RESIDENTIAL TREATMENT SERVICES

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 Service Authorization contractor, 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 Service Authorization contractor, 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.

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 Provider Manuals and 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.

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, DMAS or 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 AND UTILIZATION REVIEW REQUIREMENTS FOR PRTF AND TGH

Records must fully disclose the extent of services provided to Medicaid members. Records must clearly document the medical necessity and document how the individual's service needs match the level of care criteria for the service. This documentation must be written at the time the service is rendered, must be legible, and must clearly describe the services rendered. PRTF and TGH services that fail to meet Medicaid criteria are not reimbursable. If the required components are not present or do not comply with the documentation criteria, reimbursement will be retracted.

PRTF and TGH services require an approved service authorization prior to service delivery in order for reimbursement to occur. All information supplied by providers to DMAS or its contractor shall be fully substantiated throughout the youth's medical record.

Providers must have the correct service license from DBHDS in order to secure service authorization, provide the service and be reimbursed for the service. The service descriptions will be used to evaluate the documentation during audits of records. The following elements are a clarification of Medicaid policy regarding documentation and utilization review of PRTF and TGH services :

- The youth must be referenced on each page of the record by full name or Medicaid ID number.

- The provider must maintain a copy of the entire certificate of need and any psychosocial assessment, Independent Assessment. Certification and Coordination Team (IACCT) assessments and re-assessments to include any clinical assessment documentation conducted while the youth received residential treatment services.

- There must be documentation indicating that the youth was included in the development of the Initial Plan of Care (IPOC) and Comprehensive Individual Plan of Care (CIPOC). The IPOC and CIPOC shall be signed by the youth. The IPOC and CIPOC shall also be signed by the youth's parent or legally authorized representative. Documentation shall be provided if the youth, who is a child or an adult who lacks legal competency, is unable or unwilling to sign the IPOC and CIPOC. Signatures shall be obtained unless there is a documented medical or clinical reason that renders the youth unable to sign the IPOC and CIPOC.

- The CIPOC shall be a comprehensive and regularly updated plan of care specific to the youth’s unique treatment needs as identified in the clinical assessment and as the needs and progress of the youth changes.

- The CIPOC shall contain individualized treatment needs, goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timeframe for achieving the goals and objectives, and an individualized discharge plan that provides detail of the transition plan that at a minimum includes post discharge services, names of service providers, planned assessment dates, anticipated start dates for services and, for youth enrolled in managed care, documentation of care coordination with the youth’s MCO.

- All interventions, including the planned and allowable settings of the intervention, shall be defined in the IPOC and CIPOC. Documentation shall include how all identified interventions and settings meet the treatment needs of the youth. If an unplanned intervention occurs, the TGH or PRTF must document the need for the unplanned intervention and update the CIPOC as necessary.

- All CIPOCs shall be completed, signed, and contemporaneously dated by the team responsible for the plan of treatment.

- The CIPOC must be reviewed at a minimum, every 30-calendar days by the treatment team to determine if the goals and objectives meet the needs of the youth based on the most recent clinical review of the service documentation and assessment of functioning. The provider must evaluate and update the youth’s progress toward meeting the objectives and document the outcome of this

review. The CIPOC shall be rewritten at least annually to include an assessment and update, as clinically appropriate, of each goal and objective.

- If a youth receiving TGH services is also receiving case management services, the provider shall collaborate with the case manager by notifying the case manager of the provision of residential treatment services and send monthly updates on the youth's treatment status. A discharge summary shall be sent to the case manager within 30 calendar days of the discontinuation of services.

- Any medication prescribed as a part of the treatment, including the prescribed quantities and the dosage, must be entered in the youth's medical record.

- If the service being provided allows the utilization of a qualified paraprofessional in mental health (QPPMH) staff, documentation of supervision must meet criteria set forth in Chapters II and IV of this manual.

- A document signed by the youth and/or the youth's parent or legally authorized representative verifying freedom of choice of provider was offered and that this provider was chosen must be present in the youth's medical record.

- All medical record entries must include the dated signature of the author.

- A member signed document verifying that the youth and/or the youth's parent or legally authorized representative was notified of their appeal rights in the event of an adverse outcome must be present in the youth's medical record.

- Care coordination between all service providers who are involved in the youth's care must be documented in the CIPOC and progress notes.

- If 1:1 services are provided, there is documentation that the LMHP in TGH and physician in PRTF reviews the need for continued 1:1 supports at a minimum of every 72 hours.

Daily Therapeutic Services Documentation

Providers shall be required to maintain documentation detailing all relevant information about the youth. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. Daily therapeutic services documentation shall support the medical necessity criteria and how the youth's needs for the service match the level of care criteria. **This documentation shall be written, signed, and dated at the time the services are rendered or within one business day from the time the services were rendered.**

In addition to the documentation requirements described earlier in this chapter, the documentation shall include, at a minimum:

- Progress notes that include:
  - The name of the service rendered;
  - The date of the service rendered;
  - The contemporaneously dated signature and credentials of the person who rendered the service;
  - The setting in which the service was rendered;
  - The amount of time or units/hours spent in the delivery of service. The content of each progress note shall corroborate the time/units billed;
  - Specific interventions used;
  - How the intervention relates to the youth's stated goals and objectives as contained in the CIPOC, and, as appropriate, the youth's progress, or lack of progress, toward goals and objectives in the CIPOC
  - The youth's response to the intervention;
- Reasons for missed interventions to include: when the intervention was scheduled, the barrier to providing the intervention, how this barrier was addressed and any necessary adjustments to the plan of care to address the barrier;
- Documentation of therapeutic passes and related interventions;
- Family engagement activities and routine family contact or attempts at providing the activity and related follow up care coordination with LDSS and others involved in the treatment team and family engagement process.
- For instances where there is a lack of family engagement with the identified family, documentation shall include: dates of scheduled family engagement; any barriers to family engagement; steps to overcome barriers; plans for future family engagement; and, adjustments to the plan of care based on the family engagement plan; and
- Care coordination documentation.

Medicaid criteria for reimbursement of residential treatment services are found throughout the provider manual. In addition to the general requirements for utilization review described earlier in this chapter, utilization review for TGH and PRTF shall include, but is not limited to review of:

- Certificate of Need signed by the required team members, with a recommendation to admit the youth to residential services and an indication of why community resources do not meet the youth's needs;

- A current, signed initial plan of care (IPOC) and Comprehensive Plan of Care (CIPOC) that addresses the components listed in Chapter IV of this manual that is developed, supervised, and approved by the family or legally authorized representative, treating physician, psychiatrist, or LMHP responsible for the overall supervision and implementation of the CIPOC;

- Documentation that the youth is involved, to the extent of their ability, in the development of the IPOC and CIPOC;

- Timely review of the written Plan of Care;

- Ensure documentation in the youth's medical record supports QMHP supervision of QPPMH staff as set forth in Chapter 2 and that staff who do not meet the minimum QPPMH are working directly with a minimum of a QPPMH who is supervised by a QMHP;

- A determination that the delivered services as documented are consistent with the youth's IPOC and CIPOC;

- A determination that the delivered services are provided by qualified staff that meet the minimum requirement for the service component being delivered;

- A determination that the medical record content corroborates information provided to the FFS contractor;

- The reviewer determines whether the provider has maintained medical records sufficient to document fully and accurately the nature, scope and details of the health care provided;
- For PRTFs, validation that the physician responsible for the CIPOC, recertified the youth continues to require PRTF services at least every 30-calendar days;

- For TGHs, validation that the LMHP, LMHP-R, LMHP-RP or LMHP- S responsible for the CIPOC, recertified that the youth continues to require TGH services at least every 60 calendar days;

- Validation of documentation received during the service authorization process;

- Validation that all required provision of services are fully documented in the medical record; and

- For PRTFs, verify compliance with restraint and seclusion regulations (42 CFR §§ 483.350 – 483.376) including the reporting of serious incidents and each instance of seclusion and restraint including the communication to family members or legally authorized representatives.

<u>For Services Provided Under Arrangement (PRTF Only)</u>

Section 12005 of the Cures Act requires that individuals under 21 in PRTFs are guaranteed access to the full range of EPSDT services. A plan of care is not necessary

to authorize any other medically necessary service and these EPSDT services may be provided by the PRTF, under arrangement with a qualified non-facility provider, and/or by a qualified provider in the community not affiliated with or under arrangement with the facility.

The following requirements apply to services provided under arrangement:

- Services provided under arrangement must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement. Each IPOC and CIPOC must be updated within one (1) calendar day of the initiation of a service provided under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review.

- Each IPOC and CIPOC must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought.

- Each PRTF must document a written referral for each service provided under arrangement, and must maintain a copy of the referral in the member's medical record at the facility. The provider of the service under arrangement must also maintain a copy of the referral in the member's medical record. The referral must be consistent with the plan of care. A physician order will meet the requirement for a referral. For pharmacy services, the referral is the prescription. As a provider of services under arrangement, the prescribing provider must be employed or have a contract with the facility. Referrals should not be documented unless the provider has accepted the referral.

- Providers of services under arrangement must either be employees of the PRTF or, if they are not employees of the PRTF, they must have a fully executed contract with the PRTF in advance of provision of the service.

- The contract must include the following: 1) if the provider of services under arrangement accepts a referral, it agrees to include the NPI of the referring PRTF on its claim for payment; and 2) the provider of services under arrangement agrees to provide medical records related to the member residing in the PRTF upon request. A fully executed contract requires that a representative of the PRTF and a representative of the provider of services under arrangement signs the contract and includes their name, title, and date. A letter of understanding or letter of agreement will meet the requirement for a contract, provided that both the PRTF and provider of services under arrangement sign the letter.

- Each PRTF must maintain medical records from the provider of services under arrangement in the youth's medical record at the facility. These may include admission and discharge documents, plans of care, progress notes, treatment summaries and documentation of medical results and findings. These records must be requested in writing by the PRTF within seven (7) calendar days of discharge from or completion of the service provided under arrangement. If the records are not received from the provider of services under arrangement within 30 days of the initial request, they must be re-requested.

- If there is the potential for retroactive Medicaid eligibility, the PRTF should comply with these requirements so that the provider of services under arrangement can bill Medicaid after eligibility is confirmed.