CHAPTER VI

UTILIZATION REVIEW AND CONTROL

Table of Contents

INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through 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) or its designated contractor(s) conducts periodic utilization reviews on all programs. In addition, DMAS or its designated contractor(s) conducts compliance reviews on providers that are found to provide services that are not within the established Federal or State codes, DMAS guidelines, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that Participation Agreement, contracts, state and federal regulations, Medicaid Memos and Provider Manual requirements for services rendered are met in order to receive payment from DMAS and its contractors. Under the Participation Agreement/contract with DMAS, Magellan of Virginia and the Medicaid Managed Care Organizations (MCOs) the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives or its designated contractor(s), 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 procedures conducted by DMAS. The MCOs conduct audits for services provided to Members enrolled in Managed Care. Providers shall contact the specific MCO for information about the utilization review and control procedures conducted by the MCO.

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

DMAS or its designated contractor(s) routinely conduct compliance reviews to ensure that the services provided to Medicaid individuals are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455.

Providers and individuals are 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 peer group.

To ensure a thorough and fair review, trained professionals review all cases using available resources, including appropriate consultants, and perform on-site or desk reviews.

Overpayments will be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by DMAS, the BHSA or the MCOs if they are found to have billed these entities contrary to law or manual requirements, 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, the BHSA or the MCOs may restrict or terminate the provider's participation in the program.

DMAS contracts with Health Management Systems, Inc. (HMS) to perform audits of FFS Mental Health Services in-state and out-of-state providers that participate in the Virginia Medicaid program. DMAS will also continue to audit mental health services as well. Providers that have been audited by HMS and have questions directly pertaining to their audit may contact HMS at: VABH@HMS.com

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.

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 program 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, understanding, and adhering to applicable state and federal regulations, Medicaid Memos, their provider agreement with DMAS or its contractor, 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/her signature or the signature of his/her authorized agent on each invoice that all information provided to DMAS and its contractors is true, accurate, and complete. If provider attests to having all required licensed as required they must be able to furnish such documentation. Although claims may be prepared and submitted by an employee or contracted business partner, 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:

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

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:

Office of the Attorney General
Director, Medicaid Fraud Control Unit
202 North Ninth Street
Richmond, Virginia 23219

Member Fraud

Allegations about fraud or abuse by Medicaid enrolled individuals are investigated by the Recipient Audit Unit of the DMAS. 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. The sanction period may only be revoked or shortened by court order.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (LDSS) or to the DMAS Recipient Audit Unit via 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: recipientfraud@dmas.virginia.gov or forwarded to:

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

PATIENT UTILIZATION AND MANAGEMENT SAFETY PROGRAMS (PUMS)

The DMAS contracted MCOs must have a Patient Utilization Management & Safety Program (PUMS) for MCO enrolled members which is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and care coordination program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the MCO must refer members to appropriate services based upon the member's unique situation.

Once a Member meets the placement requirements for PUMS, the MCO may limit a member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO may limit a member to providers and pharmacies that are credentialed in their network.

If the member changes MCOs while the member is enrolled in a PUMS, the receiving MCO must re-evaluate the member within thirty (30) calendar days to ensure the member meets the minimum criteria above for continued placement in the health plan's PUMS. More information about the PUMS process is located in Chapter IV of this provider manual.

UTILIZATION REVIEW – GENERAL REQUIREMENTS

Utilization reviews of enrolled providers are conducted by DMAS, the designated contractor or the MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

Utilization reviews are comprised of desk audits, on-site record review, and may include observation of service delivery and review of all provider policies and procedures and human resource files. Dependent upon the setting, the utilization review may also include a tour of the program. Staff will visit on-site or contact the provider to request records. Utilization Review may also include face-to-face or telephone interviews with the individual, family, or significant other(s), or all. In order to conduct an on-site review, providers may also be asked to bring program and billing records to a central location within their organization. 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.

DMAS and the MCOs shall recover expenditures made for covered services when providers' documentation does not conform to standards specified in all applicable regulations. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider’s care. Such documentation shall fully disclose the extent of services provided in order to support provider’s claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered or within one business day from the time the services were rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

The review will include, but is not limited to, the examination of the following areas / items:

- If a provider lacks a full or conditional license or a provider enrollment agreement does not list each of the services provided and the locations where the provider is offering services, then during a utilization review the provider will be subject to retraction for all unlisted service and/or locations.
- Health care entities with provisional licenses shall not be reimbursed by Medicaid.

- An assessment of whether the provider is following The U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009).
- An assessment of whether the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.).
- The appropriateness of the admission to service and for the level of care, and medical or clinical necessity of the delivered service.
- A copy of the provider's license/certification, staff licenses, and qualifications to ensure that the services were provided by appropriately qualified individuals and licensed facilities.
- Verification that the delivered services as documented are consistent with the documentation in the individual's record, invoices submitted, and specified service limitations.
- The reviewer determines that all documentation is specific to the individual and their unique treatment needs. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient services and may not be adequate recordkeeping mechanisms for these services.
- The reviewer determines whether all required aspects of treatment (as set forth in the service definitions) are being provided, and also determines whether there is any inappropriate overlap or duplication of services.
- The reviewer determines whether all required activities (as set forth in the appropriate sections of this manual and related regulations) have been performed.
- The reviewer determines whether inappropriate items have been billed.
- The reviewer determines whether the amount billed matches the documented amount of time provided to the individual.
- Evidence that for members receiving substance use case management, the ARTS service provider collaborated with the substance use case manager and provided notification of the provision of services with appropriate consent meeting requirements of 42 CFR Part 2. In addition, the provider must send written monthly updates to the substance use case manager. The individual's Primary Care Provider (PCP) must be notified of services to ensure coordination of care. A written discharge summary must be sent to the PCP and substance use case manager within 30 days of the service discontinuation date. Only one type of case management can be provided at a time.

Services must meet the requirements set forth in the Virginia Administrative Code (12 VAC 30) and in the Virginia State Plan for Medical Assistance Services and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

Upon completion of on-site activities for a routine utilization review, the MCO, DMAS, or its designated contractor(s) may be available to meet with provider staff for an Exit Conference. The purpose of the Exit Conference is to provide a general overview of the utilization review procedures and expected timetables.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be noted. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting medical record documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, DMASor its designated contractor(s) will contact the provider to conduct an Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the provider.

If a billing adjustment is needed, it will be specified in the final audit findings report.

If the provider disagrees with the final audit findings report, they may appeal the findings. Refer to Chapter II for information on the provider appeal process.

MEDICAL RECORDS AND RETENTION

The provider must recognize the confidentiality of recipient 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 recipient's written consent is required for the release of information not authorized by law. Current recipient medical records and those of discharged recipients must be completed promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical/medical record.

Records of Medicaid covered services must be retained for not less than five years after the date of service or discharge. Records must be indexed at least according to the name of the recipient 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 482.24 for additional requirements.

The provider must maintain medical records on all recipients 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. All medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. Documentation should be clear and legible.

DOCUMENTATION REQUIREMENTS FOR ALL DME

Medical documentation must provide DMAS with a clear understanding of the individual's needs. The following applies to the medical justification necessary for **all DME services** regardless of whether or not service authorization (SA) is required. The documentation is necessary to identify:

- The medical need for the requested DME;
- The diagnosis related to the reason for the DME request;
- The individual's functional limitation and its relationship to the requested DME;
- How the DME service will treat the individual's medical condition;
- The quantity needed and the medical reason the requested amount is needed;
- *The frequency of use (holds more weight for expendable supplies – see "note" below);
- The estimated length of use of the equipment (holds more weight for DME especially related to rental vs. purchase);
- Any conjunctive treatment related to the use of the DME or supplies;
- How the needs were previously met and identifying changes that have occurred which necessitate the DME;
- Other alternatives tried or explored and a description of the success or failure of these alternatives;
- How the DME service is required in the individual's home or community environment; and
- The individual or caregiver's ability, willingness, and motivation to use the DME.

**NOTE: ***Frequency of use is part of the practitioner's order and describes how often a supply is used by the individual and provides the justification for the quantity ordered per

month. Frequency of use should be documented by how often the individual uses the supplies ordered. For example, an individual needs incontinent briefs and must be changed seven (7) times per day. Seven times per day is the frequency of use. The frequency of use is multiplied by 31 days and should justify the quantity ordered per month on the CMN/DMAS-352. This documentation can be noted by the day, the week or the month depending on the type of supply and the individual's needs. Some items may be used once per week or twice per month so if an item is needed less than monthly the provider should document accordingly. Frequency of use holds more weight for expendable supplies but can be required for DME. (Frequency of use means – how often something is used. Quantity means – total. The provider will need to know how often the supply is used to determine quantity).

FACE-TO-FACE DOCUMENTATION REQUIRMENTS FOR DME – FEE-FOR-SERVICE

This only applies to FFS members and not those enrolled in one of DMAS' managed care plans.

Beginning July 1, 2017, no payment shall be made for new DME (as defined in 12VAC30-50-165) unless a face-to-face encounter has been performed by an approved practitioner (outlined below) no more than six (6) months prior to the begin service date. The face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires DME.

The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering physician.

Providers must use the CMN form to document the new requirements. Completion of all elements related to the face-to-face requirements on the CMN will satisfy the face-to-face encounter documentation requirements. For DME items that require service authorization as indicated in the table below, providers must during the service authorization process, "attest" that the face-to-face encounter requirement has been met. For those items that do not require a service authorization, the CMN with the face-to-face encounter documentation should be maintained in the individual's medical record. Additional information regarding the face- to-face requirements are found in Ch. IV of this manual.

INSTRUCTIONS FOR COMPLETING THE CMN/DMAS-352

Section I - Individual Data

Section I contains demographic information for the individual and the servicing provider. This section is the **only** section of the CMN/DMAS-352 that can be changed after the practitioner has signed the CMN/DMAS-352. This information is considered technical information that will not affect the practitioner's order.

Section II – Individual Clinical Information

Section II contains the individual's information. There are eight questions that should be answered, if applicable, to the DME/supplies being requested. If the answer is "yes" to any of the questions, additional information should be provided on the CMN/DMAS-352 or in supporting documentation signed and dated by the practitioner. To the right of the eight questions is a box for description/additional information. This section can be used to provide medical justification for the item/s being ordered. This section also includes the documentation for the face-to-face encounter required for specified DME HCPCS codes. The practitioner should check the appropriate box indicating if a face-to-face was completed and the name, credentials and date of the practitioner who completed encounter. Below the eight questions are two additional questions to respond to when appropriate.

The first question must be answered on the CMN/DMAS-352 or in the supporting documentation. If the individual/caregiver is unwilling or unable to use the item it would not be covered.

The second question is the date the individual was last examined by the practitioner and must be completed on the CMN/DMAS-352 or in the supporting documentation. The individual must have seen the ordering practitioner within the last 2 years; however, some DME/supplies have stricter criteria. See the criteria for the ordered items for the guidelines in Chapter IV of this manual.

The last part of Section II is for the individual's diagnoses. The diagnoses should be related to the reason for the DME/supplies request. The ICD code is optional. The clinical diagnosis narrative is required. The date of onset should be noted if available.

Section III – Specific Physician Ordered DME and Supplies

Section III is to be completed for all DME/supplies ordered for the individual, to include each component of the DME and supplies. Page two of the CMN allows for additional orders that won't fit on the first page of the CMN.

The begin service date on the CMN/DMAS-352 is optional. If the provider enters a begin service date, the CMN/DMAS-352 must be signed and dated by the practitioner within 60

days of the begin service date in order for the CMNDMAS-352 to start from the begin service date. Refer to the following examples:

- If the begin service date is 01/01/2015 and the practitioner signs and dates the CMN/DMAS-352 on 02/03/2015, the CMN/DMAS-352 meets the 60 day requirement. If the individual is 21 years of age and older the CMN is good from 01/01/2015 to 12/31/2015, if all other requirements are met. If the individual is under 21 years old the CMN/DMAS-352 is good from 01/01/20015 to 06/30/2009, if all other requirements are met.

- If the begin service date is 01/01/2015 and the practitioner signs and dates the CMN/DMAS-352 on 03/14/2015, the CMN/DMAS-352 does not meet the 60 day signature requirement. If this individual is 21 year of age and older the CMNDMAS-352 is good from 03/14/2015 to 12/31/2015, if all other requirements are met. For an individual under 21 years of age the CMN/DMAS-352 is good from 03/14/2015 to 06/30/2015, if all other requirements are met.

- If **no** begin service date is provided on the CMN/DMAS-352 the date of the practitioner's signature is the start date of the CMN/DMAS-352. If the CMN/DMAS-352 is signed by the practitioner on 02/01/2015 and the individual is 21 of age and older the CMN/DMAS-352 is good from 02/01/2015 to 01/31/2016 if all other requirements are met. If the individual is under 21 years of age the CMN/DMAS-352 is good from 02/01/2015 to 07/31/2015, if all other requirements are met.

The HCPCS code column on the CMN/DMAS-352 is optional. However, the provider is responsible for using the correct HCPCS code for service authorization (if required) and billing. The DME provider can contact the manufacturer of the DME/supplies or visit the Noridian site at https://www.dmepdac.com/dmecsapp/do/search for coding assistance. Coding accuracy may be reviewed at post payment audit.

The item ordered description is a required field to be completed on the CMN/DMAS-352. If this section is not completed the CMN/DMAS-352 is invalid for this item. If the item is an E1399 (miscellaneous), the description of the item should not be miscellaneous DME, the provider should specify the DME item/supply.

The length of time needed should be documented on the CMN/DMAS-352 or in the supporting documentation signed and dated by the practitioner. The length of time the item is needed must be evaluated for durable items when determining whether the item is purchased or rented.

The quantity ordered column is a required field on the CMN/DMAS-352 and is part of the practitioner's order. For expendable supplies the provider must designate supplies needed for one month. If an item is not needed every month the provider may designate an alternate time frame. For example, if an individual needs a supply once every two months the provider may document 1 every 2 months or 1/2M in the quantity section. If this section is left blank the order is not complete and the CMN/DMAS-352 would be invalid for that item.

The Quantity/Frequency of use/Justification/Comments column provides a space for this documentation but can also be documented on the supporting documentation signed and dated by the practitioner. Frequency of use must be documented for expendable supplies to justify the quantity but can also be required for durable medical equipment Frequency of use is a required part of the practitioner's order and describes how often a supply is used by the individual and provides the justification for the quantity ordered per month. Frequency of use must be documented and can be determined by how often the individual uses the supplies ordered. For example, the individual needs incontinent briefs and is changed 7 times per day. Seven times per day is the frequency of use. The frequency of use is multiplied by 31 days and should justify the quantity ordered per month on the CMN/DMAS-352.

Documentation can be noted by the day, the week or the month depending on the type of supply and the individual's needs. Some items may be used once per week or twice per month so if an item is needed less than monthly the provider should document accordingly. Frequency of use holds more weight for expendable supplies but can be required for DME. (Frequency of use means – how often something is used. Quantity means – total. The provider will need to know how often the supply is used to determine quantity).

.

Section IV – Practitioner Certification

Section IV is for practitioner certification. The practitioner shall print his/her full name in the first blank. The second blank is for the practitioner signature. The third blank is for the date of the signature and should contain the full date (day/month/year). Note: An attached practitioner prescription will **not** be accepted in lieu of the practitioner's signature and date on the CMN. If orders for DME/supplies are written on both pages of the CMN, the practitioner must sign and fully date both pages on the CMN. The complete practitioner Medicaid provider number (NPI) and phone number are optional.

NOTE: The practitioner signature and full date is required on the CMN. If either the signature or full date or both is missing the **entire** CMN is **invalid** and a new CMN must be obtained. The purpose of the practitioner certification is to certify that the ordered DME/supplies are a part of the treatment plan and, in the opinion of the practitioner, are medically necessary.

DOCUMENTATION REQUIREMENTS FOR REPAIR OF RENTED OR PURCHASED DME

The provider shall document the following:

- What equipment the individual is currently using and why that equipment is no longer appropriate for the individual. This description shall include the reason why repairs could not be done or why the option to repair the equipment was not cost effective.

- The provider shall include a breakdown of what items need to be repaired and include the cost to repair the items to justify why the purchase of new equipment would be more cost effective.

- If the item is no longer appropriate due to a change in medical condition, limitations and symptoms, or if the equipment was provided inappropriately, the provider shall give justification to describe the circumstances.

- The provider must demonstrate short term need versus long term need

DOCUMENTATION REQUIREMENTS FOR SPECIFIC DME ITEMS

In addition to the Medical Necessity guidelines described in Ch. IV of this manual and the documentation requirements for all DME, described previously in this chapter, additional specific medical justification and/or documentation requirements are in place for the following DME:

<u>Hospital Beds</u>
Describe all of the following:

- How the bed will be used to treat a medical condition;
- How needs have and are currently being met;
- The functional abilities/disabilities;
- Other alternatives tried; and
- Why a non-hospital bed would not meet the individual's medical needs.

The following must be documented on the CMN/DMAS-352 or in supporting documentation, along with medical necessity for all Hospital Beds submitted under E1399:

- Will the home support the electricity requirements of the bed?
- Will the home support the weight of the bed?
- Need to list what other beds have been ruled out and why.

- Why is a standard hospital semi/total electric bed with support surface not sufficient?
- Does the bed already include a mattress?

Patient Lifts

The following must be documented on the CMN/DMAS-352 or in supporting documentation. Describe all of the following:

- The individual's weight;
- Identify the caregiver and his or her ability to use the lift;
- The individual's functional limitations;
- How needs were previously met;
- What has changed in the individual's condition to require the lift; and
- The home's accessibility for the lift

Individual Bath Chairs

The following must be documented on the CMN/DMAS-352 or in supporting documentation. Describe all of the following:

- The individual's medical condition and the need for the bath chair;
- The individual's weight;
- Identify the caregiver and his or her ability to use the equipment;
- The individual's functional limitations;
- How needs were previously met,
- What has changed in the individual's condition to require the bath chair; and
- The bathroom's accessibility for the bath chair

Documentation Requirements for All Wheelchairs

The provider **must** document **all** of the following in addition to the minimum documentation requirements:

- Document the diagnosis or condition requiring the wheelchair, and how the requested wheelchair treats that diagnosis/condition;
- Describe how any additional components added to the wheelchair will treat the diagnosis/condition;
- Describe the distance (in feet) the individual can functionally ambulate with or without an assistive device;
- Describe upper and lower extremity strength/weakness;
- Identify how the individual's needs have been met/unmet previously and what changes have occurred to now require a mobility device, or if current mobility device is not meeting need and why;

- Describe cost effective alternatives tried and ruled out;
- Describe home accessibility for the mobility device and how the requested device is needed within the individual's home or for community use;
- If the individual currently owns a wheelchair, describe the type of wheelchair, condition of the wheelchair (describe damage/cost to repair), and any special features included on the wheelchair.

In addition to CMN/DMAS-352, documentation for wheelchairs can be in the form of a letter of medical necessity (LMN), office notes, written documentation on the CMN/DMAS-352 or other supporting documentation that is signed and dated by the practitioner.

Note: All items related to wheelchairs, including correct quantities, hardware, upgraded foam, labor, any item that is an upcharge, etc., must be ordered on the CMN/DMAS-352 and justified either on the CMN/DMAS-352 or in attached, supporting, verifiable documentation, regardless of whether or not the item requires service authorization. All supporting documentation must be individual-specific and must be signed and dated by the practitioner.

Documentation Requirements for Power Wheelchairs

1. Fully completed CMN/DMAS-352, to include the minimum documentation requirements, signed and dated by the practitioner.
2. A specialty evaluation (face to face) will be required for all individuals receiving a Group 2 single power or multi-power option PWC, and Group 3, 4 or 5 PWC, or a push rim activated power assist device for a manual wheelchair. The evaluation must be performed by a health care professional with experience in fitting wheelchairs and making recommendations based on the individual's need (specifically, practitioner, physical therapist, occupational therapist, or rehabilitation engineer in coordination with the physical therapist or occupational therapist). The physical therapy and/or occupational therapy evaluation is a covered rehabilitation program service that may be billed to DMAS. DMAS requires the assessment to be performed by a physical therapist or occupational therapist, especially for wheelchairs with specialized seating and positioning components and features, or for wheelchairs operated via specialty electronics. All evaluations should include but are not limited to the following;

    - Range of motion and semi-quantitative assessment of strength in the extremities
    - Quantitative limitations to passive range of motion in the extremities
    - Detailed description of the individual's condition to include related diagnosis and history
    - Presence or absence of increased muscle tone or spasms
    - Describe head and trunk control in relation to the specific components/type of wheelchair requested

- Describe how the equipment benefits the individual in performing activities of daily living (ADLs)
- Detailed list, description and justification of wheelchair base and accessories
- Detailed description of the individual's long-term prognosis
- Size, weight and measurements of the individual
- Description of the medical condition necessitating use of a wheelchair
- Extent of the individual's ability to ambulate. If the individual can ambulate, what are the limitations to this ambulation and does it require an assistive device? If a device is currently being used, indicate the device and why the device no longer meets the individual's needs. Indicate other alternatives tried and ruled out.

3. Home Assessment – The provider must perform an on-site evaluation of the patient's home prior to delivery. A written report must be kept in the individual's clinical record. The home assessment must verify the following:
    - The wheelchair is accessible in the home setting
    - The individual can adequately maneuver the wheelchair in the home, taking into consideration:
        - Physical layout;
        - Doorway width(s);
        - Doorway thresholds; and,
        - Surfaces

4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the individual.

5. Manufacturer information to include price, make, model of wheelchair and all accessories for the wheelchairs reimbursed as Individual Consideration (IC).

<u>Documentation Requirements for Wound Care Supplies</u>

Describe all of the following:

- The total number of wounds;
- The location;
- Stage;
- Size;
- Depth;
- Drainage;
- Color of each wound;

- Who is providing the wound care (individual, caregiver, home health nurse);
- Frequency of the wound care; and
- The complete practitioner's order for the wound care

Additional documentation requirements for specific items may be found in the "Medicaid DME and Supplies Listing" in Appendix B and as described in Chapter IV of this manual.

Documentation Requirements for Communication Devices

The speech-language pathology documentation must show that the individual's ability to use the device is improving and that the individual is motivated to continue to use the device.

The CMN/DMAS-352, speech/language evaluation, and/or other verifiable supporting documentation must include all the following:

- The complete practitioner's prescription for the augmentative communication device, including an itemization of the components (i.e., special switches, special mounting devices, etc.) required by the individual;
- Documentation describing the individual's medical condition/diagnosis, including a description of the individual's disease, general prognosis, and prognosis for intelligible speech;
- Documentation if the condition permanent, temporary, or changing;
- Documentation to demonstrate if the medical condition will result in an increased or decreased need for a device in the future;
- A description of how the individual communicates medical needs now and how communication needs are currently unmet\met;
- Is the individual cognitively/physically able and motivated to use an augmentative communication device? Documentation must include an assessment of the individual's gross and fine motor skills, e.g., hand use skill, including finger dexterity;
- A description of related impairments including audio/visual, perceptual, and/or memory, that would limit his or her ability to use a device, or that would require the use of a specific augmentative communication device;
- A description of the plan to provide ongoing speech-language therapy and support in the use of the communication device in the individual's home and community; a list of other devices that have been tried by the individual (describe the success/failure); a description of how the requested device better meets the individual's medical needs than more cost- effective devices available;
- A description of the extent to which the individual and/or family/caregivers are able to properly program and utilize the device; and

- Specific information about the device including: the manufacturer's name, catalog number, product description, a photo (if available), and documentation of the provider's cost, less any discounts available.

Documentation Requirements for Enteral Nutrition

For individuals eligible for enteral nutrition, the DME provider must obtain and maintain all of the following documentation:

- The CMN/DMAS-352 is required for all nutritional supplements and supplies regardless of whether or not the individual is enrolled in a Medicaid home and community based waiver program.
- A complete description of the item(s) being supplied;
- A copy of the supplier's invoice or the dealer cost information to document the cost of the item(s) marked as Individual Consideration (IC) as listed in the Fee column of the Appendix B; any discount received must be indicated; and
- Delivery tickets for the items provided

The required medical justification can be included in the supporting documentation that is signed and dated by the practitioner. The CMN/supporting documentation must include all of the following elements:

1. Height (or length for pediatric individuals);
2. Weight (if unobtainable, may provide mid-arm circumference and triceps skinfold test data). For initial assessments, indicate the individual's weight loss over time;
3. Formula tolerance (e.g., is the individual experiencing diarrhea, vomiting, and constipation?). This element is only required if the individual is already receiving a supplement;
4. Tube or stoma site assessment, as applicable;
5. Indication of whether the supplement is the primary or sole source of nutrition;
6. Route of administration;
7. The daily caloric order and the number of calories per package, can, etc.
8. Title, signature, and date of the qualified personnel completing the assessment; and
9. Practitioner signature and date in accordance with criteria for supporting documentation. See Chapter IV of this manual.

NOTE: If the practitioner is unable to obtain a current weight, the practitioner must document the reason why a weight was unable to be obtained and how the practitioner is able to monitor therapy status without an individual's weights documented.

Documentation Requirements for Home Infusion Therapy-Certificate of Medical Necessity

The CMN/DMAS-352 must be completed for intravenous (I.V.) therapy DME services. The provider may complete the CMN/DMAS-352, but the practitioner must fully date and sign the CMN/DMAS-352 within 60 days of the begin date of service.

The I.V. Therapy Implementation form must be initiated with the beginning of each drug and therapy service provided. The I.V. Therapy Implementation Form (DMAS-354) may be completed by the provider, but must be signed and dated by the practitioner. **Do not attach either the I.V. therapy implementation form (dmas-354) or the CMN to claim requests**.

The Medicaid Program must ensure that only medically necessary I.V. therapy is provided to Medicaid individuals. For DME services, I.V. therapy providers must maintain records that contain the fully completed CMN/DMAS-352, signed and dated by the practitioner; the
I.V. Therapy Implementation Form (DMAS-354), with the begin and end dates for each drug/therapy provided and signed and dated by the practitioner; and the order to discontinue the therapy (the official end date), signed and dated by the practitioner. These forms shall be furnished to DMAS staff or its contractors upon request. The absence of documentation to support I.V. therapy services may result in the retraction of reimbursement.

DMAS forms are located on the Medicaid Web Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Documentation Requirements for Reimbursement of Apnea Monitors and Diagnostic Studies

For the initial 120 days which do not require service authorization, there must be a CMN/DMAS-352 stating the individual's diagnosis that indicates the need for a monitor or a description of the individual's condition.

All of the following documentation (listed in number 1 and 2) is required for the continued use of an apnea monitor over 120 days:

1. A CMN/DMAS-352 and documentation outlining the condition of the individual related to apnea in the previous 120 days of monitoring, including all of the following:

    a) The dates and the number of occurrences of observed apnea;
    b) An interpretation of any related diagnostic tests;

For example: an upper GI series for GE reflux; pneumograms or downloads for recording apnea monitors, that are interpreted and indicate the child had clinically significant apnea during the first 120 days and/or the condition is resolving;

c) Download reports with clinical interpretation from recording monitors. The practitioner is encouraged to order a pneumogram for those children on non- recording apnea monitors in order to document the clinical status;
d) Adequate and verifiable documentation of the oxygen flow rate for those individuals who continue on oxygen; and
e) Adequate and verifiable documentation of the month of death of any sibling who expired due to Sudden Infant Death Syndrome (SIDS) if the child was placed on the monitor for this reason; and

2. A comprehensive history and record of physical examination, with appropriate work-up including specific pulmonary studies as indicated (i.e., sleep airway studies and fluoros- copy, transcutaneous oxygen, pulse oximetry, recording monitor download analysis, and carbon dioxide monitor findings or pneumogram studies).

Documentation for pneumograms, polysomnagrams, and multi-channel sleep studies must specify the number of signals, what signals are to be done, and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis.

Documentation on the CMN/DMAS-352 must specify the number of signals, what signals are to be done and whether or not interpretation is to be done. Documentation must also include the download findings and a wave form analysis. A summary report of the study and all other required documentation must be maintained at the provider's location.

Documentation Requirements for Oxygen

The CMN/DMAS-352 must include all of the following:

- A diagnosis of the disease requiring home use of oxygen;
- The oxygen flow rate;
- An estimate of the frequency, duration of use (e.g., 2 liters per minute, 12 hours a day) and duration of need (e.g., six months or lifetime).
- Oxygen that is ordered PRN must include justification to determine the amount of oxygen that is reasonable and necessary for the individual; and
- Blood gas study results.

The CMN/DMAS-352 or supporting documentation signed and dated by the practitioner must also include the results of a blood gas study ordered and evaluated by the attending practitioner.

Documentation Requirements for Pulse Oximetry

The practitioner must document on the CMN/DMAS-352 or in supporting documentation that the individual's condition meets one of the criteria (see Ch. 4) and provides evidence of all of the following:

- Pulse oximetry readings are necessary on a daily basis in order for the individual to remain in the home;
- The individual does not have a condition which contraindicates the effective use of pulse oximetry (e.g., oxygen toxicity is a concern);
- Alternative treatments which have been attempted (e.g., periodic arterial blood gases); and
- Why periodic pulse oximetry readings (e.g., pulse oximetry reading submitted bimonthly showing SaO2 trends over a specified period of time) would not meet the practitioner's need for monitoring.

In addition, the practitioner must specify the current oxygen flow rate and the assessment parameters: the setting at which the device should be set to alarm and the intervention response or corrective action to be taken (e.g., increase oxygen to 50%, increase oxygen to 2 L/min.).

GENERAL INFORMATION

The DME provider must provide equipment and supplies as prescribed by the physician on the CMN/DMAS-352. The CMN/DMAS-352 shall not be changed, altered, or amended after the attending physician signature date. If changes in the ordered DME or supplies are necessary, as indicated by the individual's condition, the DME provider must obtain a new CMN/DMAS-352. All CMN/DMAS-352's must be signed and dated by the attending physician within 60 days from the time ordered supplies are furnished by the DME provider (CMN/DMAS-352 begin date). (12 VAC 30-50-165)

DME providers shall retain copies of the CMN/DMAS-352 and all applicable supporting documentation on file for post payment audit reviews. Durable medical equipment and supplies that are not ordered on the CMN/DMAS-352 for which reimbursement has been made by Medicaid will be retracted. Supporting documentation is allowed to justify the medical need for durable medical equipment and supplies. Supporting documentation does not replace the requirement for a properly completed CMN/DMAS-352. The dates of the supporting documentation must coincide with the dates of service on the CMN/DMAS-352 and the medical practitioner providing the supporting documentation must be identified by name and title. DME providers shall not create or revise CMN/DMAS-352's or supporting documentation for durable medical equipment and supplies provided before or after the post payment audit review has been initiated. (12VAC 30-60-75)

Some items in the “Appendix B: Durable Medical Equipment and Supplies Listing” of this manual do not have a fee and indicate that a fee is determined by individual consideration (I.C.). In those cases the provider submits for service authorization and provides documentation of their cost. This cost may be an estimate or a quote. The reimbursement amount is determined by adding 30% to the providers cost for the item. Upon receipt of the manufacturer’s invoice, if the cost is less than reported on service authorization, the provider must only bill 30% over the cost of that item. Likewise, if the cost is more than the original estimates, the provider may submit a change request to the service authorization contractor for consideration (See Appendix D of this manual for more service authorization information). The actual cost of the item billed must be documented in the individual’s record.

DME PROVIDER DOCUMENTATION RESPONSIBILITIES FOR DME AND SUPPLIES

To receive reimbursement, the DME provider must have evidence of the following documentation:

- Maintain a copy of the physician's orders (CMN) and all verifiable supporting documentation for all durable medical equipment/supplies ordered;
- Document and justify the description of services (labor, repairs, maintenance of equipment);
- Document and justify the medical necessity of all items and supplies as described in Chapter IV of this manual; and
- Once medical necessity (i.e. incontinence) is established the decision to use tab diapers or pull ups shall be left to the individual or caregiver and shall be documented by the provider on the CMN/DMAS-352; and
- Document all equipment and supplies provided to an individual in accordance with the physician's orders. The delivery ticket/proof of deliver must document the information described under the “Proof of Delivery” section below.

Miscellaneous HCPCS and Individual Consideration (IC)
All of the following must be provided and kept on file in the member’s record:

- A complete description of the item(s) being supplied;
- A copy of the supplier’s invoice or the dealer cost information to document the cost of the item(s);
- Any discount received; and
- MSRP for durable items. MSRP is not required for expendable supplies if it is not available from the manufacturer or supplier.

The manufacturer's invoice, the dealer's price list showing the dealer's cost of the item, or a statement from the manufacturer detailing estimates of cost for specially designed item, are all acceptable documentation. The documentation must include the manufacturer's cost, any discounts provided to the provider, and the provider's ancillary cost of providing the DME and/or supplies to the member. Documentation of the actual cost of the item billed must be in the member's record.

Providers must make sure that the Invoice, CMN/DMAS-352 and delivery ticket are clearly documented for the auditors and service authorization contractor to discern. For example, if the provider has multiple lines of items on a CMN/DMAS-352, the provider should make sure the invoice and delivery ticket are clearly correlated to the items on the CMN/DMAS-
352. This can be done by highlighting, numbering or another method that demonstrates which item correlates to the same item on the CMN/DMAS-352, invoice and/or delivery ticket.

Proof of Delivery

Delivery tickets must contain all of the following:

- The individual's name and Medicaid number **or** date of birth or a unique identifiers (for example, an individual's medical record number);
- A detailed description of the item being delivered. The product name and brand;
- The serial number or product number of the durable medical equipment or supplies if available, not required;
- The quantity that was delivered;
- The signature of the individual, caretaker, or their designee. The designee's signature on the delivery ticket shall be legible. If it is not legible, the supplier must note the name of the designee on the delivery ticket;
- Providers or anyone else having a financial interest in the delivery of an item shall not sign or accept an item on behalf of a Medicaid individual.

Refills or Repeat Orders

- Providers shall make affirmative contact with the individual/caregiver prior to dispensing repeat orders or refills to assure that the item is still needed, the amount is still appropriate and the individual still resides at the same location. The provider must contact the individual prior to each delivery. This contact should take place no sooner than 7 days prior to the delivery/ship date and must be documented in the individual's record. If no affirmative contact is made with the individual or caregiver the monthly refill should not be delivered until affirmative contact is made. Providers should make the individual/caregiver aware of this policy from the start of services and document this conversation in the member's record. Providers can use the

mail for affirmative contact; however, if a mailing is being used for monthly contact the provider shall have in person contact (face to face, by phone, or via electronic means such as use of a provider's web based portal or ordering system) prior to annual recertification on the CMN/DMAS-352.

- Providers shall not deliver refills sooner than 5 days prior to the end of usage. For example, they may not deliver all cases of incontinence briefs for a two month period on one date.

Shipping

- If a commercial shipping service is used, the provider's records must reference, in addition to the above information, the delivery services' package identification number, and a copy of the delivery ticket from the delivery service (this may be a printed from an on-line record on the delivery service's website). The delivery service's identification number must be on the provider's delivery ticket. It is recognized that commercial delivery services may not obtain a signature of the receiving party. Therefore, this documentation will substitute for the individual's signature above as proof of delivery.
- Providers may use a return postage-paid delivery invoice from the individual or designee as a form of proof of delivery. The descriptive information concerning the item(s) delivered, as described above, as well as the required signature/date from either the individual or designee should be included on this invoice as well.

Billing and Delivery

Providers shall not bill for dates of service prior to delivery. The provider must confirm receipt (shipping service record showing the item was delivered is acceptable) prior to billing.

For repeat orders only: Since DMAS allows the provider to ship repeat orders no sooner than five (5) days prior to the end of usage, the provider will need to bill for the item on the date of the refill month and not the delivery date to avoid overlapping claims. This should be documented in the individual's record and only done for repeat monthly orders. For example: If an individual's first months delivery was on January 1st the refill for the 2nd month and all proceeding months should also be on the 1st of the month. For billing purposes the provider should bill delivery on the 1st of the month for this member even though they may have delivered up to five (5) days prior to the 1st of the month.

Discharges from a Hospital or Nursing Facility

DME equipment and supplies delivered for home or community use for individuals being discharged from a hospital or nursing facility DME may be delivered to the facility prior to

discharge; however, the claim date of service may not begin prior to the date of discharge from the hospital or nursing facility.

DMAS RESPONSIBILITY – QUALITY MANAGEMENT REVIEW (QMR) FOR DME AND SUPPLIES

DMAS or its contractor will conduct either a desk review or an on-site quality management review (QMR) for enrolled DME and Supply providers. Such post payment review audits may be unannounced. Medical records of individuals currently receiving DME and Supplies as well as a sample of closed records may be reviewed. DMAS may also conduct an on-site investigation of any complaints that are received.

DMAS staff or its contractors may visit Medicaid individuals in their homes and conduct a professional review (covering physical, emotional, social, and cognitive factors) with respect to all of the following:

- Care being provided to the Medicaid individual by the DME and Supplies provider;
- Adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each individual;
- Necessity and desirability of the continued service to the individual;
- Feasibility of meeting the individual's health needs in alternate care arrangements;
- Verification of the existence of all documentation required by Medicaid, regardless of whether or not the item has been preauthorized; and
- Determination if the item billed was received by the individual.

NOTE: Services/items not specifically documented in the individual’s DME medical record as having been rendered or received, as described under Proof of Delivery, shall be deemed not to have been rendered, and no reimbursement shall be provided. Supporting documentation is allowed to justify the medical need for DME and supplies, but supporting documentation does not replace the requirement for a properly completed CMN/DMAS-352. (12 VAC 30-60-75)

Following a post payment review, a report will be written detailing the findings of the utilization review. Based on the review report and recommendations, DMAS or its contractor may request a corrective action plan. (12 VAC 30-60-75) Actions taken and the level of management involved will be based on the severity of the cited deficiencies which adversely affect the health and safety of the individuals, the quality of life of the individuals, or utilization control regulations.

If DMAS or its contractor requests a corrective action plan, the DME provider must submit the corrective action plan within 30 days of the receipt of the utilization review findings report, to DMAS or its contractor.

Subsequent contact may be made to the provider for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

DMAS or its contractor will deny or retract payment from the DME provider if any of the following occur, but are not limited to (12 VAC 30-60-75):

- No current, fully completed CMN/DMAS-352 (physician's order), appropriately signed and fully dated by the physician;
- Documentation does not verify that the DME item was provided to and received by the individual;
- Lack of medical documentation, signed and dated by the physician, to justify the DME and supplies; or
- Item is non-covered or does not meet DMAS criteria for reimbursement.

If reimbursement is denied by Medicaid, the DME provider shall not bill the Medicaid individual for the service that was provided.