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 the care and services paid through Medicaid, including review of utilization of the services by providers and by members. 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 requirements for services rendered are met in order to receive payment 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 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.

COMPLIANCE REVIEWS

DMAS or its designated contractor(s) routinely conduct compliance reviews to ensure that the services provided to Medicaid members 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 members 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 Medicaid if they are found to have billed Medicaid 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 may restrict or terminate the provider's participation in the program.

Effective July 1, 2009, The Department of Medical Assistance Services (DMAS) has contracted with HMS to perform audits of Outpatient Psychotherapy and Substance Abuse, Therapeutic Day Treatment, Mental Health Support Services, Intensive In-Home Services of in-state and out-of-state providers that participate in the Virginia Medicaid program. Additional mental health services may be added or substituted at a later date as deemed necessary by DMAS. DMAS will also continue to audit these services as well.

DMAS has contracted with Clifton Gunderson to perform audits of Level A and Level B Residential Services. DMAS will also continue to audit these services as well.

Providers that have been audited by HMS and have questions directly pertaining to their audit may contact HMSaudits@dmas.virginia.gov.

FRAUDULENT CLAIMS

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

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading, understanding, and adhering to applicable state and federal regulations 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 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 Division
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 East Main Street, 5th Floor
Richmond, Virginia 23219

Member Fraud

Allegations about fraud or abuse by members are investigated by the Member Audit Unit of the DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (DSS) or to the DMAS Member Audit Unit at (804) 786-0156. Reports are also accepted at the RAU Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the RAU email address: memberfraud@dmas.virginia.gov or forwarded to:

Program Manager,, Member Monitoring Unit

Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Member Monitoring Unit (RMU) of DMAS. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Member Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. 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:

Program Manager Member Monitoring Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Telephone: 1-804-786-6548
CMM HELPLINE: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the member 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/her name and telephone number in case DMAS has questions regarding the referral.

COMMUNITY MENTAL HEALTH, CASE MANAGEMENT, AND SUBSTANCE ABUSE SERVICES

Utilization Review (UR) - General Requirements

Utilization Reviews of enrolled providers of community mental health, case management, and substance abuse 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 consumer, family, or significant other(s), or both. 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.

The audit will include the examination of the following areas / items:

- If a provider lacks a license or a provider enrollment agreement that lists each if the services and locations that the Provider is offering UR will retract for all unlisted service and/or locations.

- 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 assessment, and eligibility criteria Providers who bill (A) and/or testing under the treatment code will have units retracted. They must use the (A) code for (A) only. Do not bill testing under the (A) code for treatment codes;

- 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), 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;

- Ensure documentation supports QMHP supervision of qualified paraprofessionals as set forth in Chapter IV;

- Ensure that entry level paraprofessionals are paired with a qualified paraprofessional and supervised by a QMHP as set forth in Chapter IV;

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

- Documentation that the member 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 member's Individualized Service Plan (ISP), invoices submitted, and specified service limitations; and

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

- A determination that for CMHR services requiring service authorization, the medical record content corroborates information provided to the DMAS service authorization contractor(s).

- 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 member. Checklists and boilerplate or repeated language are not appropriate.

    - 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 of services.

    - The reviewer determines whether all required activities (as set forth in the appropriate sections of the CMHRS manual) have been performed.

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

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

    - The reviewer determines that providers have documentation from DMAS 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 community mental health rehabilitative services.

    - For all community mental health rehabilitative 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 monthly updates to the case manager. The

member's PCP must be notified of services to ensure coordination of care. A discharge summary must be sent to the case manager within 30 days of the service discontinuation date. Case management can be provided through one of the following : Intensive In-Home services, Treatment Foster Care Case Management, mental health or intellectual disability/mental retardation case management from a Community Services Board, or case management for clients with developmental disabilities who are eligible for or receiving services through the Individual and Family Developmental Disabilities Support Waiver. Only one type of case management can be provided at a time.

Services must meet the requirements set forth in 12 VAC 130-540 through 590 and in the Virginia *State Plan for Medical Assistance Services* and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

Upon completion of on-site activities for a routine 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. If there is additional information or documentation that was not provided for review, this documentation may be submitted by the provider with a request for further review. The provider's request must detail the discrepancy in question and include any additional supporting medical record documentation that was written at the time the services were rendered to verify the claims as billed. 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 date stamped by DMAS. 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 your facility.

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.

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, 11th Floor
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 REQUIRED FOR COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES AND CASE MANAGEMENT SERVICES

The Provider Agreement requires that records fully disclose the extent of services provided to Medicaid members. Records must clearly document the medical or clinical necessity and support needs 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.

To describe the service, review the service description, select the procedure code in Chapter V of this manual which most appropriately describes the service rendered and documented, and enter the appropriate procedure code in the record. 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 member must be referenced on each page of the record by full name or Medicaid ID number.
- The record must contain a preliminary working DSM-IV diagnosis and a psychiatric/psychological assessment upon which the diagnosis or ISP is based.
- Members should be referred for a physical examination as needed. The results of a physical examination should be a part of the mental health record.
- An assessment completed by appropriately qualified staff must be included for all services based on service specific criteria and time frames
- An assessment of adaptive functioning is required to support medical necessity criteria.
- An individualized and member specific ISP must be part of the record.

- The enrolled provider must develop and maintain written documentation for each service billed. Adequate documentation is essential for audits of billed services. The documentation must 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 required to deliver the service. A log sheet may be used for recording this information.

- Individualized and member specific progress notes are also part of the minimum documentation requirement and are to convey the member's status, staff interventions, and, as appropriate, progress toward goals and objectives in the ISP. Progress notes must be entered for each service that is billed. The content of each progress note must corroborate the time/units billed. The interventions documented must be reflective of the service definitions and the assessment and ISP. A service start and stop time is recommended. Progress notes must include a dated signature of the qualified provider.

- 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 member was notified of their appeal rights.

DOCUMENTATION REQUIRED FOR COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES <u>INDEPENDENT CLINICAL ASSESSMENT ("ICA")</u>

<u>UR – Providers of Services that Require an ICA</u>

In addition to reviewing all other aspects of the service detailed in Regulations and the DMAS CMHRS Manual, the review will include the examination of the following areas/items related to the IA:

- **The provider must maintain a copy of the <u>entire</u> ICA in each recipient's file.**

- The provider may not bill for an assessment or for any IIH, TDT, or MHSS services before the IA has been completed. **Any billing for assessments or services that occurred prior to the completion of the IA will be retracted. If the IA does not recommend the service that was provided, all billing for that service for that recipient will be retracted.**