Utilization Review and Control (MHS)

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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.

Fee for Service (FFS) Contractor

Magellan of Virginia serves as the FFS contractor and is responsible for the management and administration of the Fee for Service (FFS) behavioral health benefit programs under contract with DMAS. Magellan of Virginia is authorized to constitute, oversee, enroll, and train a provider network; render service authorizations; adjudicate and process claims; gather and maintain utilization data; reimburse providers; perform quality assessment and improvement activities; conduct member outreach and education; resolve member and provider issues; and perform utilization management of services and provide care coordination for members receiving FFS Medicaid-covered behavioral health services. Magellan of Virginia’s authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia.

FINANCIAL REVIEW AND VERIFICATION (MHS)

> 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 (MHS)

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 its contractor if they are found to have billed DMAS or its contractor 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 its contractor 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 (MHS)

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. 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 Main Street

Richmond, Virginia 23219

Reports may be made to Magellan of Virginia via one of the following methods:

- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit Email: Compliance@MagellanHealth.com
- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit Email: SIU@MagellanHealth.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

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, 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 (RAU) through RAU's Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Email referrals can be sent to the RAU email address: recipientfraud@dmas.virginia.gov. Also, written referrals may be mailed to:

Department of Medical Assistance Services

Division of Program Integrity

Supervisor, Recipient Audit Unit

Department of Medical Assistance Services

600 East Broad Street

Richmond, Virginia 23219

MENTAL HEALTH SERVICES (MHS)

Utilization Review (UR) - General Requirements

Utilization Reviews of enrolled providers of mental health services, including community mental health rehabilitative services (CMHRS), enhanced behavioral health (EBH), and case management services are conducted by DMAS or its designated contractor. 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.

UR is comprised of desk audits, on-site record review, and may include observation of service delivery. It may 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 be asked to bring program and billing records to a central location within their organization.

DMAS and/or its contractor 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 or its contractor

Services must meet the requirements set forth in 12VAC30-50-130, 12VAC30-50-226, 12VAC30-60-5, 12VAC30-60-61, 12VAC30-60-143, and 12VAC30-130-2000 and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

The UR review will include examination of the following requirements:

- 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, during a Utilization Review the provider will be subject to retraction for all unlisted service and/or locations. A copy of the provider's license/certification may be reviewed.

- Health care entities with provisional licenses shall not be reimbursed as Medicaid providers of mental health services.

- Providers must comply with the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures with 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 member's medical record must demonstrate the appropriateness of the admission to service and for the level of care based upon the service definition, the provider assessment, and medical necessity criteria.

- Services shall be rendered by staff who meet provider requirements as define in Chapter II, Chapter IV and the Appendices to this manual. Copies of required staff Department of Health Professions (DHP) licenses or registrations and qualifications for Licensed Mental Health Professionals (LMHP), LMHP-Residents (LMHP-Rs), LMHP-Supervisees (LMHP-Ss) and LMHP-Residents in Psychology (LMHP-RPs), Qualified Mental Health Professionals (QMHPs), Psychiatrists, Nurse Practitioners, Occupational Therapists, Registered Nurses and Licensed Practical Nurses and documentation of qualifications for Qualified Paraprofessional in Mental Health QPPMHs to ensure that the assessments and services were provided by appropriately qualified individuals as defined in Chapter II, Chapter IV and Appendixes of this manual. The reviewer may refer any concerns related to staff DHP registrations and licenses to DHP;

- Ensure documentation supports LMHP or QMHP supervision of QPPMHs as

set forth in Chapter II, Chapter IV and the Appendices to this manual;

- A current, signed Individual Service Plan (ISP) detailing the need for the specific services;

- Documentation that the individual is involved, to the extent of his/her ability, in the development of the ISP;

- A determination that the delivered services as documented are consistent with the individual's ISP and invoices submitted;

- A determination that the delivered services are provided by qualified staff that meet the minimum requirement for the service being delivered. As indicated, required supervision of staff is documented and included in the clinical record.

- A determination that for mental health services requiring service authorization, the medical record content corroborates information provided to DMAS or it contractor.

- The reviewer determines whether appropriate activities are billed under the assessment code, that all required data elements are met, and that the assessment code is otherwise being used appropriately to include a review of whether the provider followed requirements for Comprehensive Needs Assessment billing described in Chapter IV of this manual. Psychological testing should be billed under outpatient psychiatric services and not under assessment billing.
- The reviewer determines that all documentation is specific to the individual. 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 definition) are being provided, and also determines whether there is any inappropriate overlap or duplication of services.

- The reviewer determines whether inappropriate items (i.e. staff travel time tutoring, mentoring) have been billed.

- The reviewer determines whether the amount billed matches the documented amount of time provided to the individual.

- The reviewer determines that providers have documentation from Magellan of Virginia (FFS only) stating that they are in compliance with DMAS marketing requirements.

- The service provider must also inform the primary care provider or pediatrician of the receipt of mental health services.

- For all mental health services that allow concurrent provision of case management, the service provider must collaborate with the case manager and provide notification of the provision of services. In addition, the provider must send written monthly updates to the case manager. A written discharge summary must be sent to the case manager within 30 days of the service discontinuation date. Only one type of case management can be provided at a time.

Additionally, the following shall result in denial of reimbursement:

- Services based upon missing, incomplete, or outdated documentation.
- Services for which an individual does not receive all required components.
- Services that are not provided on the day or at the time indicated on the claim.

- Service components that are not provided by the required staff.
- Services involving prohibited activities as defined in the "Prohibited Activities for all Mental Health Services" section of Chapter IV and in the service specific sections of Chapter IV and the Appendices to this manual.

Upon completion of on-site activities for a routine UR, DMAS staff or its designated contractor(s) may be available to meet with provider staff. The purpose of the Exit Conference is to provide a general overview of the UR 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. Their request notice is considered filed when it is received by DMAS or its contractor. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, DMAS or its contractor's staff 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.

A plan of correction may be requested based on the findings of the visit. 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 by filing a written notice of appeal with the DMAS Appeals Division within 30 days of the receipt of this letter. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed and must be Sent to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be considered untimely.

DOCUMENTATION REQUIREMENTS FOR MENTAL HEALTH SERVICES

Records shall fully disclose the extent of services provided to Medicaid members. Records must clearly document the medical or clinical 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.

Some Medicaid covered services require an approved service authorization prior to service delivery in order for reimbursement to occur. To obtain service authorization, all providers' information supplied to the DMAS or its contractor shall be fully substantiated throughout individuals' medical records.

Providers shall maintain documentation that demonstrates that individuals providing services have the required qualifications established by DMAS, DHP or DBHDS.

Providers must have the correct service license from DBHDS in order to secure service authorizations and registrations, 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:

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

- A Comprehensive Needs Assessment shall be required prior to developing an Individual Services Plan (ISP) and a valid Comprehensive Needs Assessment as defined in Chapter IV of this manual is required as a reference point for the ISP during the entire duration of services. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessments/re-assessments and ISPs as defined in Chapter IV of this manual shall be denied reimbursement.

- The Comprehensive Needs Assessments must be completed face-to-face by an LMHP, LMHP-S, LMHP-R, or LMHP-RP prior to initiating each of the following services:

    - Intensive In-home Services (IIH) for Children and Adolescents
    - Therapeutic Day Treatment (TDT) for Children and Adolescents
    - Mental Health Partial Hospitalization Program Services (Assessment may also be completed by a physician assistant or nurse practitioner)
    - Intensive Outpatient Services (Assessment may also be completed by a physician assistant or a nurse practitioner)
    - Psychosocial Rehabilitation
    - Assertive Community Treatment (Assessment may also be completed by a physician assistant or a nurse practitioner)
    - Mental Health Skill-building Services
    - Multisystemic Therapy
    - Functional Family Therapy
    - Applied Behavior Analysis (Assessment may also be completed by a Licensed Assistant Behavior Analyst)

- For services that allow a nurse practitioner who is not a psychiatric/mental health nurse practitioner, a physician assistant or a Licensed Assistant Behavior Analyst to complete the initial assessment, this assessment is used only for that service and cannot be used a comprehensive needs assessment for another service.

- An assessment completed by an individual who is not an LMHP, LMHP-R, LMHP-RP or LMHP-S cannot be used as a Comprehensive Needs Assessment nor can it be updated by a LMHP, LMHP-R, LMHP-RP, LMHP-S to be used as a Comprehensive Needs Assessment.

- Comprehensive Needs Assessments must contain a documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all fifteen elements to qualify for reimbursement. The Comprehensive Needs Assessment shall document the medical necessity criteria and how service needs match the level of care criteria.

- Comprehensive Needs Assessments must address all 15 required elements and support medical necessity criteria as presented in the service authorization and the most current ISP.

- Comprehensive Needs Assessments and ISPs must be up to date based on the clinical and service needs of the individual.

- Comprehensive Needs Assessments must be reviewed and updated as specified in the Comprehensive Needs Assessment section of Chapter IV.

- If there is a lapse in IIH services for more than 31 consecutive calendar days without any communications from family members/legal guardian or the individuals with the service provider, the provider shall discharge the individual.

- If there is a lapse in TDT services that is greater than 31 consecutive calendar days, the provider shall discharge the individual.

- A new Comprehensive Needs Assessment is conducted prior to resuming CMHRS or EBH services after a lapse in services of greater than 31 days if the previous Comprehensive Needs Assessment is outdated as defined in

Chapter IV.

- A new Comprehensive Needs Assessment is conducted prior to resuming CMHRS or EBH services after a discharge if the previous Comprehensive Needs Assessment is outdated as defined in Chapter IV.

- For obtaining a service authorization, the information contained in the Comprehensive Needs Assessment must be used when providing the medical necessity for each service requested on behalf of the individual.

- The record must contain a preliminary working DSM diagnosis and a Comprehensive Needs Assessment upon which the diagnosis and ISP is based.

- Individual shall be referred for a physical examination as needed. The results of a physical examination should be a part of the medical record.

- The provider shall determine who the primary care provider is and inform him or her of the individual's receipt of mental health services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted. Care coordination shall also be documented.

- An individualized and individual specific ISP must be part of the record. The ISP must address the issues as documented in the Comprehensive Needs Assessment. For services that don’t require ISPs, providers must follow all plan of care or treatment plan requirements contained in the service specific section of this manual.

- There must be documentation indicating that the individual was included in the development of the ISP and the ISP shall be signed by the individual. If the individual is a youth, the ISP shall also be signed by the youth’s parent/legal guardian. Documentation shall be provided if the individual,

who is a youth or an adult who lacks legal competency, is unable or unwilling to sign the ISP.

- The ISP shall be a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the Comprehensive Needs Assessment.

- The ISP contains treatment or training 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 timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services.

- All interventions and the projected and allowable settings of the intervention shall be defined in the Individual Service Plan. Documentation shall include how all identified intervention and settings meet the treatment needs of the individual.

- The ISP must be reviewed at a minimum, every 90 days to determine if the goals and objectives meet the needs of the individual based on the most recent clinical review of the service documentation and assessment of functioning. The provider must evaluate and update the member's progress toward meeting the individualized service plan objectives and document the outcome of this review. The ISP shall be rewritten at least annually.

- All ISPs shall be completed, signed, and contemporaneously dated by the allowed professional for the service (as detailed in Chapters II and IV and the Appendices to this manual) who prepares the ISP within a maximum of 30 calendar days from the date of initiation of services unless otherwise specified. The youth’s ISP shall also be signed by the parent/legal guardian, as appropriate, and the adult individual shall sign his own. If the individual, whether a youth or an adult, is unwilling to sign the ISP, then the service provider shall document the clinical or other reasons why the individual was not able or willing to sign the ISP. Signatures shall be obtained unless there is a medical or clinical reason that renders the individual unable to sign the

ISP.

- Any ISP deviation as well as the reason for the deviation shall be documented in the individual's medical record;

- If the provider has an existing, valid Comprehensive Needs Assessment as defined in Chapter IV of this manual but feels an additional Comprehensive Needs Assessment is needed, they may choose to complete a Comprehensive Needs Assessment and bill the appropriate Comprehensive Needs Assessment code that corresponds to the service/treatment. Documentation must be present to justify the need for the additional Comprehensive Needs Assessment.

- If an individual receiving mental health services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30- 50-430, the provider shall collaborate with the case manager by notifying the case manager of the provision of mental health services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the case manager within 30 calendar days of the discontinuation of services.

- Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.

- Any drugs prescribed as a part of the treatment, including the prescribed quantities and the dosage, must be entered in the record.

- If the service being provided allows the utilization of QPPMH or QMHP-E staff, then the documentation of supervision must meet criteria set forth in Chapters II and IV of this manual.

- A member-signed document verifying freedom of choice of provider was offered and this provider was chosen must be present in the record.

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

- A member signed document verifying that the individual was notified of their appeal rights.

- Service coordination between all health care service providers who are involved in the individual's care is required and must be documented in the ISP and Progress Notes.

- DBHDS requires the supervision of services that are intensive or clinical in nature such as IIH or TDT, must be provided by a LMHP or LMHP-S, LMHP-R, or LMHP-RP. These supervisors must be available for consultation as needed, around the clock every day including weekends and holidays.

- DBHDS requires the supervision of services that are supportive in nature such as psychosocial rehabilitation or MHSS shall be provided an LMHP, LMHP-S, LMHP-R, LMHP-RP or QMHP-A.

- For services where group counseling is allowed, reimbursement is not allowed for more than 10 individuals regardless of Medicaid eligibility unless the LMHP, LMHP-R, LMHP-RP or LMHP-S documents clinical justification for exceeding 10 individuals.

- For Applied Behavior Analysis, group treatment reimbursement is not allowed for more than 5 youth regardless of Medicaid eligibility unless the LBA, LABA or LMHP documents clinical justification for exceeding 5 youth.

- For Applied Behavior Analysis, group family treatment reimbursement is not

allowed for more than 5 caregivers regardless of Medicaid eligibility unless the LBA, LABA or LMHP documents clinical justification for exceeding 5 caregivers.

- For services where individual counseling is a required service component for reimbursement, services must be provided face-to-face and one-on-one.

Progress Note Documentation

- Providers shall be required to maintain progress notes detailing all relevant information about the Medicaid individuals who are in providers' care. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. Progress notes shall support the medical necessity criteria and how the individual'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.**

- Progress notes shall also include, at a minimum:
    - The name of the service rendered,
    - The date of the service rendered,
    - The signature and credentials of the person who rendered the service,
    - The setting in which the service was rendered, and
    - 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.

- DMAS and its contractors shall not reimburse for dates of services in which the progress notes are not individualized and case-specific. Duplicated progress notes shall not constitute the required case-specific individualized

progress notes. Each progress note shall demonstrate unique differences particular to the individual's circumstances, treatment, and progress. Claim payments shall be retracted for services that are supported by documentation that does not demonstrate unique differences particular to the individual.

- Progress notes must contain individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes.

- Individualized and case-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP.

- Progress notes for services provided in group settings must indicate the number of participants in the group.

Psychosocial Rehabilitation Documentation Requirements

The documentation requirements for this service are different than what is applied to the other CMHRS services because of the milieu-based service model used in psychosocial rehabilitation services.

- Services must be documented in the individual’s records as having been provided consistent with the ISP. Daily documentation that describes the activities chosen by the members, such as logs and sign in sheets, will be necessary to ensure that the documentation correlates with the units billed for each day of service, to convey a summary of the daily activities and group activities, the impressions of each member in the activity, and support the overall time billed for the day of programming.

- Progress notes shall be individualized and member-specific and shall not be duplicated. Each progress note shall demonstrate unique differences particular to the individual's circumstances, treatment and progress. Progress notes for psychosocial rehabilitation services must be completed monthly. Notes must specifically describe the activities and interventions chosen by the member and other interventions that were provided by the program. Monthly progress notes should describe how the service provider has worked to provide interventions and work with the individual toward engagement in the therapeutic milieu and attainment of individualized service plan goals as offered by the clubhouse model.

MHSS Documentation Requirements – validating prior psychiatric history

- Providers may use their own records to validate prior history, however they must clearly document in the MHSS note where in the electronic record substantiating information (ex: doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date) can be found. If an individual sees a psychiatrist outside of the agency and the medication area of the record is documented to reflect the psychiatric history and prescribed medications, then in that section of the record each of the required elements in the regulation including: the worker who checked the record, what record was viewed and the person who wrote the note that was viewed, the name of the organization that the record belongs to, the date and time the record was reviewed, the specific placement provided, the type of treatment previously provided, the name of the treatment provider, and the dates of the previous treatment must be provided. A MHSS note directing the reader to refer to another section of the individual's medical record with the same provider agency will be accepted as meeting the requirement. Again, it must clearly document in the MHSS note where in the electronic record substantiating information can be found.

- The provider shall document evidence of the psychiatric medication history, as required by above under the medical necessity requirements by maintaining a photocopy of prescription information from a prescription bottle or by contacting a prior provider of health care services or pharmacy

after obtaining written consent from the individual. Prescription lists or medical records, including discharge summaries, obtained from the pharmacy or current or previous prescribing provider of health care services that contain:

- name of prescribing physician;
- name of medication with dosage and frequency; and
- date of prescription shall be sufficient to meet this criteria.

Family member statements shall not suffice to meet this requirement.

- The MHSS regulations outline specific documentation requirements in order to satisfy the criteria for validating medication history. Examples include either photocopies of the prescription information from the bottle or contacting the prior provider. Providers may use their own records to validate medication history (doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date), however they must clearly document in the MHSS note where in the electronic record substantiating information can be found.

In the absence of such documentation, the current provider shall document all contacts (i.e. telephone, faxes, electronic communication) with the pharmacy or provider of health care services with the following minimum elements:

- name and title of the caller;
- name and title of prior professional who was called'
- name of organization that the professional works for;
- date and time of call;
- specific prescription confirmed;
- name of prescribing physician;
- name of medication; and
- date of prescription.

Treatment Foster Care Case Management (TFC-CM)

DMAS or its contractor will conduct utilization review to ensure that treatment foster care case management is provided according to the requirements set forth in this manual. Periodic, unannounced, utilization review on-site and desk reviews of provider medical records will be made to ensure services were provided under a

comprehensive treatment plan and that progress reports are current and complete. All service and documentation requirements must be met. The child must meet the eligibility requirements for the service, and providers must meet the qualifications set forth by the Department of Social Services (DSS). All services must be thoroughly documented in the child's record.

The State Recognized uniform assessment instrument for Psychiatric Services, the Child and Adolescent Needs and Strengths (CANS) Assessment Tool, must be timely and available for review, and the scoring must support the child's documented symptoms and behaviors that indicate the need for the service at admission. A new CANS is required to be in the record for each 90-day period throughout the stay. The CANS scores are required to be current and submitted to the service authorization contractor for each service authorization period, and must be part of the medical record and are subject to review. If services reimbursed by Medicaid do not meet the program criteria requirements or are not properly documented, payment will be retracted.

Upon completion of an on-site review the utilization review analyst(s) may meet with staff members as selected by the provider for an exit conference. The exit conference will provide an overview of the findings from the review, and based on the review team's report and recommendations, DMAS or its contractor may take any corrective action necessary regarding retraction of payment. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services and utilization control regulations.

Upon completion of an on-site or desk review, DMAS or its contractor will respond to the provider in writing and cite federal or state regulations and policy and procedures that were not followed outlining any retractions necessary.

If DMAS or its contractor requests a corrective action plan, the TFC-CM provider must submit the plan, within 30 days of the receipt of notice, to the utilization review analyst(s) who conducted the review. Subsequent visits/desk reviews may be made for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

Sources of Information

MediCall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to confirm member eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. Specific instructions on the use of the verification systems are included in “Exhibits” at the end of this chapter.

Automated Response System (ARS)

Providers may use the Internet to verify member eligibility and perform other inquiry functions. Inquiries can be submitted in real-time. Specific instructions on the use of the ARS are included in “Exhibits” at the end of this chapter.

HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

- (804)786-6273 Richmond Area & out-of-state long distance
- 1-800-552-8627 In-state long distance (toll free)

The HELPLINE is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.

The Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for member eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to members, and members who have questions about the Medicaid Program should be directed to their local departments of social services. If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to members.