 42 CFR Sections 456.200 through 456.245.

b. List of current Utilization Management Committee members and physician advisors to determine that the Committee's composition is as prescribed in 42 CFR Sections 456.205 through 456.206.

c. Verification of Utilization Management Committee meetings, including dates and list of attendees to determine that the Committee is meeting according to their Utilization Management meeting requirements.

d. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR Sections 456.241 through 456.245.

e. Topic of one on-going Medical Care Evaluation Study to determine that the hospital is in compliance with 42 CFR Section 456.245.

f. From a list of randomly selected paid claims, the free-standing psychiatric facility must provide a copy of the certification for services; a copy of the physician admission certification for services, independent team certification if applicable; a copy of the required medical, psychiatric, and social evaluations; and the written plan of care for each selected stay to determine the hospital's compliance with the *Code of Virginia* Sections 16.1-335 through 16.1-348 and 42 CRF Sections 441.152, 456.160, and Sections 456.180 through 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may be retracted.

g. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a free-standing psychiatric facility consistent with 42 CFR Section 456.160.

h. The physician, or physician assistant, or nurse practitioner, acting within the scope of practice as defined by state law and under the supervision of a physician, must recertify, at least every 60 days that the individual continues to require inpatient services in a psychiatric facility.

i. Validation of documentation received during the preauthorization process.

j. All required provision of services must be fully documented in the medical record.

k. Compliance with restraint and seclusion regulations will be reviewed (42 CFR §§ 483.350 – 483.376).

The freestanding psychiatric hospital shall not receive a per diem reimbursement for any day that:

- The initial or comprehensive written plan of care fails to include within three business days of the initiation of the service provided under arrangement all services that the individual needs while at the freestanding psychiatric hospital and that will be furnished to the individual through the freestanding psychiatric hospital's referral to an employed or contracted provider of services under arrangement;

- The comprehensive plan of care fails to include within three business days of the initiation of the service the prescribed frequency of such service or includes a frequency that was exceeded;

- The comprehensive plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;

- The referral to the service provided under arrangement was not present in the patient's freestanding psychiatric hospital record;

- The service provided under arrangement was not supported in that provider's records by a documented referral from the freestanding psychiatric hospital;

- The medical records from the provider of services under arrangement (i.e., admission and discharge documents, plans of care, progress notes, treatment summaries, and documentation of medical results and findings) (i) were not present in the patient's freestanding psychiatric hospital record or had not been requested in writing by the freestanding psychiatric hospital within seven days of

completion of the service or services provided under arrangement or (ii) had been requested in writing within seven days of completion of the service or services, but had not been received within 30 days of the request, and had not been re-requested; or

- The freestanding psychiatric hospital did not have a fully executed contract or an employee relationship with the provider of services under arrangement in advance of the provision of such services. For emergency services, the freestanding psychiatric hospital shall have a fully executed contract with the emergency services hospital provider prior to submission of the ancillary provider's claim for payment.

The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service billed prior to receiving a referral from the freestanding psychiatric hospital or in excess of the amounts in the referral.

Absence of any of the required documentation for either freestanding facilities or acute care hospitals may result in retraction of payment. Services not documented in the individual's record as having been provided will be determined not to have been provided, and retractions may be made.

Utilization Review Process

DMAS or its contractors conduct utilization review audits on providers of inpatient psychiatric services for Medicaid individuals within freestanding psychiatric facilities and acute care psychiatric facilities. These audits are conducted to determine that the provider is in compliance with the regulations governing mental hospital utilization found in 42 CFR, Section 456.150 and general acute care hospitals found in 42 CFR, Section 456.50-456.145. These audits can be performed either on-site or as a desk audit. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

Criteria for Reimbursement

Psychiatric services that fail to meet Medicaid criteria are not reimbursable. Such non-reimbursable services will be denied upon service authorization or at the time of the post-payment utilization review.

Medicaid criteria for reimbursement of inpatient psychiatric services are found throughout the provider manual and include, but are not limited to:

- A Pre-Admission Screening Report, signed by the required team members, with a recommendation to admit the individual to inpatient services and an indication of why community resources do not meet the individual's needs;

- Certificate of need or independent team certification for admission that is completed and dated prior to admission and the request for authorization;

- Provision of all ordered services in the individual's written plan of care by qualified professionals;

- Written Plan of Care completed by specified professionals and addressing the components listed in Chapter IV of this manual;

- Timely review of the written Plan of Care;
- Dated signatures of qualified service providers on all medical documentation; and
- Medical records sufficient to document fully and accurately the nature, scope and details of the health care provided.

Upon completion of an on-site review the utilization review analyst(s) may meet with staff members as selected by the provider for an exit conference. The exit conference will provide an overview of the findings from the review, and based on the review team's report and recommendations, DMAS may take any corrective action necessary regarding retraction of payment. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services and utilization control regulations.

Upon completion of an on-site or desk review, DMAS will respond to the provider in writing and cite federal or state regulations and policy and procedures that were not followed outlining any retractions necessary.

If DMAS requests a corrective action plan, the provider must submit the plan, within 30 days of the receipt of notice, to the utilization review analyst(s) who conducted the review. Subsequent visits/desk reviews may be made for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

OUTPATIENT PSYCHIATRIC SERVICES

DMAS or its contractor will conduct periodic, utilization review on-site or as desk reviews of individuals currently receiving psychiatric services, including Mental Health Clinic Services. DMAS or its contractor may also review a sample of closed medical records. DMAS or its contractor may also conduct an on-site investigation as follow-up to any complaints received.

Documentation Criteria

Providers of outpatient psychiatric services are expected to document the requirements outlined in this manual, as well as the following:

- History, to include:
  - The onset of the diagnosis and functional limitations;
  - Family dynamics; ability/desire of the family/caretakers to participate and follow through with treatment;
  - Reasons that may require consideration (foster care, dysfunctional family);
  - Previous treatment and outcomes;
  - Medications, current and history of;
  - Medical history if relative to current treatment;
  - Treatment received through other programs (Department of Aging and Rehabilitative Services, day treatment, Special Education, Community Services Board/Behavioral Health Authority, or the Department of

Behavioral Health and Developmental Services clinics.
  - Functional limitations; if any
- Plan(s) of Care (POC), and review of the plan of care signed and dated by the LMHP. An initial plan of care is required to be completed at the start of services. The POC may be incorporated in the Psychiatric Diagnostic Interview.
- Medical Evaluation (evidence of coordination with the primary care physician (PCP), if applicable, or documentation that it is not applicable). The purpose of the evaluation is to rule out any underlying medical condition as causing the symptoms, and to ensure that any underlying medical conditions are being treated. The provider is expected to have the results of a medical evaluation in the individual's medical record or indicate that the individual's condition either does not warrant an evaluation or an evaluation was recommended and for what reasons.
- Results of a Diagnostic Evaluation done within the past year.
- Documentation of a psychiatric diagnosis that is current, within the past year.
- Progress Notes for each unit (must be individual-specific, must describe how the activities of the session relate to the individual -specific goals, describe the therapeutic intervention, the length of the session, the level of participation in treatment, the modalities of treatment, the type of session [group, individual, medication management], the progress or lack thereof toward the goals, and the plan for the next treatment and must contain the dated signatures of the providers).
- Evidence of discharge planning and discharge summary.

Outpatient psychiatric services that fail to meet Medicaid criteria are not reimbursable. Such non-reimbursable services will be denied upon service authorization or at the time of the post-payment utilization review.

Upon completion of an on-site review the utilization review analyst(s) may meet with staff members as selected by the provider for an exit conference. The exit conference will provide an overview of the findings from the review, and based on the review team's report and recommendations, DMAS may take any corrective action necessary regarding retraction of payment. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services and utilization control regulations.

Upon completion of an on-site or desk review, DMAS or its contractor will respond to the provider in writing and cite federal or state regulations and policy and procedures that were not followed outlining any retractions necessary.

If DMAS or its contractor requests a corrective action plan, the outpatient psychiatric service provider must submit the plan, within 30 days of the receipt of notice, to the utilization review analyst(s) who conducted the review. Subsequent visits/desk reviews may be made for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

MEDICAL RECORD RETENTION

The provider must recognize the confidentiality of individuals' medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for

the release of information. The individual's written consent is required for the release of information not authorized by law. Documentation in all current individual medical records and those of discharged individuals must be completed promptly. All clinical information pertaining to an individual must be centralized in the individual's clinical/medical record.

Records of all outpatient psychiatric services must be retained for not less than five years after the date of discharge. Records must be indexed at least according to the name of the individual to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). **Refer to 42 CFR 485.721 for additional requirements**.

Upon the transfer of ownership or closure of a service provider or facility, the current provider or facility is required to notify DMAS Provider Enrollment and the supervisor of the MHUR/Hospital Utilization Review Unit in writing within 30 days of the effective date of the change. Information required concerning the change includes, but is not restricted to, the effective date of the change and who will have custody of the files/records. Send notice to:

Department of Medical Assistance Services
Hospital Utilization Review Supervisor
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
Or
Department of Medical Assistance Services
Provider Enrollment
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

Providers must notify Magellan of Virginia via VAProviders@MagellanofVirginia.com and any contracted Medicaid MCO.

The facility or agency must maintain medical records on all individuals in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information.

FRAUDULENT CLAIMS

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law. Some examples of falsifying records include, but are not limited to:

- Creation of new records when records are requested

- Back-dating entries
- Post-dating entries
- Writing over, or adding to existing documentation (except as described in late entries, addendums or corrections, which would include the dated signature of the amendments)

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The Virginia Medicaid Program, DMAS, maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations, Medicaid Memos, the provider agreement, Magellan of Virginia and MCO contract if applicable, and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee or business contractor providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 692-0480

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Reports may be made to Magellan of Virginia via one of the following methods:

- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit Email: Compliance@MagellanHealth.com

- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit Email: SIU@MagellanHealth.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

Member Fraud

Allegations about fraud or abuse by individuals are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (DSS) or to the DMAS Recipient Audit Unit at (804)786-0156. Reports are also accepted at the RAU Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the RAU email address: memberfraud@dmas.virginia.gov or forwarded to:

Program Manager, Recipient Audit Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid enrolled individuals suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate individuals on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voicemail receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.