CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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UTILIZATION REVIEW AND CONTROL

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 recipients. 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, 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.

COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients 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 recipients 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's peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records, as necessary.

Statistical sampling and extrapolation may be used in a review. The Department may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also 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 regulation, 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, Medicaid may restrict or terminate the provider's participation in the program.

INPATIENT AND RESIDENTIAL PSYCHIATRIC SERVICES

General Acute Care Hospital Audits

The audits for General Acute Care Hospitals for psychiatric stays shall consist of a review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in 42 CFR §§ 456.100 through 456.145.

2. List of current Utilization Management Committee members and physician advisors to determine that the Committee's composition is as prescribed in the 42 CFR §§ 456.105 through 456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and lists of attendees to determine that the Committee is meeting according to its utilization management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR §§ 456.141 through 456.145.

5. Topic of one ongoing Medical Care Evaluation Study to determine if the hospital is in compliance with the 42 CFR § 456.145.

6. From a list of randomly selected paid claims, the facility must provide a copy of the physician admission certification and written plan of care for each selected stay to determine the hospital's compliance with 42 CFR §§ 456.60 and 456.80. If any of the required documentation does not meet the requirements found in the 42 CFR §§ 456.60 through 456.80, reimbursement may be retracted.

7. The facility may appeal in accordance with the *Administrative Process Act* (§§ 2.2-4000 et seq., of the Code of Virginia) any adverse decision resulting from such audits, which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.

Absence of any of the above mentioned documentation requirements for either freestanding facilities or acute care hospitals may result in retraction of payment. Services not documented in the recipient’s record as having been provided will be determined not to have been provided, and retractions may be made.

The Department of Medical Assistance Services (DMAS) is required to conduct annual utilization review audits on providers conducting inpatient psychiatric services for Medicaid recipients within inpatient psychiatric facilities and acute care psychiatric

facilities. These audits are conducted to determine that the provider is in compliance with the regulations governing mental hospital utilization found in 42 CFR, Section 456.150 and general acute care hospitals found in 42 CFR, Section 456.50-456.145. These audits can be performed either on-site or as a desk audit. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

In addition, DMAS shall review all inpatient claims for individuals over the age of 21, which are suspended, for exceeding the 21-day limit per admission in a 60-day period for the same or similar diagnoses prior to reimbursement for the stay.

Utilization Review Process

DMAS will conduct annual utilization review audits for freestanding psychiatric providers and general acute care psychiatric providers. At least once a year, DMAS staff will contact the psychiatric provider to request recipient records. DMAS will conduct both desk and on-site audits.

Free-Standing Psychiatric Facilities Audits

The audits for freestanding psychiatric facilities shall consist of a review of the following:

a. Copy of the freestanding psychiatric facilities' Utilization Management Plan to determine compliance with the regulations found in 42 CFR Sections 456.200 through 456.245.

b. List of current Utilization Management Committee members and physician advisors to determine that the Committee's composition is as prescribed in 42 CFR Sections 456.205 through 456.206.

c. Verification of Utilization Management Committee meetings, including dates and list of attendees to determine that the Committee is meeting according to their Utilization Management meeting requirements.

d. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR Sections 456.241 through 456.245.

e. Topic of one on-going Medical Care Evaluation Study to determine that the hospital is in compliance with 42 CFR Section 456.245.

f. From a list of randomly selected paid claims, the free-standing psychiatric facility must provide a copy of the certification for services; a copy of the physician admission certification for services, independent team certification; a copy of the required medical, psychiatric, and social evaluations; and the written plan of care for each selected stay to determine the hospital's compliance with the *Code of Virginia* Sections 16.1-335 through 16.1-348 and 42 CRF Sections 441.152, 456.160, and Sections 456.180 through 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may be retracted.

g. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a free-standing psychiatric facility consistent with 42 CFR Section 456.160.

h. 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, must recertify, at least every 60 days, that the individual continues to require inpatient services in a psychiatric facility.

i. Validation of documentation received during the preauthorization process.

Criteria For Reimbursement

Psychiatric 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 inpatient psychiatric services are found throughout the provider manual and include, but are not limited to:

- A Pre-Admission Screening Report, signed by the team 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 prior to admission 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 4 of this manual; and
- Timely review of the Plan of Care.

Reconsiderations and Appeals

At the conclusion of the audit, DMAS will submit a letter to the provider with the results of the audit. If retractions are necessary, the provider will be notified of the amount. DMAS

may request a plan of action if deemed necessary to ensure future compliance with the requirements listed earlier in this section. If the provider does not agree with the results of the audit, the provider has the right to request reconsideration and state why the retraction should not be made. All requests for reconsideration must be in writing and must be received by DMAS within 30 days of the date on the Audit Result letter. Mail all reconsideration requests to:

DMAS
Prior Authorization Utilization Review Supervisor
Division of Program Integrity
600 E. Broad Street, Suite 1300
Richmond, VA 23219

If the decision to continue denial of reimbursement is made by DMAS, the provider may request an informal fact-finding conference by submitting a request in writing and including all information as to why the retraction should not be made. Requests must be submitted within 30 days of the notice of reconsideration results to:

Director, Appeals Division
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS upholds the decision to retract, the provider may further appeal by requesting a formal evidentiary hearing and submitting a request in writing within 30 days of the notice of the results of the informal fact-finding conference. The request must be mailed to:

Director, Appeals Division
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

TREATMENT FOSTER CARE CASE MANAGEMENT

DMAS will conduct utilization review to ensure that case management is provided according to the requirements set forth in Chapter IV of this manual. Periodic, unannounced, utilization review on-site visits 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. There must be face-to-face contact with the child, case manager, and caseworker no less than twice per month. 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 Uniform Assessment Instrument (Child and Adolescent Functional Assessment Scale [CAFAS] or Pre-School and Early Childhood Functional Assessment Scale [PECFAS]) must be available for review, and the scoring support the child's documented symptoms and behaviors that indicate the need for the service. If services reimbursed by Medicaid do not meet the program criteria requirements or are not properly documented, payment may be retracted.

Reconsiderations and Appeals

At the conclusion of the audit, DMAS will submit a letter to the provider with the results of the audit. If retractions are necessary, the provider will be notified of the amount. DMAS may request a plan of action if deemed necessary to ensure future compliance with the requirements listed earlier in this section. If the provider does not agree with the results of the audit, the provider has the right to request reconsideration and state why the retraction should not be made. All requests for reconsideration must be in writing and must be received by DMAS within 30 days of the date of the Audit Result letter. Mail all reconsideration requests to:

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Director, Appeals Division
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS upholds the decision to retract, the provider may further appeal by requesting a formal evidentiary hearing and submitting a request in writing within 30 days of the notice of the results of the informal fact-finding conference. The request must be mailed to:

Director, Appeals Division
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

OUTPATIENT PSYCHIATRIC SERVICES

DMAS Utilization Review Responsibilities

DMAS will routinely conduct utilization review to ensure that the psychiatric services provided to Medicaid recipients are medically necessary, appropriately documented, and are provided by the appropriate provider. Participating Medicaid providers must ensure

that the utilization control requirements described in this chapter are met. If they are not, retractions may be made and reimbursement for continued services may be discontinued.

Utilization controls are important to ensure quality 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.

Utilization Review Visits

Medical records of recipients currently receiving psychiatric services as well as a sample of closed medical records may be reviewed. DMAS may also conduct an on-site investigation as follow-up to any complaints received.

Periodic, unannounced, utilization review on-site visits or desk reviews will be made to each psychiatric provider to review medical records and conduct an overall review of the provision of services with respect to all of the following:

- Comprehensive care being provided;
- Adequacy of the services available to meet the current health needs and to promote the maximum physical and emotional well-being of each recipient for the scope of services offered;
- Medical necessity of the continued services;
- Feasibility of meeting the recipient's psychiatric needs at an alternate level of care; and
- Verification of agency/provider adherence to DMAS requirements in accordance with federal and state regulations.

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 of 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 any federal or state regulations that were not followed. In addition, a letter outlining any retractions necessary as a result of not following federal or state regulations will be sent to the provider.

If DMAS requests corrective action plans, the psychiatric 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.

Documentation Criteria

Providers of outpatient psychiatric services are expected to follow the guidelines listed below when providing services to Virginia Medicaid recipients.

Recipient Criteria

- Must be Medicaid-eligible (The provider must verify eligibility).
- Must have a psychiatric diagnosis including current mental status documented in the medical progress notes.
- Must participate and be compliant with treatment (e.g., some individuals with mental retardation [MR] or some babies under two may not have the ability to understand the treatment).
- Must have documented evidence of a medical evaluation or a plan to obtain a medical evaluation on the presenting problem(s).

Medical Evaluation (conducted by the Primary Care Physician [PCP]): The purpose of a medical evaluation is to:

- Rule out any underlying medical condition as causing the symptoms.
- Ensure that any underlying medical conditions are being treated.
- Perform an annual medical evaluation (Early and Periodic Screening, Diagnosis and Treatment only).

* The provider is expected to have the results of such an evaluation in the recipient's medical record or indicate that the recipient's condition either does not warrant an evaluation or an evaluation was recommended and for what reasons.

Diagnosis

- Must document the chief complaint related to the diagnosis.
- Must be a psychiatric diagnosis.
- Must be a current (within the past year) diagnosis.
- Must be related to the criteria for psychiatric services: (A through D must be present according to the Virginia *State Plan for Medical Assistance*)

  A. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels, which have been impaired;

  B. Exhibits deficits in peer relations, deficits in dealing with authority, hyperactive, poor impulse control, clinically depressed, or demonstrates other dysfunctional symptoms having an adverse impact on attention and concentration, the ability to learn, and/or the ability to participate in employment, educational, or social activities;

C. Is at risk for developing or requires treatment for maladaptive coping strategies; and

D. Presents a reduction in an individual adaptive and coping mechanism or demonstrates extreme increase in personal distress.

Functional Limitations *(if applicable*)

- Must document how A through D relate/affect the individual's functional limitations (for example, how is school performance affected if the child is hyperactive or has difficulty with attention and concentration).
- How do symptoms affect activities of daily living and/or functioning in the community, school, home, job?

History

- Onset of the diagnosis and/or functional limitations.
- Family dynamics; ability/desire of the family/caretakers to participate and follow through with treatment.
- Reasons that may require consideration (foster care, dysfunctional family)
- History of previous treatment and outcomes.
- Medication history and current medications.
- Medical history (i.e., brain injury) *if relative to current treatment need.*
- Treatment received through other programs/therapies (Department of Rehabilitative Services, day treatment, Special Education, Community Services Board, or the Department of Mental Health, Mental Retardation and Substance Abuse Services clinics).
- Date the individual first received services for this diagnosis.

Plan of Care (elements of the initial plan of care)

- *Focus of the Plan* must be related to the diagnosis.
- Must indicate client-specific goals related to symptoms and behaviors.
- Must indicate treatment modalities used and documentation specific to the appropriateness of the modalities (why the modality was chosen for this individual; all modalities will be considered with appropriate documentation).
- Must indicate estimated length that treatment will be needed.

- Must indicate frequency of the treatments/duration of the treatment.
- Must indicate documentation of the family/caregiver participation.
- Qualified provider must sign and date the plan of care.
- The Plan of Care must be reviewed by the provider every 90 days or every sixth session, whichever time frame is shorter, from the date of the provider's signature.

Continuation Plan

- Has there been a relapse?
- Has there been a significant change in the environment?
- Is the individual at risk for moving to a higher level of care?
- Positive/negative changes relative to the symptoms.
- Documented review of the plan of care by a qualified therapist/personnel (the provider).

Documentation Required (what must be in the medical record)

- History.
- Functional limitations.
- Plan(s) of Care, and all subsequent reviews, signed and dated by the provider.
- Medical Evaluation (evidence of coordination with the PCP, if applicable, or documentation that it is not applicable).
- Results of a Diagnostic Evaluation done within the past year.
- Global Assessment Score (GAS).
- Progress Notes for each session (must describe how the activities of the session relate to the client-specific goals, the length of the session, the level of participation in treatment, the modalities of treatment, the type of session [group, individual], the progress or lack thereof toward the goals, and the plan for the next treatment and must contain the signatures of the providers).
- Evidence of Discharge Planning.
- Discharge Summary (including the reason for the discharge and any follow-up needed).

Absence of any of the above information may result in a denial or a retraction.

Criteria for Reimbursement

Psychiatric services that fail to meet DMAS criteria are not reimbursable.

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

- Provision of services by qualified professionals;
- Completed plan of care signed and dated by the qualified professional;
- Progress notes with dated signatures for each session.

Reconsiderations and Appeals

Payment to the psychiatric services provider may be denied when the provider has failed to comply with established DMAS law, regulation, or policy guidelines. (Virginia *State Plan for Medical Assistance*, Supplement 1 to Attachment 3.1-A&B, Section 7-D, 1-9).

The psychiatric services provider has the right to request reconsideration of denials. The request for reconsideration and all supporting documentation, must be submitted within 30 days of written notification to:

DMAS
Payment Processing Unit Supervisor
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS will review the documentation submitted and provide the psychiatric services provider with a written response to the request for reconsideration. If the denial is upheld, the provider has the right to appeal the reconsideration decision by requesting an informal fact-finding conference within 30 days of written notification of the reconsideration decision. The provider must submit a detailed statement of the factual and legal basis for each item under appeal. The notice of appeal and supporting documentation shall be sent to:

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

If the denial is upheld, the provider has the right to appeal the informal fact finding decision by requesting a formal evidentiary appeal within 30 days of written notification of the informal fact finding decision. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services

600 East Broad Street, Suite 1300
Richmond, Virginia 23219

MEDICAL RECORDS AND RECORD RETENTION

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

Records of 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 recipient 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***.

The facility or agency must maintain medical records on all recipients 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 psychotherapy session must be written at the time the service is rendered and must be signed and dated by the therapist rendering the service. If the therapy session is rendered by an unlicensed therapist, and under the direct, personal supervision of a qualified, Medicaid enrolled provider, the therapy session must contain not only the dated signature of the therapist rendering the service but also the dated signature of the supervising provider. Each therapy session must contain the co-signature of the supervising provider on the date the service was rendered indicating that he or she has reviewed the note.

All psychiatric 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. For more complete information, refer to the Medicaid *Physician Manual*. 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.

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 the Department of Medical Assistance Services 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
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 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
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 patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred recipients 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 recipients 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 recipient 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.