

CHAPTER VI
UTILIZATION REVIEW AND CONTROL

Chapter VI

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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 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 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 or the MCOs may restrict or terminate the provider's participation in the program.

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 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.

Early Intervention Documentation Requirements

Individual Record Documentation

The Provider Agreement requires that records fully disclose the extent of services provided to individuals with Medicaid/FAMIS Plus or FAMIS benefits. Records must clearly document the medical or clinical necessity and support needs for the

service. This documentation must be written within five (5) business days of the date of the time the service is rendered, must be legible, and must clearly describe the services rendered.

To describe the service, review the service descriptions for each procedure code in Chapter V of this manual and select the service description which most appropriately describes the service rendered and documented. The service descriptions will be compared to the codes billed in order to evaluate the documentation during audits of records. The following elements are a clarification of DMAS policy regarding documentation:

- The enrollee must be referenced on each page of the record by full name or Medicaid/FAMIS ID number;
- The enrolled provider must develop and maintain written documentation for each service billed. The enrolled provider must maintain each child's EI record at the local lead agency or the local agency that houses the system's service coordinators. It is acceptable to have EI records located at satellite offices of the local lead agency or service coordinators' agency as long as there is easy access to the records by local lead agency administrators for billing and supervision purposes; and
- Children's EI records must be made available to the State Lead Agency, the DBHDS, and DMAS upon request and at the location designated by the State Lead Agency.

Each child's EI record shall include the documentation specified in Chapter 9 of the [ITCVA Practice Manual](#) Contact Notes

The term "contact note" is intended to be interchangeable with other commonly used terms such as "progress note," or "case note." Local Infant & Toddler Connection systems and EI providers are not required to call their documentation contact notes. Further guidance and requirements on contact notes are located in the Part C Practice Manual and page 8 of this chapter. Contacts (face to face, phone, email, text) with the family that fail to meet DMAS and DBHDS criteria are not reimbursable.

Contact notes must meet all the requirements in Chapter 9 of the [ITCVA Practice Manual](#).

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See the DBHDS Practice Manual for a Contact Note Checklist.

Case Management / Service Coordination Documentation Requirements

- Documentation of Intake, Initial Early Intervention Service Coordination Plan, eligibility determination and assessment for service planning;
- IFSP completed and signed by required parties, including IFSP reviews and Annual IFSPs;
- Contact Notes of all allowable activities and length of time documented in minutes for rendering each allowable activity;
- Documentation of rights and procedural safeguards and Medicaid right to appeal; and
- Contact Notes written within five (5) business days of service rendered.

Provider and Staff Qualifications

EI supports and services must be provided only by qualified practitioners. Practitioners, except audiologists, registered dietitians and physicians, who provide EI services, must be certified by the DBHDS as an Early Intervention Professional, Early Intervention Specialist, or an Early Intervention Case Manager prior to rendering billable EI services. EI providers must also be enrolled with DMAS and contracted and credentialed with a health plan. See Chapter II for more information about practitioner qualifications and certification.

Service Provided by Qualified Provider Staff / Practitioners

Utilization review will include a determination that the delivered services were provided by qualified staff. The following will be used for provider staff / practitioner review:

- Individual practitioners' discipline specific licenses or certificates;
- Current EI Certification for EI practitioners; and
- Documentation of supervision of Certified Early Intervention Specialists;

Certified Early Intervention Professionals who provide supervision of certified Early Intervention Specialists must document their ongoing clinical supervision of services provided by the Early Intervention Specialist and must maintain that documentation per record retention requirements section of this Chapter. If an Early Intervention Professional observes an Early Intervention Specialist during a service session, then both the Early Intervention Professional and the Early Intervention Specialist must sign the contact note.

Reimbursement Requirements

Utilization review determines that the delivered services as documented are consistent with the individual's IFSP, claims submitted, and specified service limitations. The following will be reviewed and considered during a review:

- The type and amount of service billed match the documented service delivered. Dates, types, and amount of service as recorded on the DMAS billing report are compared against documented services as noted on the contact notes, assessment notes, IFSP and/or IFSP review notes;
- The type and amount of service provided and documented reflect the assessment results, IFSP outcomes, and service frequency and length written on the IFSP;

- The paid service must be specifically listed on an IFSP that is certified by the physician, physician’s assistant, or nurse practitioner. If an IFSP review is held and services are changed as a result, certification by the physician, physician’s assistant or nurse practitioner of the changes to the IFSP is required. Annual IFSPs require a new certification by the physician, physician’s assistant or nurse practitioner;
- The documentation of missed sessions and reason why sessions were missed;
- The documentation must meet requirements listed in the Individual Record Documentation section. If there is no documentation during the period for which services were billed to support that services were delivered, or if the documentation does not meet the requirements listed in the Individual Record Documenting section, payment may be retracted. If documentation is present but the amount of service delivered does not match the amount of service billed, a billing adjustment is required to correct instances of over-billing or funds may be retracted if there is no documentation to justify the variance;
- The progress notes for services are completed within the five (5) business day timeline;
- The family/guardian is involved in the development of the IFSP; and
- The treatment period for all individuals is defined as the period defined in the IFSP. If the length or frequency of an EI intervention session is different from what is certified on the IFSP, the practitioner must document in a contact note clear reason(s) or purpose for the alteration from the IFSP.

Failure to adhere to any DMAS or DBHDS policies, Federal or State regulations may result in retraction of payments.

Service Coordination Monthly Requirements for Reimbursement

DMAS may be billed for a monthly Service Coordination unit when the following minimum requirements are met:

1. At least one of the allowable activities as listed below must occur and is documented by the service coordinator/case manager during the month in which the activity occurred with the child, the family, service providers, or other organizations on behalf of the child/family. The contact must be relevant to the child/family needs and the IFSP. The service may not duplicate any other DMAS service;

Allowable activities are listed in Chapter 11 of the [ITCVA Practice Manual](#).

-) results? _____ Yes _____ No