Utilization Review and Control (Plan First)

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Under the provisions of federal regulations, Medical Assistance Programs must provide for continuing review and evaluation of care and services paid by Medicaid and the Children's Health Insurance Program (also knows as Virginia's Family Access to Medical Insurance Security Plan - FAMIS), including review of utilization of the services by providers and by recipients. Federal regulations of 42CFR§§455–456 and 42CFR§§457.490 set forth requirements for detection and investigation of 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 documentation requirements, quality management and utilization review/control requirements handled by the Department of Medical Assistance Services (DMAS).

The Provider Agreement requires that the records fully disclose the extent of services provided to individuals receiving covered services. Records must be made available to authorized state and federal personnel in the form and manner requested.

Providers must follow both the general documentation requirements for all providers as outlined in this chapter. Documentation must be in accordance with the requirements of the individual licensing board within the Department of Health Professions and the requirements detailed in this manual.

General Documentation Requirements

Use of the electronic signatures, for clinical documentation purposes, shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Providers must follow DMAS guidelines set forth regarding electronic signatures (DMAS Memorandum "Use of Electronic Signatures" 8/20/2004 available online at:

http://dmasva.dmas.virginia.gov/Content_pgs/pr-memos.aspx.

Only a medical doctor (MD) may use a rubber stamp and the stamped signature must be initialed and dated by the MD. However, these methods do not override other requirements that are not for DMAS purposes. If a MD chooses to use a rubber stamp on documentation requiring his or her signature, the MD whose signature the stamp represents must have documented a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. The MD must initial and completely date all rubber-stamped signatures.

The provider must recognize the confidentiality of medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern records' use and removal and the conditions for the release of information. The member/responsible party's written consent is required for the release of information not authorized by law.

Record Retention

Regulations of the Virginia Board of Medicine (18VAC85-20-26) state that practitioners must maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

Records of a minor member, including immunizations, must be maintained until the member reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the member;

Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or

Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

After October 19, 2005, practitioners must post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records can only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.

NOTE: All forms mentioned in this chapter may be located at the DMAS website at: http://dmasva.dmas.virginia.gov/.

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.

DMAS Quality Management Review Responsibilities

Quality management controls are important to ensure quality of care as well as the appropriate provision of services and the medical necessity for services. Many of the review and control requirements respond to Federal and State regulations; all participating providers must comply with all of the requirements.

DMAS or its contractors must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes the review of the utilization of services rendered by providers to members.

Medical records of members currently receiving DMAS reimbursable services as well as a sample of

closed medical records may be reviewed. DMAS or its contractors may also conduct an on-site investigation as follow-up to any complaints received.

Periodic, unannounced, quality management review on-site visits or desk reviews will be made. Review may include but is not limited to:

- The comprehensive care being provided;
- The adequacy of the services available to meet the current health needs and to promote the maximum physical and emotional well-being of each member for the scope of services offered;
- The necessity and desirability of the continued services;
- The documentation to support medical necessity and authorization for services; and
- For verification of agency/provider adherence to DMAS requirements in accordance with federal and state regulations.

Upon completion of an on-site review, DMAS staff will meet with staff members for an exit conference. The exit conference will provide an overview of the findings from the review. A report will be written detailing the findings. Based on the review team's report and recommendations, DMAS may take corrective action. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services.

If DMAS requests corrective action plans, the provider must submit the plan, within 30 days of the receipt of notice. Subsequent visits/desk reviews may be made for the purpose of follow-up deficiencies, complaint investigations, or to provide technical assistance.

Reimbursement Requirements

Services that fail to meet DMAS criteria are not reimbursable. Such non-reimbursable services may have payment retracted as a result of a quality management review. DMAS criteria for general reimbursement of general Medicaid/FAMIS services provided are found throughout the provider manual. It is the responsibility of the provider to adhere to the requirements documented in this manual as well as by the individuals licensing board.

Referring Members to Client Medical Management

DMAS providers may refer Medicaid/FAMIS patients suspected of inappropriate use or abuse of Medicaid/FAMIS services to the Recipient Monitoring Unit (RMU) in DMAS. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program (CMM). If CMM enrollment is not indicated, RMU staff may educate members 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. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit

Division of Program Operations

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) 786-5799

When making a referral, provide the name and Medicaid/FAMIS number of the member and a brief statement regarding the nature of the utilization problems. Hospitals continue to have the option of using the “Non-Emergency Use of the Emergency Room” Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

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