CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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INTRODUCTION

Under the provisions of federal regulations, Medical Assistance Programs must provide for continuing review and evaluation of care and services paid by Medicaid and the Children's Health Insurance Program (CHIP), including review of utilization of the services by providers and by recipients. Federal regulations at 42 CFR §§ 455–456 and 42 CFR §§ 457.490 set forth requirements for detection and investigation of fraud and abuse to maintain program integrity, and require implementation of a statewide program of utilization control to ensure high quality care as well as the appropriate provision of services. This chapter provides information on documentation requirements (referred to in this chapter as Medicaid documentation requirements) and quality management reviews handled by the Department of Medical Assistance Services (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.

GENERAL DOCUMENTATION REQUIREMENTS

Local Education Agency (LEA) providers, and their associated service rendering providers must follow the general documentation requirements for all providers as outlined in the Physician/Practitioner Provider Manual located on the Virginia Medicaid Portal, as well as additional documentation requirements for specific services outlined in this chapter. Documentation must also be in accordance with the requirements of the applicable licensing board and applicable Virginia statutes and regulations.

Records of services must be retained for not less than six years after the last date of service. Documentation must be complete, accurate, readily accessible and systematically organized to facilitate retrieval and compilation of information upon request of DMAS. Service documentation to support billing must clearly identify the recipient of services using the student's full name, and Medicaid or FAMIS ID number. 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.

The following types of service documentation must be maintained and made accessible at the request of DMAS:

Individualized Education Program (IEP) Documentation

The IEP plan is used to document those services that are medically necessary, require the skill level of or supervision by a DMAS-qualified provider, and that the treatment prescribed is in accordance with standards of medical practice.

Service-Specific Evaluations

DMAS covers evaluations performed by a DMAS-qualified provider, acting within the scope of his or her license. This includes Medical Evaluations performed by a physician, nurse practitioner or physician assistant, and evaluations performed by specific covered service-providing disciplines (Physical Therapy (PT), Occupational Therapy (OT), Speech and Language Pathology (SLP), Audiology, or Psychiatry, Psychology and Mental Health. In order to bill for evaluations, the evaluation (listed as a service) or the service type providing the evaluation (i.e., PT, OT, SLP, Audiology, or Psychiatry, Psychology and Mental Health) must be included or referenced in the student's IEP.

Plans of Care (POC)

A plan of care (POC) must be documented for on-going PT, OT, SLP, Audiology, Nursing and Personal Care services referenced in the IEP. Each POC must include:

- The medical diagnosis or identifying issue to be addressed by the service;
- Type and frequency of service required to address the issue;
- Measurable long term goals;
- Interventions, treatments or modalities associated with each goal;
- Goals must relate to the services outlined in the IEP;
- Date of POC implementation; and
- Signature, title and date (month/day/year) of the DMAS qualified provider as confirmation that they developed the POC.

Student Progress or Service Logs

Documentation of on-going services provided and student progress (e.g., progress notes, service logs) must be maintained as required for the provider type and must:

- Clearly identify the provider/therapist rendering the service;
- Include progress/response to treatment being made; and any change in the identifying issue or treatment; and
- Be completed as soon as possible.

For services rendered by providers under supervision, the progress or service logs must also contain:

- Supervisor confirmation that services rendered by persons under their direction were carried out according to the documented plan of care. Confirmation must include the supervisor's signature; and
- Supervisor signature confirmation of a supervisory visit at least every 90 days for purposes of ensuring that services are being carried out according to the plan of care.

Signatures

All documentation requiring a provider signature must use a signature format including the first initial, last name and title of the provider, and dated (month/day/ye).

Electronic Signatures

Providers must follow DMAS guidelines set forth regarding electronic signatures. DMAS requirements for electronic signatures are listed in the DMAS Physician/Practitioner Manual, Chapter VI.

SERVICE-SPECIFIC DOCUMENTATION REQUIREMENTS

Medical Evaluations

In addition to the general documentation requirements stated previously in this chapter, documentation of medical evaluations must also include the following:

- Positive and negative examination findings;
- Diagnostic tests ordered and the results of the tests;
- Diagnoses;
- An indication of whether further treatment is needed; and
- Referral sources, including the name of the referring physician, nurse practitioner or physician assistant.

Physical Therapy, Occupational Therapy, Speech-Language Pathology and Audiological

Services

In addition to the general documentation requirements stated previously in this chapter, the record must also include the following:

- Documentation of service-specific evaluation results that include:
  - Reason for the evaluation;
  - Medical/treating diagnoses;
  - Current findings;
  - Current functional status (strengths and deficits); and
  - Summary of previous treatment and results.
- A POC that includes:
  - The specific medical diagnosis or identifying issue to be addressed by the service;
  - Type and frequency of service required to address the issue;
  - Long-term goals that:
    - Relate to the services outlined in the IEP;
    - Are expressed in terms of desired, measurable functional outcomes;
    - Specify interventions, treatments, modalities or methods to be used to achieve the goal;
    - Include the date of POC implementation; and
    - Include a time frame for achieving the goal that is no longer than one year from the implementation date of the POC.
  - A discharge goal or goals.
  - Signature, title and date (month/day/year) of the DMAS qualified provider as confirmation that they developed the POC.

  A POC is valid for up to 12 months from date of implementation, however, the POC must be revised when there are significant changes in the student's condition and/or functional status that necessitate changes to their treatment, goals, or frequency or duration of services. Such changes may be documented with a new POC or as an addendum to an existing POC.

  When POC changes are due solely to the child's participation in summer session (i.e., extended school year) those changes may be reflected in an addendum to the student's POC. A new POC is not required. In these cases, the provider may revert back to the primary POC at the end of summer session, when the new school year begins.

- A discharge summary must be completed when a service is discontinued. The discharge summary must include:
  - A summary of the student's progress relative to treatment goals;
  - The reason for discharge;

- The student's functional status at discharge compared to admission status;
- The student's status relative to established long-term goals met or not met;
- The recommendations for any follow-up care; and
- The full signature, title and date (month/day/year) by the qualified provider completing the discharge summary.

Note, a discharge summary must also be written if the service continues, but no longer meets DMAS requirements for billing (i.e., qualified provider determines that services are not required, but IEP team determines that services will continue).

A discharge summary is not required if:

- The student and their IEP are transferring to another school within the division, and the services are to continue; or
- Services are temporarily paused, regardless of reason, but the IEP remains in place and the qualified provider intends to resume the current plan of care.

Nursing

In addition to the general documentation requirements stated previously in this chapter, nursing documentation must include the following:

- A written order from a DMAS-enrolled physician, nurse practitioner or physician assistant for skilled nursing services and services supervised by a nurse;
- A POC that includes:
  - All services resulting from physician, physician assistant and/or nurse practitioner written order(s). Multiple written orders from multiple qualified providers may be documented together in a single plan of care;
  - The specific medical condition or conditions, including applicable ICD diagnosis code(s) to be addressed by nursing services;
  - Goals and objectives for each nursing service included;
  - Medication, treatment and/or procedures required by the nurse for each goal addressed;
  - Time tables including dose (as applicable for medications) and frequency of service; and
  - Signature of the RN completing the POC.

- A Nursing Log that includes:
  - Student name and date of birth;
  - Student's Medicaid or FAMIS 12-digit ID number;
  - Current diagnosis;
  - Date (month/day/year), time of day, and amount of time (total number of minutes) of the nursing service entered by the responsible licensed nurse;

- Actual nursing procedure rendered;
- Student's response to treatment;
  - N = Normal
  - V = Variance from normal or standard. Note: If the student's response is a variance from normal or standard, the responsible licensed nurse must document a written explanation in the comment section of the Student Log.
- Actions related to nursing services, including notifying parents, calling the physician or notifying emergency medical services, as applicable;
- Any prescribed drugs which are part of the POC, including dosage, route of administration and frequency;
- Any changes from the physician, physician assistant or nurse practitioner written order;
- Identification of the nurse rendering the service; and
- Signature of a licensed RN as confirmation that services rendered by themselves or persons under their direction were carried out according to the Plan of Care.

Psychiatry, Psychology, and Mental Health

In addition to the documentation requirements for all LEA providers outlined in the beginning of this chapter, documentation supporting psychiatry, psychology and mental health services must also include the following, regardless of the type of psychiatry, psychology or mental health service provided or type of provider providing the service:

- Educational history, medical history, family history and previous psychological treatment to include:
  - The onset of the diagnosis and functional limitations;
  - Situational factors that may impact treatment (e.g., foster care, incarcerated parent);
  - Previous treatment and outcomes;
  - Medications, current and history of;
  - Medical history, if relative to current treatment;
  - Treatment received through other programs (e.g., Department for Aging and Rehabilitative Services, Therapeutic Day Treatment, Special Education, Community Services Board, or other behavioral health providers (intensive in-home and other therapy services, medications, etc.).

Documentation to support on-going counseling services must also include:

- A mental status examination
- A plan for treatment that includes:

  - Individual-specific goals related to symptoms and behaviors;
  - Treatment modalities to be used;
  - Estimated length that treatment will be needed;
  - Frequency of the treatments/duration of the treatment; and
  - Documentation of family/caregiver participation in the plan for treatment (if applicable).
- Diagnostic impressions documented with in the previous 12 months.

Documentation to support psychological testing evaluation services must include:

- Clear referral question and presenting concern(s);
- Source(s) of information used in completing the evaluation;
- Tests administered;
- Interpretation of test data and other clinical information;
- Diagnostic impressions; and
- Recommendations

Documentation for each billed counseling session must include:

- Length of the session;
- Level of participation in treatment;
- Type of session (e.g., group, individual);
- How the activities of the session relate to the student-specific goals;
- Progress or lack thereof toward the goals;
- Plan for the next session; and
- Signature of the provider

<u>Personal Care Assistance</u>

In addition to the general documentation requirements for all LEA providers outlined in the beginning of this chapter, documentation for personal care services must also include the following:

- A POC that includes:
  - The specific medical diagnosis or identifying issue to be addressed by the personal care service.
  - Type of intervention, treatment or modality to be used, and frequency of service required to address the issue. If the intervention involves administration of medications, include the dose and frequency of medication administration.
  - Measurable long-term goal(s)
  - Date of POC implementation.
  - Signature, title and date (month/day/year) of the DMAS supervising qualified provider as conformation that they developed the POC.

If two or more disciplines are utilizing personal care assistant services as a part of their service plan, each discipline must develop a separate, discipline-specific plan of care signed by each DMAS qualified provider supervising the service within the scope of their license.

- A log of personal care assistant services that includes:
  - Date (month/day/year) and amount of time (total number of minutes) of the service;
  - Procedures performed;
  - Student's response to procedures including description of response if varied from normal;
  - Identification of the staff person rendering the service.

Specialized Transportation

LEAs that bill for specialized transportation must maintain documentation to support billing for each trip made. Trip is defined as the one-way transport of a covered student from (to) their home or another designated "originating site" to (from) the location where a covered services is provided. Documentation of each trip billed must include:

- Trip service date;
- The names of all students in attendance on the bus for that trip;
- Signature and date of the Driver or Bus Attendant on that trip;
- Medicaid or FAMIS ID numbers of the students enrolled in Medicaid or FAMIS; and
- Service provided connected to that trip

The LEA may only bill for transportation provided on a day that the student received a covered service

QUALITY MANAGEMENT REVIEW

Quality management controls are important to ensure quality of care as well as the appropriate provision of services and the medical necessity for services. Many of the review and control requirements respond to federal and state regulations; all participating providers must comply with all of the requirements.

DMAS or its contractors must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes the review of the utilization of services rendered by providers to students.

Medicaid/FAMIS records of students currently receiving DMAS reimbursable services as well as a sample of closed Medicaid/FAMIS records may be reviewed. DMAS or its contractors may also conduct an on-site investigation as follow-up to any complaints received.

Periodic, unannounced, quality management review on-site visits or desk reviews will be made. Review may include but is not limited to:

- The comprehensive care being provided;
- The adequacy of the services available to meet the current health needs and to promote the maximum physical and emotional well-being of each student for the scope of services offered;
- The necessity and desirability of the continued services;
- The documentation of the services in the student's IEP to support medical necessity and authorization for services; and
- For verification of agency/provider adherence to DMAS requirements in accordance with federal and state regulations.

Upon completion of an on-site review, DMAS staff will meet with staff members for an exit conference. The exit conference will provide an overview of the findings from the review. A report will be written detailing the findings. Based on the review team's report and recommendations, DMAS may take corrective action. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services.

If DMAS requests corrective action plans, the local education agency must submit the plan, within 30 days of the receipt of notice. Subsequent visits/desk reviews may be required for the purpose of follow-up deficiencies, complaint investigations, or to provide technical assistance.

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 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. 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

Providers are responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. Providers are also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The Providers certify this 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, 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

Recipient Fraud

Allegations regarding issuance of non-entitled benefits and/or fraud and abuse by non-providers 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 and/or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card-sharing and prescription forgeries.

If it is determined that non-entitled benefits were issued, 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 12 months beginning with the month of the fraud conviction. The sanction period may only be revoked or shortened by court order. Referrals should be made to:

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