CHAPTER VI UTILIZATION REVIEW AND CONTROL

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INTRODUCTION

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 individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS or its contractor, 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 reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by 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.

UTILIZATION REVIEW (UR) - GENERAL REQUIREMENTS

Utilization reviews of enrolled providers of residential treatment services are conducted by DMAS or it 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 Magellan 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.

Upon completion of a UR, DMAS staff or its designated contractor(s) may be available to meet either face to face or telephonically with provider staff. The purpose of the Exit Conference is to provide a general overview of the UR procedures and expected timetables. DMAS 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.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be outlined and DMAS will cite federal or state regulations and policy and procedures that were not followed. 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. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, DMAS 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 facility address on record.

If a billing adjustment is needed, it will be specified in the final audit findings report. If a Plan of Correction is also offered and requested, the provider will have 30 days (unless otherwise indicated) from receipt of the final audit findings report to submit the plan to DMAS or its designated contractor(s) for approval.

Subsequent visits/desk reviews may be made for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

If DMAS requests a corrective action plan, the provider must submit the plan, within 30 days of the receipt of notice, to the utilization review analyst(s) who conducted the review.

APPEALS

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 RESIDENTIAL TREATMENT SERVICES INCLUDING PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF) AND THERAPEUTIC GROUP HOMES (TGH)

The Provider Agreement and Magellan contract requires that records 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. Psychiatric Residential Treatment Facility Services that fail to meet Medicaid criteria are not reimbursable. If the required components are not present or do not comply with the documentation criteria, reimbursement will be retracted.

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 service authorization contractor, or the behavioral health service authorization contractor shall be fully substantiated throughout individuals' medical records.

To describe the service, review the service description, select the procedure code in accord with your Magellan contract which describes the service rendered and documented, and enter the appropriate procedure code in the record. Providers must have the correct service license from the Department of Behavioral Health and Developmental Services (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.

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

- There must be documentation indicating that the individual was included in the development of the Initial Plan of Care (IPOC) and Comprehensive Individual Plan of Care (CIPOC). The IPOC and CIPOC shall be signed by the individual. The IPOC AND CIPOC shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a child or an adult who lacks legal competency, is unable or unwilling to sign the IPOC AND CIPOC.

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

- The CIPOC 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 planned and allowable settings of the intervention shall be defined in the Initial and Comprehensive Plan of Care. Documentation shall include how all identified intervention and settings meet the treatment needs of the individual.

- All CIPOCs shall be completed, signed, and contemporaneously dated by the team responsible for the plan of treatment. The child's or adolescent's CIPOC shall also be signed by the parent/legal guardian and the adult individual shall sign his own. If the individual, whether a child, adolescent, or an adult, is unwilling to sign the CIPOC, then the service provider shall document the clinical or other reasons why the individual was not able or willing to sign the CIPOC. Signatures shall be obtained unless there is a medical or clinical reason that renders the individual unable to sign the CIPOC.

- The CIPOC must be reviewed at a minimum, every 30 days by a PRTF treatment team and every 60 days by a TGH treatment team 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 objectives and document the outcome of this review. The CIPOC shall be rewritten at least annually.

- If an individual receiving TGH services is also receiving case management services the provider shall collaborate with the case manager by notifying the case manager of the provision of residential treatment services and 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.

- 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 paraprofessional 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.

- 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 in the event of an adverse outcome.

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

DAILY SERVICE DOCUMENTATION FOR PRTF AND TGH

Providers shall be required to maintain documentation 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. Daily service documentation 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.**

The daily 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;
- 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;
- Reasons for missed interventions;
- Documentation of therapeutic leave and related interventions;
- Family engagement activities and routine family contact or attempts at providing the activity and related follow up coordination with DSS, Magellan and others involved in the treatment team and family engagement process; and
- Care coordination documentation.

The facility or agency must maintain medical records on all individuals 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.

Each psychiatric treatment session must be written at the time the service is rendered and must include the dated signature of the professional rendering the service.

All psychiatric treatment medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. 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. For additional information on physician signatures, refer to the Medicaid *Physician Manual*.

PROGRESS NOTES

DMAS 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 CIPOC.

UTILIZATION REVIEW OF PSYCHIATRIC RESIDENTIAL TREATMENT SERVICES AND THERAPEUTIC GROUP HOMES

Medicaid criteria for reimbursement of residential treatment services are found throughout the provider manual. Utilization review will include, but is not limited to review of:

- 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 as Medicaid providers of residential treatment services.

- 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 based upon the service definition, the service specific provider intake, and medical necessity criteria.

- The medical or clinical necessity of the delivered service;

- A copy of the provider's license/certification, staff licenses, and qualifications for Licensed Mental Health Professional (LMHP, LMHP-R, LMHP-S and LMHP-RP), Qualified Mental Health Professional (QMHP), and paraprofessionals to ensure that the services were provided by appropriately qualified individuals as defined in Chapter II of this manual;

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

- Written IPOC and CIPOC completed by specified professionals and addressing the components listed in Chapter IV of this manual;

- Timely review of the written Plan of Care;

- Dated signatures of qualified service providers on all medical documentation;

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

- A current, signed initial plan of care (IPOC) and Comprehensive Plan of Care (CIPOC) that shall be developed, supervised, and approved by the family or legally authorized representative, treating physician, psychiatrist, or LMHP responsible for the overall supervision of the CIPOC;

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

- A determination that the delivered services as documented are consistent with the individual's Initial and Comprehensive Individual Plan of Care(CIPOC), invoices submitted, and specified service limitations;

- A determination that the delivered services are provided by qualified staff that meet the minimum requirement for the service being delivered and the provision of all ordered services in the individual's written treatment plan by qualified professionals;

- As indicated, supervision of QPPMH staff is documented and included in the clinical record;

- A determination that for residential treatment services requiring service authorization, the medical record content corroborates information provided to

Magellan;

- 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;

- 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 the provider has maintained medical records sufficient to document fully and accurately the nature, scope and details of the health care provided;

- The reviewer determines whether all required aspects of treatment are being provided, and also determines whether there is any inappropriate overlap or duplication of services;

- The reviewer determines whether all required activities/service requirements (as set forth in the appropriate sections of the residential treatment manual and related regulations) have been performed;

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

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

<u>Specific Utiilziation Review</u> for Psychiatric Residential Treatment:

- Validation that the physician, or physician assistant, or nurse practitioner, acting within the scope of practice as defined by state law and under the supervision of a physician, recertifies, at least every 30 days that the individual continues to require inpatient services in a psychiatric facility;

- Validation of documentation received during the preauthorization process;

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

- Verifiy compliance with restraint and seclusion regulations (42 CFR §§ 483.350 – 483.376).

For Services Provided Under Arrangement (PRTF Only):

- Services provided under arrangement, needed while residing in a PRTF, must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement. Each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of a service provided under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Inpatient Psychiatric Facilities (IPFs) should begin preparations now to include routine or expected services provided under arrangement in each plan of care.

- Each initial and comprehensive plan of care must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought.

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

- Providers of services under arrangement must either be employees of the IPF or, if they are not employees of the IPF, they must have a fully executed contract with the IPF in advance of provision of the service, with the exception of emergency services. For emergency services, the contract must be executed before the provider of emergency services bills DMAS for the emergency services. IPFs should begin preparations now to contract with usual providers of services under arrangement who are not employees of the IPF.

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

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

received from the provider of services under arrangement within 30 days of the initial request, they must be re-requested.

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

- The referral from the IPF shall be documented in the records of the provider of services under arrangement.

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MEDICAL RECORDS AND RECORD RETENTION

The provider must recognize the confidentiality of individuals' 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 individual's written consent is required for the release of information not authorized by law. Documentation in all current individual medical records and those of discharged individuals must be completed promptly. All clinical information pertaining to an individual must be centralized in the individual's clinical/medical record.

Records of all outpatient psychiatric 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 individual 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 and the supervisor of the MHUR/Hospital Utilization Review Unit 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. Send notice to:

Department of Medical Assistance Services
Hospital Utilization Review Supervisor
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
Or

Department of Medical Assistance Services
Provider Enrollment
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

Fee for service providers must notify Magellan of Virginia via VAProviders@MagellanofVirginia.com.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or State law. Some examples of falsifying records include, but are not limited to:

- Creation of new records when records are requested;
- Back-dating entries;
- Post-dating entries;
- Writing over; or
- Adding to existing documentation (except as described in late entries, addendums or corrections, which would include the dated signature of the amendments).

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 Virginia Medicaid Program, DMAS, 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, Medicaid Memos, the provider agreement, Magellan contract if applicable, 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 the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee or business contractor 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
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300

Richmond, Virginia 23219
Telephone: (804) 692-0480

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 individuals 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
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Telephone: (804) 786-0156

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid enrolled individuals suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or 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 individuals 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. Voicemail receives after-hours referrals. Written

referrals should be mailed to:

Supervisor, 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

When making a referral, provide the name and Medicaid number of the individual and a brief statement about 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.