CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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CHAPTER VI
UTILIZATION REVIEW AND CONTROL

INTRODUCTION

Under federal regulations, the Medical Assistance Program must review and evaluate the care and services paid through Medicaid, including the provision of services by providers and the utilization of services by program participants/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 contractors, conducts periodic quality management reviews on all programs. 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 Provider Participation Agreement with DMAS, the provider also agrees to provide access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or authorized representatives, and authorized federal personnel upon reasonable request.

This chapter provides detailed information on provider documentation requirements. This chapter also provides information on quality management reviews (QMRs), utilization control and audits conducted by DMAS or its contractors.

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.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

DMAS providers may refer Medicaid individuals suspected of inappropriate use or abuse of Medicaid services to the Division of Program Integrity within the Department of Medical Assistance Services. Referred individuals will be reviewed by staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. If CMM enrollment is not indicated, Program Integrity staff may educate individuals on the appropriate use of medical services, including emergency room services.

Referrals may be made by telephone, fax, or in writing. Written referrals should be mailed to.

Department of Medical Assistance Services
Division of Program Integrity
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 quality management problems, as well as the provider name and telephone number. 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.

U.R. PLANS & QMR: INTENSIVE REHABILITATION & CORF SERVICES

Quality Management Review (QMR)

Quality management reviews are important to ensure high quality care and the appropriate provision of services. Many of the review requirements respond to federal and/or state mandates. Rehabilitation providers must comply with all of the requirements in order to receive Medicaid reimbursement for the services provided. (*Virginia Administrative Code*, 12 VAC 30-60-120; *Code of Federal Regulations,* 42 CFR, Part 456 – Utilization Control, and Parts 482 and 485 – Conditions of Participation)

Admission Review

DMAS, or its contractors, requires quality management review of intensive rehabilitative services for all Medicaid admissions. The intensive rehabilitation provider must have an annual utilization review plan approved by the Office of Health Facilities Regulation, Virginia Department of Health, or the appropriate licensing agency in the state in which the institution is licensed. DMAS staff or its contractors will review the functions associated with approved hospital utilization review plans for compliance with the *Code of Federal Regulations (CFR)*, 42 CFR §§ 456.101 through 456.145 (Reference these 42 CFR regulations for additional federal requirements for UR plans, admission reviews, and medical care evaluation studies).

The facility's utilization review coordinator must approve the medical necessity, within one business day of admission and document in the utilization review plan and the individual's medical record.

Utilization Review (UR) Plan

Following admission, an initial stay review date must be assigned within the 50th percentile of norms approved by the Utilization Review Committee except in circumstances properly documented in the progress notes and reflected on the utilization review sheets. Continued or extended stay review must be assigned prior to or on the date assigned for the initial stay. If the facility's Utilization Review Committee believes that an intensive continued stay is not medically necessary, it may review the case at any time.

If the admission or continued stay is found to be medically unnecessary, the attending physician must be notified and permitted to present additional information. If the hospital physician advisor continues to find the admission or continued stay unnecessary, a notice of adverse decision must be made within

one business day after the admission or continued stay is denied. Copies of this decision must be sent by the designated agent to the hospital administrator, attending physician, individual and/or the individual's authorized representative

Medical Care Evaluation Studies (MCEs)

As part of their utilization review plan, hospitals must have one medical care evaluation study in process and one completed study each calendar year.

Utilization Review Plan (CORFs)

The Comprehensive Outpatient Rehabilitation Facilities (CORF) must have in effect a written utilization review plan implemented at least quarterly to assess the necessity of services and to promote the most efficient use of services provided by the facility. The Utilization Review Committee, consisting of physicians and professionals representing each of the services provided by the facility, a committee of this group, or a group of similar composition comprised of professional personnel not associated with the facility, must carry out the utilization review plan. Refer to 42 CFR § 485.66 for additional requirements.

The utilization review plan must contain written procedures for evaluating the following:

- Admissions, continued care, and discharges using, at a minimum, the criteria established in the individual care policies of the facility;
- The applicability of the plan of care/treatment plan to established goals; and
- The adequacy of clinical records to assess the quality of services provided, to determine whether the facility's policies and clinical practices are compatible, and to promote the appropriate and efficient utilization of services.

Rehabilitation providers must provide the same rehabilitation services to the Medicaid individual as provided to the general population, in accordance with the established Medicaid reimbursement rate. A Medicaid-enrolled provider must accept Medicaid payment as payment in full.

Services not specifically documented in the individual's medical record as having been rendered will be deemed not rendered, and reimbursement will not be provided. All rehabilitative services shall be provided in accordance with guidelines found in the *Virginia Administrative Code* and the *Virginia Medicaid Rehabilitation Manual*.

DOCUMENTATION REQUIREMENTS: INTENSIVE REHABILITATION AND CORF SERVICES

Physician Certifications, Recertifications and Renewal of the Plan of Care Orders

- A physician is required to complete the admission certification (DMAS-127) of intensive rehabilitation services and the initial plan of care orders.

- A 60-day recertification (DMAS-128) must be performed by a physician, or a licensed practitioner of the healing arts, such as a nurse practitioner or a physician assistant, within the scope of his/her practice under State law.
- If therapy services are recertified by a practitioner of the healing arts other than a physician, supervisory requirements must be performed by a physician as required by the Virginia Department of Health Professions regulations. [Virginia State Code § 54.1-2857.02; 42 Code of Federal Regulations, 456.60 (a)(1)(b)(1), 456.80 (a)].
- For CORF providers, the provider requirements do not permit nurse practitioners or physician assistants to order CORF intensive rehabilitation services. A physician is responsible for all documentation requirements, including, but not limited to, admission certifications, recertifications, plan of care orders, progress notes, etc., as defined in this chapter. [42 Code of Federal Regulations, 485.58 (a)(1)].
- Providers must refer to Chapter IV of this manual for additional clarification on program and documentation requirements.

Physician Documentation Requirements (or other licensed practitioners)

Physician Admission Rehabilitation Evaluation:
The physician admission rehabilitation evaluation must include, but is not limited to, the following:

- The prognosis, clinical signs and symptoms necessitating admission;
- A description of prior treatment and, if applicable, attempts to rehabilitate the individual in a less intensive setting;
- History and Physical Exam;
- The written initial certification statement (DMAS-127) of the need for intensive rehabilitation; and
- The identification of a discharge plan/disposition.

Physician Plan of Care/Treatment Plan:
The physician plan of care/treatment plan must be written specific to the individual and must include orders for medications, rehabilitative therapies (including the frequency and duration of services), treatments, diet, and other services as needed such as psychology, social work, therapeutic recreation, etc. The plan must be reviewed and updated at least every 60 days on the DMAS-126.

Physician Admission and Discharge Orders:
The physician is responsible for admission and discharge orders (if verbal orders are given, written orders must be signed and dated within three calendar days). A physician order is required to discontinue any therapy treatment prior to an individual's discharge.

Physician Progress Notes:
The physician progress notes must be written at least monthly (every 30 days) and must include, but is not limited to:

- Changes in the individual's condition;
- Individual response to treatment;
- Renewal of recertification statement of the continuing need for intensive

rehabilitation written at least every 60 days on the DMAS-128; and
- Discharge disposition statement.

Required DMAS Forms for Physician Use – DMAS 126, 127 and 128

DMAS has three (3) forms that are required for physician use (implemented on May 1, 2002), for each Medicaid admission or if an individual is anticipated to be Medicaid eligible, these forms must be fully completed, signed and dated by the physician. The Code of Federal Regulations (CFR) require physician certification and recertification for intensive/inpatient or CORF rehabilitation per 42 CFR 456.60.

The three required DMAS forms are:

- DMAS Intensive Rehabilitation Physician Plan of Care Review (DMAS-126),
- DMAS Intensive Rehabilitation Admission Certification (DMAS-127), and
- DMAS Intensive Rehabilitation 60-Day Recertification (DMAS-128).

NOTE: Refer to the DMAS Medicaid Web Portal, Provider Forms Search link located at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal for access to these three required forms.

DMAS-126: For those intensive/inpatient or CORF rehabilitation stays that continue for 60 days or more, the physician must complete the DMAS-126 form. Review of the 60-day plan of care (DMAS-126) renewal is defined as reviewing all physician orders pertaining to medications, rehabilitative therapies, treatments, diet, and other services as needed such as psychology, social work, therapeutic recreation, etc. The plan of care review of the physician orders provides the physician with an opportunity to review the individual's status over the past two months, rather than a day-to-day review. The physician must determine in writing on the DMAS-126 form, what services need to be continued, added, changed, or deleted, based on the individual's needs. The required form (DMAS-126) must be fully completed, signed and dated by the physician, and placed in the physician order section of the medical record.

DMAS-127: For all new intensive/inpatient or CORF admissions of a Medicaid individual or for those anticipated to be Medicaid eligible, the physician must complete the DMAS-127 form for admission certification, which is a federal regulatory requirement. The physician is acknowledging that the individual does meet the intensive inpatient rehabilitation criteria for admission and the physician is certifying that the individual meets the certification requirements. The required form (DMAS-127) for this purpose must be fully completed, signed and dated by the physician, and placed in the physician order section of the medical record.

DMAS-128: For those intensive/inpatient or CORF rehabilitation stays that continue for 60 days or more, the physician must complete the DMAS-128 form for the 60-day recertification, which is a federal regulatory requirement. The physician is acknowledging that the individual continues to meet the intensive inpatient or CORF rehabilitation criteria for continued stay and the physician is certifying that the individual meets the recertification requirements. The required form (DMAS-128) for this purpose must be fully completed, signed and dated by the physician, and placed in the physician order section of the medical record.

NOTE: For an individual who has applied for and is pending Virginia Medicaid eligibility and it is even remotely anticipated that the person may become Medicaid eligible (either during or after an inpatient rehabilitation stay), it is *strongly recommended* that the DMAS-127 admission certification form be completed upon admission, so the provider avoids the possible risk of not receiving Medicaid reimbursement, if needed. If the person remains 60 days or more, it is *strongly recommended* that the DMAS-126 and DMAS-128 forms be completed. If Medicaid is approved retroactively, and the provider billed Medicaid for any portion of the stay, if any of these forms were not completed upon admission or at the 60 day interval, this will be an audit and possible retraction issue for the entire stay if these required forms were not completed.

Physician Signature Requirements

All physician documentation must be signed and fully dated (month/day/year) by the physician. A required physician signature for DMAS purposes may include signatures, written initials, computer/electronic entry, or rubber stamp initialed by the physician at the time used. 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 facility administration with a signed statement to the effect that he/she is the only person who will use the rubber stamp.

The use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the providers own internal policies. Refer to the *Electronic Signatures* section located in this chapter for more detailed information.

Rehabilitation Nursing

A registered nurse (RN), or a licensed practical nurse (LPN) under the supervision of a registered nurse (RN), is responsible for and must complete, sign, title and fully date, all of the following:

- An admission evaluation and a written plan of care/treatment plan with measurable individual goals completed within 24 hours of admission;
- A review of the individual plan of care/treatment plan, as needed, but at least every two weeks; and
- A weekly nursing summary, which reflects the care provided, individual/family education, changes in the individual's condition, the individual's response to treatment; and revision of the individual goals as needed; and
- Medications and treatments administered and charted as ordered by the physician.
- A review of medications, at least monthly, to include identification of medications that may be discontinued or altered, and validation of the proper administration of ordered medications.

The individual's condition must require, in addition to any acute rehabilitation nursing services, the nursing knowledge and skills necessary to identify nursing

needs and treat individuals whose conditions are characterized by altered cognitive and functional ability. The need for these rehabilitative nursing services is determined by deficits documented in the rehabilitative nursing admission assessment. This assessment and a physician-approved plan of care/treatment plan are developed by a registered nurse (or LPN under the supervision of the RN) experienced in rehabilitation.

The registered nurse (or LPN under the supervision of the RN) develops the plan of care/treatment plan by documenting individualized, measurable, goals with time frames for goal achievement and the nursing interventions necessary to assist the individual in achieving the goals. The nursing plan of care/treatment plan must reflect the expectation of significant improvement in the identified deficits. When using computerized and/or standardized plans of care, documentation must incorporate all of the above described plan of care components and be specific to the individual's needs.

A program participant/individual's response to nursing interventions and any resultant changes in the individual's goals must be documented in the weekly nursing summary by nurses responsible for the individual's care. The registered nurse must review the individual's response to the nursing plan of care/treatment plan at least every two weeks and document any necessary modifications to the plan of care/treatment plan.

Upon the individual's discharge from services, the RN (or LPN under the supervision of the RN) must complete a comprehensive discharge summary, to include the following components: functional outcome of the long-term goals, recommendations for follow-up care, and discharge disposition. The discharge summary must be completed within 30 days of the individual's discharge. The provider's discharge instruction form for the individual does not meet the DMAS documentation requirements for a discharge summary.

Rehabilitative Therapies (PT, OT, SLP, Cognitive, Therapeutic Recreation)

All rehabilitation services must be ordered by a physician or other licensed practitioner prior to the provision of services.

Admission Evaluation: Each therapist's admission evaluation must be completed by a registered or licensed therapist within seven (7) calendar days of admission and must include, but is not limited to:

- Medical Diagnosis of the individual;
- Clinical signs and symptoms;
- Medical history;
- Summary/History of any previous rehabilitation services;
- Prior/current functional status; and
- Therapist's recommendation for treatment.

Plan of Care/Treatment Plan: A plan of care/treatment plan within seven (7) calendar days of admission, specifically designed for the individual must be established and must include, but is not limited to:

- Individual measurable long-term and short-term goals;
- Time frames of achievement for all goals;
- Interventions (modalities/treatments/procedures);

- Frequency and duration of the therapies; and
- Discharge disposition/plan.

Progress Notes: Progress notes must be written at least every two weeks and must include, but are not limited to:

- Individual's response to treatment; and
- Review of the plan of care/treatment plan/goals.

Discharge from Services: Upon the individual's discharge from services, the licensed therapist must complete a comprehensive discharge summary, to include all of the following components:

- Functional outcome of the long-term goals,
- Recommendations for follow-up care,
- Discharge disposition,
- Completed within 30 days of the individual's discharge, and
- Signed, titled and fully dated by the licensed therapist.

Therapist Supervision of a Therapy Assistant (Applicable to PT, OT, and SLP)

Direct supervision by a qualified therapist includes initial direction and periodic observation of the individual's actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the licensed therapist (not the therapy assistant). When services are provided by a licensed or certified therapy assistant (i.e.: PTA, COTA, CFY/SLP or Speech-Language Assistant), the licensed therapist (i.e.: PT, OT, or SLP) must conduct an on-site supervisory visit at least every 30 days while therapy is being conducted, observe, and document accordingly.

If the supervisory therapist co-signs the assistant's progress visit notes, this action alone does not constitute a 30-day supervisory visit note. The supervisory therapist shall review the progress notes of the therapy assistant. The supervisory therapist documentation of the 30-day note shall include a review of the plan of care with the assistant and comments on any adjustments or revisions to the individual's therapy goals, as needed. If no adjustments or revisions are needed, the therapist should document accordingly. The supervisory 30-day review note must be signed, titled and fully dated by the therapist. Lack of documentation of the 30-day supervisory visit notes will result in a DMAS audit retraction of provider reimbursement.

Psychologist and Social Worker

All psychology and social work services must be ordered by a physician prior to the provision of services.

Admission Evaluation: An admission evaluation for psychology services must be written by a licensed psychologist or a licensed clinical social worker. For social work services an admission evaluation must be written by a qualified social worker within seven (7) calendar days of admission and must include:

- Psycho-Social History;
- Diagnosis; and
- Identified needs/problems.

Plan of Care/Treatment Plan: A plan of care/treatment plan within seven (7) calendar days of admission specifically designed for the individual must be established, reviewed/revised every two weeks and must include:

- Individual measurable long-term and short-term goals;
- Time frames for all goals;
- Interventions/approaches used;
- Frequency and duration of services offered; and
- Discharge disposition/plan*.

*Discharge planning is an integral part of the individual's plan of care/treatment plan developed by the team and coordinated by the social worker. The discharge plan must be addressed during the admission evaluation and must be reviewed/revised relative to the individual's and family's response to the rehabilitation program.

Progress Notes: Progress notes must be written at least every two weeks and must include, but are not limited to:

- Individual's response to treatment; and
- Review of the plan of care/treatment plan.

Discharge Summary: Upon the individual's discharge from services, the psychologist and social worker must complete a comprehensive discharge summary that includes the all of the following components:

- Functional outcome of the long-term goals,
- Recommendations for follow-up care,
- Discharge disposition,
- Discharge summary must be completed within 30 days of the individual's discharge, and
- Must be signed, titled and dated by the licensed staff.

Interdisciplinary Team

The interdisciplinary (ID) team must prepare written documentation of the ID plan of care/treatment plan within seven (7) calendar days of admission.

Documentation must include, but is not limited to:

- Needs of the individual;
- Individualized, measurable long and short-term goals;
- Approaches/interventions to be used to meet the goals;
- The discipline(s) responsible for the interdisciplinary goals;
- Evidence of goal revision and progress;

- Time frames for all goals; and
- Team plan reviewed/revised at least every two (2) weeks

Included in the interdisciplinary plan of care/treatment plan must be a discharge plan. This plan must facilitate an appropriate discharge and must include, but is not limited to:

- Individual's discharge destination;
- Any modifications and alterations necessary at the individual's home for discharge; and
- Alternative discharge plans if the initial plan is not feasible.

The effectiveness of an intensive rehabilitation program depends on the continuing coordination of all the professional disciplines involved in the individual's rehabilitation. Team conferences held at least every two weeks are required in order to review the plan of care/treatment plan, assess and document the individual's progress as well as any problems impeding progress. The team will consider possible resolutions to the identified problems, reassess the continuing validity of the rehabilitation goals established at the time of the initial evaluation, reassess the need for any adjustment in these goals or in the prescribed treatment program, and re-evaluate discharge plans.

Team documentation must demonstrate a coordinated team approach. A review by the various team individuals of each other's progress notes does not constitute a team conference. A team conference must be held at least every two weeks to include a review of the plan of care and a summary of the team conference, noting the team members/disciplines (by full name and title) attendance and participation, as documented in the clinical record. Documentation must include approaches and progress made toward meeting established interdisciplinary goals, revisions/changes to goals, and revisions to the discharge plan.

General Documentation Requirements for Intensive Rehabilitation and CORF

For each individual, there must be a written plan of care/treatment plan established and reviewed and signed by a physician every 60 days. Services not specifically documented in the individual's record as having been rendered will be deemed not to have been rendered, and any inappropriate payment may be recovered by DMAS or its contractors. Each entry in the medical record must be signed, titled and dated (month/day/year) by the provider of treatment.

The medical record must include all of the following, but is not limited to:

- Diagnosis, current medical findings, including functional status, and the clinical signs and symptoms of the individual's condition, including the diagnosis justifying admission, and documentation of the extent to which the individual is aware of the diagnosis and prognosis;

- An accurate and complete chronological picture of the individual's clinical course and treatments, including any prior rehabilitation treatment. If appropriate, the summary of treatment furnished and the results achieved during previous periods of rehabilitation services or institutionalization must be provided;

- Plans of care/treatment plans by the interdisciplinary team and each

involved discipline, specifically designed for the individual to include realistic, measurable, individualized goals with time frames for goal achievement;

- Physician orders and plan of care/treatment plan prior to the provision of services;
- Documentation of all treatment rendered to the individual with specific attention to the frequency, duration, interventions, response, and progress toward established goals. All entries must be fully signed and fully dated by the provider of the treatment (include the full name and title);
- Documentation of supervision of therapy assistants completed by a licensed therapist every 30 days as described in this chapter;
- Documentation of changes in the individual's condition and changes in the plans of care/treatment plans (team and/or individual discipline);
- Documentation of team conferences, including the names of all attending;
- Discharge plans (see below); and
- Discharge summaries describing functional outcome, follow-up plans, and discharge disposition. The discharge summaries must be completed within 30 days of the individual's discharge.
- NOTE: If a therapy or service is discontinued prior to the individual's discharge from the intensive or CORF rehabilitation program, the therapist or other discipline must obtain a physician discharge order.

Discharge Planning for Intensive Rehabilitation and CORF

Discharge planning must be an integral part of the overall plan of care/treatment plan developed at the time of admission to the program.

- The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination.
- The individual or the responsible party shall participate in the discharge planning.
- The discharge plan must demonstrate that adequate arrangements/services are made to meet the individual's needs in the new environment.
- Documentation concerning changes in the discharge plan as determined by the response to treatment, shall be entered into the record at least every two weeks as a part of the team conference, but more often if the individual's situation warrants.

DOCUMENTATION REQUIREMENTS: OUTPATIENT REHABILITATION SERVICES

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

The individual's medical record must contain sufficient documentation to clearly identify the individual and justify the need for services. Each discipline, physical therapy, occupational therapy, and speech-language pathology services must adhere to the documentation requirements.

Providers of Service

A physician or other licensed practitioner of the healing arts, such as a nurse practitioner or a physician assistant, within the scope of his/her practice under State law, may order services, develop the plan of care, and complete physician initial certification and recertifications under the direct supervision of a physician. If therapy services are ordered by a practitioner of the healing arts other than a physician, supervisory requirements must be performed by a physician as required by the Virginia Department of Health Professions regulations. (Virginia State Code § 54.1-2857.02; 42 Code of Federal Regulations, 440.130 (d), 485.711)

Early Intervention Services and School Therapy Services

Providers who offer PART C - Early Intervention Services (EIS) treatment for children under the age of 3, should refer to covered services and documentation requirements in the Early Intervention Services Manual on the DMAS Medicaid Web Portal located at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. For outpatient rehabilitation providers who provide rehabilitation therapy to Medicaid special education children within the school setting, providers should also refer to the DMAS Medicaid Web Portal for the LEA (Local Education Agency) Manual for information.

The required outpatient rehabilitation documentation in the individual's medical record must include **all** of the following, but is not limited to:

Physician Documentation (or other licensed practitioner)

A physician's order is required prior to the initiation of the evaluation/assessment.

Physician orders must include all of the following, but is not limited to:

- A physician order/script prior to the initiation of the evaluation/assessment that identifies the specific therapy(s);
- A physician order/plan of care for treatment that identifies the therapy, measurable, individualized goals with time frames for goal achievement, modalities interventions, frequency, and duration;
- A physician order for discharge from services is required; and

- Each physician's entry into the record must be legibly signed, titled, and fully dated by the physician making the entry.

The physician is responsible for admission and discharge orders (if verbal orders are given, written orders must be signed and dated within three calendar days).

Therapist Documentation

Therapist assessment/evaluation must include all of the following, but is not limited to:

- Medical diagnosis;
- Clinical signs and symptoms;
- Medical history;
- Current functional status (strengths and deficits);
- Justification of therapeutic interventions;
- Summary of previous rehabilitative treatment and results;
- Extent to which the individual/responsible party is aware of the diagnosis and prognosis; and
- Therapist recommendation for treatment, signature/title/date.

When physician ordered, an evaluation or re-evaluation must be completed by a therapist when an individual is admitted to a service, when there is significant change in an individual's condition, or when an individual is readmitted to a service. There is no required time frame for completion of the therapy assessment once a physician order is received; however, it is recommended that the therapist conduct an evaluation/assessment in a timely manner to benefit the individual being assessed and to carry out the physician order.

Plan of Care/Treatment Plan

The plan of care/treatment plan must be specifically designed for the individual by the physician after consultation with the therapist(s). The initial plan of care/treatment plan may be prepared and signed by the therapist and then sent to the physician for signature. The plan of care/treatment plan must be reviewed/renewed by the therapist and the physician with modifications determined by the individual's response to therapy every 60 days or annually depending on the individual sub-group classification (for more information, refer to Chapter IV of this manual).

Any initial plan of care/treatment plan or periodic renewal written by the qualified therapist must be signed and dated by the physician within 21 days of implementation of the plan. If a physician signature is not obtained within 21 days of the implementation of the plan of care, reimbursement will not be made for that plan of care until the date of the physician signature. Reimbursement will not be made if, at the time of the physician signature, the plan of care valid time frame has expired. Services provided without a physician's dated signature or incomplete physician's order will not be reimbursed.

The plan of care/treatment plan must include all of the following, but is not limited to:

- Medical diagnosis;
- Current functional status (strengths and deficits);
- Individualized, measurable goals (long-term and short-term) which describe the anticipated level of functional improvement;
- Achievement time frames for all goals;
- Therapeutic interventions/treatments to be utilized by the therapist;
- Frequency and duration of the therapies; and
- Identification of a discharge plan and anticipated discharge date.

Discharge Planning

The discharge plan is developed upon admission as an integral part of the initial plan of care/treatment plan and must include all of the following, but is not limited to:

- The individual's anticipated functional status at discharge;
- The individual's anticipated discharge disposition and date;
- The individual's or responsible party's participation in discharge planning; and
- The changes in the plan as determined by the individual's response to therapy.

Verification of Services/Progress Notes

Progress notes must be accurate and provide a complete chronological picture of the individual's treatments and clinical course. Each therapy visit must be documented in the medical record. Failure to properly document the extent of services rendered in detail can result in an audit retraction of reimbursement.

Documentation must include all of the following, but is not limited to:

- Dated documentation for each individual treatment session (visit);
- Modality/treatment/activity utilized;
- Individual response to therapy relative to established goals;
- Changes in functional status;
- Changes in individual condition;
- Recommendations for continued treatment relative to established goals;
- Recommendations for continued treatment relative to modifications to the plan of care/treatment plan; and
- Identification of the therapist providing the treatment, including the full name and title, and signature date.

Progress note documentation by therapy assistants must meet the supervisory requirements as outlined in Chapter IV of this manual. Supervisory documentation must be evident every 30 days in the progress note section of the medical record.

Discharge Summary

The discharge summary must be completed within 30 days of discharge and must include all of the following, but is not limited to:

- The reason for discharge;
- The individual's functional status at discharge compared to admission status;

- The individual's status relative to established long-term goals met or not met;
- The recommendations for any follow-up care;
- The individual's discharge destination; and
- The qualified therapist, who developed the plan of care/treatment plan, must fully sign, title, and date the discharge summary.

NOTE: A physician discharge order is required to discontinue therapy services. The therapist discharge summary may be used to fulfill the physician discharge order requirements as long as the physician signs the summary within 30 days of discontinuation of services.

Therapist Supervision of a Therapy Assistant (Applicable to PT, OT, and SLP)

Direct on-site supervision by a qualified therapist includes initial direction and periodic observation of the individual's actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the licensed therapist (not the therapy assistant). When services are provided by a licensed or certified therapy assistant (i.e.: PTA, COTA, CFY/SLP or Speech-Language Assistant), the licensed therapist (i.e.: PT, OT, or SLP) must conduct an on-site supervisory visit at least every 30 days while therapy is being conducted, observe, and document accordingly.

If the supervisory therapist co-signs the assistant's progress visit notes, this action alone does not constitute a 30-day supervisory visit note. The supervisory therapist shall review the progress notes of the therapy assistant. The supervisory therapist documentation of the 30-day note shall include a review of the plan of care with the assistant and comments on any adjustments or revisions to the individual's therapy goals, as needed. If no adjustments or revisions are needed, the therapist should document accordingly. The supervisory 30-day review note must be signed, titled and fully dated by the therapist. Lack of documentation of the 30-day supervisory visit notes will result in a DMAS audit retraction of provider reimbursement.

General Documentation Requirements for Outpatient Rehabilitation

DMAS criteria for reimbursement of general outpatient rehabilitation are found throughout the provider manual and include all of the following, but are not limited to:

- A physician initial order, signed and dated by the physician prior to the provision of therapies;
- Evidence of the therapist admission assessment/evaluation;
- Provider "program-mandated" evaluations or re-evaluations will not be reimbursed;
- A plan of care/treatment plan prior to the provision of therapies;
- The plan of care/treatment plan signed and dated by the physician within 21 days of the implementation of the plan of care/treatment plan;
- Review and renewal of the physician order and plan of care/treatment

plan every 60 days for acute conditions requiring services for less than 12 months;
- Review and renewal of the physician order and plan of care/treatment plan annually for non-acute, long-term conditions requiring services for greater than 12 months; the therapist plan of care/treatment plan with goals reviewed based on acute or non-acute conditions;
- Documentation of significant progress toward the individual goals within a reasonable period of time;
- Discipline progress notes for each therapy visit;
- Documentation of the appropriate and timely discharge planning; and
- Documentation of the discharge summary, upon the individual's discharge

GENERAL DOCUMENTATION REQUIREMENTS FOR INTENSIVE, CORF AND OUTPATIENT REHABILITATION SERVICES

Medical Records and Record Retention

The facility or agency must recognize the confidentiality of individual 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. 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 rehabilitative services must be retained for a minimum of not less than five (5) years after the date of discharge or in the case of a minor, three (3) years after the individual becomes of age under State law, or (5) years after the date of discharge whichever is longer. Records must be indexed at least according to the last 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 regulations.

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.

All rehabilitative 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. For more complete information, refer to the Medicaid *Physician Manual*. 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.

Electronic Signatures

The Department of Medical Assistance Services' (DMAS) clarified written policy regarding the use of electronic signatures for clinical documentation purposes, per a special Medicaid Memo dated August 20, 2004. Provider failure to properly maintain or authenticate medical records (sign and date the entry) may result in the retraction of Medicaid payments.

An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Use of the electronic signatures, for clinical documentation purposes, shall be deemed to
constitute a signature and will have the same effect as a written signature on a document.
Providers must have written policies and procedures in effect regarding use of electronic
signatures. In addition to complying with security policies and procedures, providers who use electronic signatures, must sign a statement assuring that they alone will have access to and use the key or computer password. The policies and procedures and statements of exclusive use must be maintained and available at the provider's location.

Additionally, the use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. These requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records. For guidance on billing, please refer to Chapter V of this manual.

Addendum or Corrections to Medical Record Documentation

If an addendum or additional documentation is needed in a medical record, standard medical practice is to note the additional documentation as an "addendum", and sign and fully date the addendum documentation at the time of the additional entry.

If a correction is needed to a medical record entry that is discovered as an error, the standard medical practice is for the responsible staff member to strike through the error, note the correction and either sign or initial the correction, and fully date the correction.

There is a difference between an addendum and correction to a medical record and an alteration to a medical record. Providers cannot alter existing documentation. For example, once an audit has been initiated, a document cannot be altered as a result of a DMAS audit in order to correct any identified deficiencies found during the audit. This action is falsifying medical documentation and is prohibited. Another example is a staff individual signing and dating orders or documentation for a physician. Only the physician can sign and date his/her orders or medical record entries. All signatures, titling, and dating of record entries must be done at the time the documentation is written and not back-dated or photocopied signatures. Alteration of medical record documentation can result in a referral to the Medicaid Fraud Control Unit at the State Attorney General's Office for further investigation.

Quality Management Review Responsibilities of Intensive, CORF and Outpatient Rehabilitation

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.

The Department of Medical Assistance Services (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 individuals. Compliance with documentation requirements is critical in establishing that services were actually performed by the appropriately qualified provider, and the services were performed according to the physician orders and the individual's medical needs.

Medical records of individuals currently receiving rehabilitation as well as a sample of closed medical 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 individual for the scope of services offered;
- The necessity and desirability of the continued services;
- The feasibility of meeting the individual's rehabilitation needs at an alternate level of care; and
- 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 provider staff 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 request provider 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 rehabilitation provider must submit the plan, within 30 days of the receipt of notice. Subsequent visits/desk reviews may be made for the purpose of follow-up deficiencies, complaint investigations, or to provide technical assistance.

NOTE: Consideration by DMAS of the need for continued care does not replace the function of the provider's Utilization Review Committee for intensive rehabilitative services.

Reimbursement Requirements

Rehabilitative services that fail to meet DMAS criteria are not reimbursable. Such non-reimbursable services will be denied at the time of the service authorization request or payment retracted as a result of a quality management review, which may result in referral to the Division of Program Integrity.

NOTE: For current information on provider fraud, individual fraud, fraudulent claims, or provider appeals, refer to Chapter II of this manual. For current information on client appeals, refer to Chapter III of this manual. For billing information, refer to Chapter V.

Contact Information for Provider Questions

After reviewing this manual, if rehabilitation providers continue to have clinical or documentation related questions, providers have the following options:

- The "Ask Questions" link on the DMAS website, listed under the Long-Term Care and Waiver Services section. The link access is: http://www.dmas.virginia.gov/Content_pgs/ltc-faq_form.aspx

- Questions may be directed to the DMAS e-mail address at: dmasinfo@dmas.virginia.gov

- Virginia Medicaid Web Portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal

- Billing or Policy Questions, call the DMAS Provider Helpline at:

  1-804-786-6273 Richmond area and out-of-state long distance
  1-800-552-8627 All other areas (in-state, toll-free long distance

  The helpline is for provider use only. Providers must have their Medicaid National Provider Identification Number (NPI) available when calling.