Utilization Review and Control (PP)

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Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of care and services paid by Medicaid, including review of utilization of the services by providers and by members. Federal regulations of 42 CFR §§ 455 – 456 set forth requirements for detection and investigation of Medicaid fraud and abuse to maintain program integrity and require implementation of a statewide program of utilization control to ensure high quality care as well as the appropriate provision of services. This chapter provides information on utilization review and control requirements handled by the Department of Medical Assistance Services (DMAS).

Financial Review and Verification

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

Overview to Utilization Review Activities

The Department of Medical Assistance Services (DMAS) conducts utilization review to ensure that the care meets quality standards. Medicaid requires that effective utilization review be maintained on a continuing basis to ensure the medical necessity of the services for which Medicaid provides reimbursement and to promote the most efficient use of available health facilities and services. Participating Medicaid providers are responsible for ensuring that requirements, such as record documentation for services rendered, as well as Federal and State codes is met in order to receive reimbursement from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon request. The provider incurs the cost associated with providing these records to the requesting authority.

Providers and members are identified for review either from systems-generated reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Provider reviews are initiated on a regular basis to meet federal requirements as indicated in the code of Federal Regulations (CFR). Random sampling may be used to determine areas for on-site reviews, as well as computerized exception

reports which look at utilization patterns for providers and members. Exception reports developed for providers and members compare billing activities and utilization patterns with those of their respective peers.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources including consultants and contractors. These audits will be conducted as desk and/or on-site audits. DMAS will notify the provider by written request for clinical records. Failure to comply with the request for records will be determined as an overpayment for the billed service. Facilities must have these records available for the reviewer the date and time specified on the Request for Records letter. If a facility fails to comply with the request for records for the on-site audit, an overpayment to DMAS will be required. DMAS staff will not issue extensions for on-site audits.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to federal and state regulation or statute, failed to maintain any record or adequate documentation to support their claims, failed to provide valid information to obtain prior authorization, or billed for medically unnecessary services. Due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Corrective actions for members include education on the appropriate use of health care, restriction to designated providers for utilization control, recovery of misspent funds, and referral for further investigation of allegations of fraudulent activities. Loss of Medicaid coverage can result from a conviction of Medicaid fraud.

Criteria for Reimbursement

Services that fail to meet Medicaid criteria are not reimbursable. Such non-reimbursable services will be denied upon preauthorization or at the time of the post-payment utilization review.

Medicaid criteria for reimbursement of services are found throughout the provider manual and include, but are not limited to:

- A Pre-Admission Screening Report, signed by the physician, with a recommendation to admit the individual to inpatient services and an indication of why community resources do not meet the individual’s needs;
- Certificate of need for admission that is completed and dated at the time of admission for a general acute care hospital, or within 14 days for a freestanding psychiatric facility and the request for authorization;

- Provision of services by qualified professionals;
- Plan of Care completed by specified professionals and addressing the components listed in Chapter IV of this manual;
- Timely review of the Plan of Care;
- For the home health services that exceed five (5) visits and require service authorization, home health providers must during the service authorization process, attest" that the face-to-face encounter requirement has been met.
- Dated signatures of qualified service providers on all medical documentation;
- Documentation of the medical necessity for services billed; and
- Maintain medical records sufficient to document fully and accurately the nature, scope and details of the health care provided.
- Completion of all elements related to the face-to-face requirements on the CMN will satisfy the face-to-face encounter documentation requirements. For DME items that require service authorization, providers must during the service authorization process, attest" that the face-to-face encounter requirement has been met. For those items that do not require a service authorization, the CMN with the face-to-face encounter documentation must maintained in the individual's medical record.

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 may take any corrective action necessary regarding retraction of payment. Actions taken and the level on management involved will be based on the severity of the cited deficiencies regarding adequacy of services and utilization control regulations.

Upon completion of a desk review, DMAS will respond to the provider in writing and cite federal or state regulations and/or policy and procedures that were not followed outlining any retractions necessary.

If DMAS requests corrective action plans, the 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.

Fraudulent Claims

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. 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 and adhering to applicable state and federal regulations 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 or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit

Program Integrity Section

Division of Cost Settlement and Audit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

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:

Director, Medicaid Fraud Control Unit

Office of the Attorney General

900 E. Main Street, 5th Floor

Richmond, Virginia 23219

Recipient Fraud

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid 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.

If it is determined that benefits to which the individual was not entitled were approved, 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.

Referrals should be made to:

Supervisor, Recipient Audit Unit

Program Integrity Section

Division of Cost Settlement and Audit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Medical Records and Record Retention (PP)

The facility or agency must recognize the confidentiality of member 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 member's written consent is required for the release of information not authorized by law. Current member medical records and those of discharged members must be completed promptly. All clinical information pertaining to a member must be centralized in the member's clinical/medical record.

Records of services must be retained for not less than five years after the date of discharge. Records must be indexed at least according to the name of the member to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). ***Refer to 42 CFR 485.721 for additional requirements***.

Upon the transfer of ownership or closure of a service provider or facility, the current provider or facility is required to notify DMAS Provider Enrollment in writing, within 30 days of the effective date of the change. Information required concerning the change includes, but is not restricted to the effective date of the change and who will have custody of the files / records.

The facility or agency must maintain medical records on all members 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 on the date of service delivery. A required physician signature for DMAS purposes may include signatures, computer entry, or rubber-stamped signature initialed by the physician. These methods only apply to DMAS requirements. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the provider's administration with a signed statement to the effect that he or she is the only person who has the stamp and he or she is the only person who will use it. The physician must initial and completely date all rubber-stamped signatures at the time the rubber stamp is used. An electronic signature that meets the following criteria is acceptable for clinical documentation:

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

Referrals to the Client Medical Management Program (PP)

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred clients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate clients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit Division
of Program Integrity

Department of Medical Assistance Services 600

East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

Fax: (804) 371-8891

When making a referral, provide the name and Medicaid number of the client and a brief statement about the nature of the utilization problems. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.