COMMONWEALTH of VIRGINIA

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TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **MICHELLE A. L'HOMMEDIEU**
Assistant Attorney General

DATE: **March 8, 2013**

SUBJECT: **Emergency Regulations for the 2012 Client Medical Management Update (3854 / 6405)**

I am in receipt of the attached regulations to amend and update the Client Medical Management (CMM) Program. You have asked the Office of the Attorney General to review and determine if DMAS has the legal authority to promulgate the regulation and if the regulation comports with state and federal law.

Based on that review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325, has the authority to promulgate this regulation, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

The authority for this emergency action is found in Va. Code § 2.2-4011(B). Chapter 3, Item 307 UU of the 2012 *Acts of the Assembly* grants DMAS the authority to promulgate these regulations. Accordingly, these regulations qualify for the "emergency" exemption from Article 2 requirements. A Notice of Intended Regulatory Action relating to the proposed replacement regulations must be filed with the Registrar within sixty days of the effective date of the emergency regulations, and does not appear to have been filed at this time. The proposed replacement regulations must be filed with the Registrar within 180 days after the effective date

of the emergency regulations. This regulation does not amend the State Plan; therefore, approval by the Centers for Medicare and Medicaid Services will not be required.

If you have any questions or need additional information about this regulation, please contact me at 786-4074.

cc: Kim F. Piner, Esquire

Attachment

Project 2290 - Emergency/NOIRA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

2012 Client Medical Management Update

Part XIII

Client Medical Management Program

12VAC30-130-800. Definitions.

The following words and terms when used in this part shall have the following meanings unless the context clearly indicates otherwise:

"APA" means the Administrative Process Act established by Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 of the Code of Virginia.

~~"Abuse by recipients" means practices by recipients which are inconsistent with sound fiscal or medical practices and result in unnecessary costs to the Virginia Medicaid Program.~~

~~"Abuse by providers" means practices which are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Virginia Medicaid Program or in reimbursement for a level of utilization or pattern of services that is not medically necessary.~~

"Abuse" or "abusive practices" means practices by individuals or providers which are inconsistent with sound fiscal or medical practices and result in unnecessary costs to the Virginia Medicaid program.

"Card-sharing" means the intentional sharing of ~~a recipient~~ an individual's eligibility card for use by someone other than the ~~recipient~~ individual for whom it was issued, or a pattern of repeated unauthorized use of ~~a recipient~~ an individual's eligibility card by one or more persons

other than the ~~recipient~~ individual for whom it was issued due to the failure of the ~~recipient~~ individual to safeguard the card.

"Client Medical Management (CMM) Program ~~(CMM)~~ for ~~recipients~~ individuals" means the ~~recipients'~~ individuals' utilization control program designed to prevent abuse and promote improved and cost efficient medical management of essential health care for noninstitutionalized ~~recipients~~ individuals through restriction to one primary care provider, one pharmacy, ~~and one transportation provider,~~ or any combination of these ~~three~~ designated providers. Referrals may not be made to providers restricted through the Client Medical Management Program, nor may restricted providers serve as covering providers for restricted individuals.

"Client Medical Management (CMM) Program ~~(CMM)~~ for providers" means the providers' utilization control program designed to complement the ~~recipient~~ individual abuse and utilization control program in promoting improved and cost efficient medical management of essential health care. Restricted providers may not serve as designated providers for restricted ~~recipients~~ individuals. Restricted providers may not serve as referral or covering providers for restricted ~~recipients~~ individuals.

"Code of Federal Regulations" or "CFR" means the source where Medicaid federal regulations are located (42 CFR Part 430 through Part 505).

~~"Contraindicated medical care" means treatment which is medically improper or undesirable and which results in duplicative or excessive utilization of services.~~

"Contraindicated use of ~~drugs~~ medication" means the concomitant use of two or more drugs whose combined pharmacologic action produces an undesirable therapeutic effect or induces an adverse effect by the extended use of a drug with a known potential to produce this effect.

“Controlled substance” means a substance that has a potential for abuse because physical and psychic dependence and tolerance may develop upon repeated administration and are classified as Schedule 1 through 5 drugs.

~~"Covering provider" means a provider designated by the primary provider to render health care services in the temporary absence of the primary provider.~~

"DMAS" means the Department of Medical Assistance Services. The Department of Medical Assistance Services is the state agency designated by the General Assembly, to administer Title XIX of the Social Security Act.

“Dental services” means covered dental services available to Medicaid/FAMIS eligible children as well as the limited, emergency services available to Medicaid eligible adults.

"Designated ~~provider~~ physician/pharmacy" means the provider who agrees to be the designated ~~primary~~ physician~~, designated~~ or pharmacy~~, or designated transportation provider~~ from whom the restricted ~~recipient~~ individual must first attempt to seek ~~health care~~ medical or pharmaceutical services. Other providers may be established as designated physician or pharmacy providers with the approval of DMAS.

"Diagnostic category" means the broad classification of diseases and injuries found in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) which is commonly used by providers in billing for medical services.

“Diagnosis” means (i) the process of determining by examination the nature and circumstances of a diseased condition; (ii) the decision reached from such examination.

"Drug" means a substance or medication intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease as defined by the Virginia Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).

"Duplicative medical care" means two or more practitioners are concurrently ~~treat~~ treating the same or similar medical problems or conditions falling into the same diagnostic category, but excluding confirmation for diagnosis, evaluation, or assessment.

"Duplicative medications" means more than one prescription of the same drug or more than one drug in the same therapeutic class.

"Eligibility card" means the document issued to each Medicaid individual listing the name and Medicaid number (either the identification or billing number) of the eligible individual. This document may be in the form of a plastic card magnetically encoded, allowing electronic access to inquiries for eligibility status.

"Emergency hospital services" means those hospital services that are necessary to treat a medical emergency. Hospital treatment of a medical emergency necessitates the use of the most accessible hospital available that is equipped to furnish the required services.

"EPSDT" means the Early and Periodic Screening, Diagnosis, and Treatment Program which is federally mandated for eligible individuals ~~under the age of 21~~ younger than 21 years of age.

"Essential medical services" means quality medical services, including but not limited to, preventive care, emergency services, maternity care, hospital and physician services, and prescription drug services as set out in the State Plan for Medical Assistance.

"Excessive medical care" means obtaining greater than necessary services such that health risks to the ~~recipient~~ individual or unnecessary costs to the Virginia Medicaid Program may ensue from the accumulation of services or obtaining duplicative services.

"Excessive medications" means obtaining medication in greater than generally acceptable maximum therapeutic dosage regimens or obtaining duplicative medication from more than one practitioner.

~~"Excessive transportation services" means obtaining or rendering greater than necessary transportation services such that unnecessary costs to the Virginia Medicaid Program may ensue from the accumulation of services.~~

"FAMIS" means the Family Access to Medical Insurance Security program as created by Title XXI of the Social Security Act.

"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 laws.

"Health care" means any covered ~~services~~ service, including equipment~~,~~ or supplies~~, or transportation services,~~ provided by any ~~individual~~ person, organization, or entity that participates in the Virginia Medical Assistance Program.

"Home and community-based services" means a range of community services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to § 1915(c) of the *Social Security Act* to be offered to individuals as an alternative to institutionalization.

"Hospice services" means services, pursuant to § 1905(o) of the *Act*, that are reasonable and necessary for the palliation or management of the terminal illness, if the terminal illness runs its normal course.

"Immunization" means the creation of immunity against a particular disease using a vaccination.

"Individual" means the recipient of Medicaid covered services which are provided under the authority of Title XIX of the *Social Security Act*.

"Java-Server Utilization Review System" or "JSURS" means a computer subsystem of the Virginia Medicaid Management Information System (VAMMIS) which collects claims data and

computes statistical profiles of individual and provider activity and compares them with that of their particular peer group.

"Managed Care Organization" or "MCO" means an entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed agreement with the Department to provide services covered under the Medallion II (pursuant to 12 VAC 30-120-360 *et seq*.) and FAMIS (pursuant to 12 VAC 30 Chapter 141) programs.

"Medical emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that in the absence of immediate medical attention could reasonably be expected to result in (i) placing the ~~client's~~ individual's health in serious jeopardy, (ii) serious impairment of the individual's bodily functions, or (iii) serious dysfunction of any bodily organ or part.

~~"Medical management of essential health care" means a case management approach to health care in which the designated primary physician has responsibility for assessing the needs of the patient and making referrals to other physicians and clinics as needed. The designated pharmacy has responsibility for monitoring the drug regimen of the patient.~~

"Medically necessary" means services which are reasonable and necessary for the diagnosis or treatment of an illness, condition, injury, or to improve the function of a disability, consistent with community standards of medical practice and in accordance with Medicaid/FAMIS policies.

"Noncompliance" means failing to follow Client Medical Management Program policies and procedures, or a pattern of utilization which is inconsistent with sound fiscal or medical practices. Noncompliance includes, but is not limited to, failure to follow a recommended treatment plan or drug regimen; failure to disclose to a provider any treatment or services

provided by another provider; requests for medical services or medications which are not medically necessary~~; or excessive use of transportation services~~.

~~"Not medically necessary" means an item or service which is not consistent with the diagnosis or treatment of the patient's condition or an item or service which is duplicative, contraindicated, or excessive.~~

"Pattern" means a combination of qualities, acts, or tendencies that result in duplication or frequent occurrence.

"Practitioner" means a health care provider licensed, registered, or otherwise permitted by law to distribute, dispense, prescribe, and administer drugs or otherwise treat medical conditions.

"Primary care provider" or "PCP" means ~~the designated primary physician responsible for medical management of essential health care for the restricted recipient~~ a physician or nurse practitioner practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

"Provider" means ~~the individual, facility or other entity registered, licensed, or certified, as appropriate, and enrolled by DMAS to render services to Medicaid recipients eligible for services~~ a person, organization, or institution with a current, valid license or certification, as applicable, and participation agreement with DMAS who or which will (i) render service to Medicaid individuals who are eligible for covered services; (ii) submit a claim or claims for the rendered services, and; (iii) accept as payment in full the amount paid by the Virginia Medicaid/FAMIS program.

"Psychotropic drugs" means drugs which alter the mental ~~state~~ activity, behavior or perception. ~~Such~~ Examples of such drugs include~~, but are not limited to,~~ morphine, barbiturates, hypnotics, antianxiety agents, antidepressants, and antipsychotics.

~~"Recipient" means the individual who is eligible, under Title XIX of the Social Security Act, to receive Medicaid covered services.~~

~~"Recipient eligibility card" means the document issued to each Medicaid enrollee; an individual document issued to each Medicaid recipient listing the name and Medicaid number (either the identification or billing number) of the eligible individual. This document may be in the form of a plastic card magnetically encoded, allowing electronic access to inquiries for eligibility status.~~

"Renal dialysis services" means services that aid the process of diffusing blood across a semi-permeable membrane to remove substances that a normal kidney would eliminate, including poisons, drugs, urea, uric acid, and creatinine. Renal dialysis services help to restore electrolytes and acid-base imbalances.

"Restriction" means an administrative action imposed on ~~a recipient which~~ an individual that limits access to specific types of health care services through a designated primary provider or an administrative action imposed on a provider to prohibit participation as a designated primary provider, referral, or covering provider for restricted ~~recipients~~ individuals.

"Social Security Act" means the Act, enacted by the 74th Congress on August 14, 1935, which provides for the general welfare by establishing a system of federal old age benefits, and by enabling the states to make more adequate provisions for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws.

"State Plan for Medical Assistance" or "the Plan" means the ~~document listing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act~~ comprehensive written statement submitted by the department to the Centers for Medicare and Medicaid Services (CMS) for approval, describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures, and conditions for obtaining Federal financial participation.

~~"Surveillance and Utilization Review Subsystem (SURS)" or "Automated Exception Analysis (AEA)" means a computer subsystem of the Medicaid Management Information System (MMIS) which collects claims data and computes statistical profiles of recipient and provider activity and compares them with that of their particular peer group.~~

"Therapeutic class" means a group of drugs with similar pharmacologic actions and uses.

"Under-use" or "under-utilization" means an occurrence where there is evidence that a patient did not receive a service or procedure whose benefits exceeded the risks.

"Utilization control" means the control of covered health care services to assure the use of cost efficient, medically necessary or appropriate services.

12VAC30-130-810. Client Medical Management Program for ~~recipients~~ individuals.

A. Purpose. The Client Medical Management Program is ~~a utilization control program designed to prevent abuse and promote improved and cost efficient medical management of essential health care~~ designed to assist and educate Medicaid individuals in appropriately using medical and pharmacy services. Individuals who use these services excessively or inappropriately, as determined by DMAS may be assigned to a single physician or pharmacy, or both. CMM also monitors individual compliance with program guidelines.

B. Authority.

1. Federal regulations at 42 CFR 456.3 require the Medicaid agency to implement a statewide surveillance and utilization control program ~~and 42 CFR 455.1 through 455.16 require the Medicaid agency to conduct investigations of abuse by recipients~~ that (i) safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; (ii) assesses the quality of those services; (iii) provides for the control of the utilization of all services provided under the plan, and; (iv) provides for the control of the utilization of inpatient services.

2. Federal regulations at 42 CFR 431.54(e) allow states to restrict ~~recipients~~ individuals to designated providers when the ~~recipients~~ individuals have utilized services at a frequency or amount that is not medically necessary in accordance with utilization guidelines established by the state. ~~42 CFR 455.16(c)(4) provides for imposition of sanctions for instances of abuse identified by the agency.~~

C. Identification of Client Medical Management Program participants. DMAS shall identify ~~recipients~~ individuals for review from computerized reports such as but not limited to ~~Recipient SURS or AEA~~ individual Java-Server Utilization Review System (J-SURS), VAMMIS, Oracle or by written referrals from agencies, health care professionals, or other ~~individuals~~ persons. Certain individuals reviewed may not be restricted when evidence indicates that the prescription or medical service utilization patterns, or both, are for appropriate therapy.

D. ~~Recipient~~ Individual evaluation for restriction.

1. DMAS shall ~~review recipients~~ utilize data as indicated in subdivision C of this section to conduct a review of individuals to determine if services are being utilized at a frequency or amount that results in a level of utilization or a pattern of services which is not medically necessary or which exceeds the thresholds established ~~in these regulations~~ by the department. Evaluation of utilization patterns can include but is not limited to review by the department ~~staff~~ of medical records or computerized reports, or

both, generated by the department reflecting claims submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab ~~and~~ or diagnostic procedures, or both, and hospital admissions~~, and referrals~~.

2. Restricted individuals shall have reasonable access to all essential medical services. These restrictions shall not apply to hospital emergency services.

~~2.~~3. Abusive activities shall be investigated and, if appropriate, the ~~recipient~~ individual shall be reviewed for educational intervention or restriction, or both. ~~Recipients demonstrating questionable patterns of utilization or exceeding reasonable levels of utilization shall be reviewed for restriction.~~ Interventions shall be based on a two-tiered system.

a. Lock-in. If DMAS' review determines that an individual's data is either: (i) inappropriate, (ii) questionable patterns of utilization exist; or (iii) reasonable levels of utilization are exceeded, then the department shall initiate the individual's restriction to either a physician or pharmacy, or both.

(1) Once an individual is locked-in, this period shall last for 24 months from the enrollment date. During this lock-in period, the individual shall be required to use the services of the designated physician or pharmacy, or both.

(2) The individual may visit physicians or specialists other those who are designated only by a written referral.

(3) The individual may obtain prescriptions from pharmacies other than the designated pharmacy only in an emergency when the designated pharmacy is closed or when the designated pharmacy does not stock, or is not able to obtain in a timely manner, the required medication.

(4) DMAS may restrict an individual if any of the following activities or patterns or levels of utilization are identified. These activities, patterns, or levels of utilization include but shall not be limited to:

(a) Two occurrences of having prescriptions for the same drugs filled two or more times on the same or the subsequent day;

(b) Utilizing services from three or more prescribers and three or more dispensing pharmacies in a three-month period;

(c) Receiving more than a total of 24 prescriptions in a three-month period;

(d) Receiving more than 12 psychotropic prescriptions, more than 12 analgesic prescriptions, or more than 12 prescriptions for controlled drugs which have the potential for abuse, in a three-month period;

(e) Exceeding the maximum therapeutic dosage of the same drug or multiple drugs in the same therapeutic class, which have been prescribed by two or more practitioners, for a period exceeding four weeks;

(f) Receiving two or more drugs, duplicative in nature or potentially addictive (even within acceptable therapeutic levels), dispensed by more than one pharmacy or prescribed by more than one practitioner for a period exceeding four weeks;

(g) Receiving narcotic prescriptions from two or more prescribers without supporting diagnoses indicative of use;

(h) Utilizing three or more different physicians of the same type or specialty in a three-month period for treatment of the same or similar condition or conditions;

(i) Two or more occurrences of seeing two or more physicians of the same type or specialty on the same or subsequent day for the same or similar diagnosis;

(j) One or more providers recommend restriction for medical management because the individual has demonstrated inappropriate utilization practices;

(k) Duplicative, excessive, or contraindicated utilization of medication, medical supplies, medical visits, procedures, diagnostic tests or appliances dispensed by or prescribed by more than one provider for the time period specified by DMAS;

(l) Use of emergency hospital services for three or more emergency room visits for non-emergency care during a three-month period;

(m) A pattern of noncompliance or utilization of services which is inconsistent with sound fiscal or medical practices. Noncompliance or inappropriate utilization can be characterized by, for example:

(i) Failure to disclose to a provider any treatment or services provided by another provider;

(ii) Failure to follow a drug regimen or other recommended treatment;

(iii) Requests for medications or medical services which are not medically necessary;

(iv) Use of hospital emergency services for self-referral, non-acute episodes of care or solely for non-acute management of chronic diagnoses/symptoms; or

(v) Underuse or underutilization of medically necessary services that result in higher costs for the management of the medical condition.

(n) One or more documented occurrences of the use of the eligibility card to obtain drugs under false pretenses, which includes, but is not limited to, purchase or attempt to purchase drugs via a forged or altered prescription;

(o) One or more documented occurrences of card-sharing or documented occurrences of alteration of the individual eligibility care, or both; OR,

(p) One or more documented occurrences of paying cash for controlled substances, analgesic drugs, or psychotropic drugs in addition to the use of the eligibility card to obtain similar or duplicative controlled substances.

~~3. DMAS may restrict recipients if any of the following activities or patterns or levels of utilization are identified. These activities or patterns or levels of utilization include but shall not be limited to:~~

~~a. Exceeding 200% of the maximum therapeutic dosage of the same drug or multiple drugs in the same therapeutic class for a period exceeding four weeks.~~

~~b. Two occurrences of having prescriptions for the same drugs filled two or more times on the same or the subsequent day.~~

~~c. Utilizing services from three or more prescribers and three or more dispensing pharmacies in a three-month period.~~

~~d. Receiving more than 24 prescriptions in a three-month period.~~

~~e. Receiving more than 12 psychotropic prescriptions or more than 12 analgesic prescriptions or more than 12 prescriptions for controlled drugs with potential for abuse in a three-month period.~~

~~f. Exceeding the maximum therapeutic dosage of the same drug or multiple drugs in the same therapeutic class for a period exceeding four weeks. In addition, such drugs must be prescribed by two or more practitioners.~~

~~g. Receiving two or more drugs, duplicative in nature or potentially addictive (even within acceptable therapeutic levels), dispensed by more than one pharmacy or prescribed by more than one practitioner for a period exceeding four weeks.~~

~~h. Utilizing three or more different physicians of the same type or specialty in a three-month period for treatment of the same or similar conditions.~~

~~i. Two or more occurrences of seeing two or more physicians of the same type or specialty on the same or subsequent day for the same or similar diagnosis.~~

~~j. Duplicative, excessive, or contraindicated utilization of medications, medical supplies, or appliances dispensed by or prescribed by more than one provider for the time period specified by DMAS.~~

~~k. Duplicative, excessive, or contraindicated utilization of medical visits, procedures, or diagnostic tests from more than one provider for the time period specified by DMAS.~~

~~l. Use of emergency hospital services for three or more emergency room visits for nonemergency care during a three-month period.~~

~~m. One or more providers recommends restriction for medical management because the recipient has demonstrated inappropriate utilization practices.~~

~~n. A pattern of noncompliance which is inconsistent with sound fiscal or medical practices. Noncompliance is characterized by, but not limited to:~~

~~(1) Failure to disclose to a provider any treatment or services provided by another provider;~~

~~(2) Failure to follow a drug regimen or other recommended treatment;~~

~~(3) Requests for medical services or medications which are not medically necessary;~~

~~(4) Excessive use of transportation services; or~~

~~(5) Use of transportation services with no corresponding medical services.~~

~~o. One or more documented occurrences of use of the eligibility card to obtain drugs under false pretenses, which includes, but is not limited to the purchase or attempt to purchase drugs via a forged or altered prescription.~~

~~p. One or more documented occurrences of card-sharing.~~

~~q. One or more documented occurrences of alteration of the recipient eligibility card.~~

E. ~~Recipient~~ Individual restriction procedures.

1. DMAS shall advise affected ~~recipients~~ individuals by written notice of the proposed restriction under the Client Medical Management Program. Written notice shall include an explanation of restriction procedures and the ~~recipient's~~ individual's right to appeal the proposed action.

2. The ~~recipient~~ individual shall have the opportunity to select designated physician or pharmacy providers, or both. If ~~a recipient~~ an individual fails to respond by the date specified in the restriction notice, DMAS shall select designated ~~providers~~ physician or pharmacy providers, or both.

3. DMAS shall not implement restriction if a valid appeal, consistent with 12 VAC 30-110-210, is noted. (See subsection K of this section.)

4. DMAS shall restrict ~~recipients~~ individuals to their designated ~~providers~~ physician or pharmacy, or both, for ~~36~~ 24 months.

F. Designated providers.

1. A designated ~~primary~~ physician or pharmacy, or both, must be a ~~physician who~~ provider that is enrolled ~~as an individual~~ ~~practitioner~~ in Virginia Medicaid and ~~who~~ that is unrestricted by DMAS.

2. ~~A designated pharmacy provider must be a pharmacy that is enrolled as a community pharmacy and that is unrestricted by DMAS.~~ Physicians or pharmacy providers, or both, who are under the CMM Program for Providers shall not serve as designated providers, shall not provide services through referral, and shall not serve as covering providers for restricted individuals.

3. ~~A designated transportation provider must be enrolled as a taxi, registered driver, or wheelchair van and be unrestricted by DMAS. Recipients shall be assigned to the type of provider who meets the appropriate level of transportation that is medically necessary.~~

~~4. Providers restricted through the Client Medical Management Program may not serve as designated providers, may not provide services through referral, and may not serve as covering providers for restricted recipients.~~

~~5.~~ Physicians with practices limited to the delivery of emergency room services may not serve as designated primary providers.

~~6.~~4. Restricted ~~recipients~~ individuals shall have reasonable access to all essential medical services. These restrictions shall not apply to hospital emergency services.

~~7~~5. Other ~~provider types~~ physicians or pharmacies, or both, may be established as designated providers as needed but only with the approval of DMAS.

G. Provider reimbursement.

1. DMAS shall reimburse for covered ~~outpatient~~ medical~~,~~ or pharmaceutical, or both, and physician services for restricted individuals only when they are provided by the designated providers, or by physicians seen on a written referral from the PCP, or in a medical emergency consistent with the methodologies established for such services in the State Plan for Medical Assistance. ~~Prescriptions may be filled by a nondesignated pharmacy only in emergency situations when the designated pharmacy is closed, or~~

~~when the designated pharmacy does not stock, or is unable to obtain the drug in a timely manner.~~

2. DMAS shall require a written referral, in accordance with published procedures, from the PCP for payment of covered outpatient services by nondesignated practitioners unless there is a medical emergency requiring immediate hospital treatment. Services exempt from these referral requirements include:

a. Family planning services;

b. Annual or routine vision examinations (under age 21);

c. Dental services (under age 21);

d. Emergency services;

e. EPSDT well-child exams/screenings (under age 21);

f. Immunizations (under age 21);

g. Home- and community-based care waiver services such as private duty nursing or respite services;

h. Renal dialysis services;

i. Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two; and

j. Hospice services.

3. ~~When a transportation restriction is implemented, DMAS shall reimburse for covered transportation services only when they are provided by the designated transportation provider, or on referral from the designated transportation provider, or in a medical emergency~~.

~~4.~~ Designated primary care providers (PCPs) shall receive a monthly case management fee for each assigned ~~recipient~~ individual.

~~H. Client medical management identification material. DMAS shall provide an individual recipient eligibility card listing the recipient's designated primary care providers or a plastic card for each restricted recipient. DMAS shall provide correspondence to the recipient listing the name, address, and telephone number of each designated provider and the effective date of restriction to each provider.~~

~~I~~H. Changes in designated providers.

1. DMAS must give prior ~~authorization~~ approval to all changes of designated providers.

2. The ~~recipient~~ individual or the designated provider may initiate requests for change for the following reasons:

a. Relocation of the ~~recipient~~ individual or provider.

b. Inability of the provider to meet the routine health or pharmaceutical needs of the ~~recipient~~ individual.

c. Breakdown of the ~~recipient/provider~~ individual/provider relationship.

3. If the designated provider initiates the request and the ~~recipient~~ individual does not select a new physician or pharmacy, or both, ~~provider~~ by established deadlines, DMAS shall select a provider, subject to concurrence from the provider or providers.

4. If DMAS denies the ~~recipient's~~ individual's request for a particular physician or pharmacy, or both, the ~~recipient~~ individual shall be notified in writing and given the right to appeal the decision. (See subsection K of this section.)

~~J~~I. Review of ~~recipient~~ individual restriction status.

1. During the restriction period, DMAS shall monitor ~~the recipient's~~ an individual's utilization no less frequently than every 12 months and follow up with the ~~recipient~~ individual to promote appropriate utilization patterns.

2. DMAS shall also review ~~a recipient's~~ an individual's utilization prior to the end of the restriction period to determine restriction termination or continuation. ~~(See subsection D of this section.)~~

a. DMAS shall extend utilization control restrictions for ~~each 36~~ 12 months if any of the following conditions is identified:

(1) The ~~recipient's~~ individual's utilization patterns include one or more conditions listed in subdivision ~~D 3~~ D 4 of this section.

(2) The ~~recipient~~ individual has not complied with ~~Client Medical Management Program~~ CMM procedures resulting in services or medications received from ~~one or more~~ any nondesignated providers, as demonstrated by their submitted claims, without a written referral or in the absence of a medical emergency.

(3) The ~~recipient~~ individual has not complied with ~~Client Medical Management Program~~ CMM procedures as demonstrated by a pattern of documented attempts to receive ~~services or~~ medications from ~~one or more~~ any nondesignated ~~providers~~ provider ~~without a written referral or~~ in the absence of a medical emergency when the designated pharmacy is closed, or when the designated pharmacy does not stock, or is unable to obtain the medication in a timely manner.

(4) One or more of the designated providers recommends continued restriction status because the ~~recipient~~ individual has demonstrated noncompliant behavior which is being controlled by ~~Client Medical Management~~ CMM Program restrictions.

(5) Any changes of designated provider have been made due to the breakdown of the ~~recipient/provider~~ individual/provider relationship as a result of the ~~recipient's~~ individual's noncompliance.

b. DMAS shall notify the ~~recipient~~ individual and designated physician or pharmacy, or both, provider in writing of the review decision. If restrictions are continued, written notice shall include the ~~recipient's~~ individual's right to appeal the proposed action. (See subsection K of this section.)

c. DMAS shall not implement the continued ~~recipient~~ individual restriction if a valid appeal is noted pending the completion of the appeal action. Should the outcome of the appeal action support implementation of the restriction, it shall be promptly implemented.

J. Member education of service utilization. If an individual's utilization merits concern because his patterns exceed limits, but do not fully meet the criteria for restriction, then monitoring or education, or both, shall be an option.

K. ~~Recipient~~ Individual appeals.

1. ~~Recipients~~ Individuals shall have the right to appeal any adverse action taken by DMAS under these regulations.

2. ~~Recipient~~ Individual appeals shall be held pursuant to the provisions of Part I (12VAC30-110-10 et seq.) of 12VAC30 Chapter 110, Client Appeals.

12VAC30-130-820. Client Medical Management Program for providers.

A. Purpose. The ~~Client Medical Management Program~~ CMM Program is a utilization control program designed to promote improved and cost-efficient medical management of essential health care.

B. Authority.

1. Federal regulations at 42 CFR 456.3 require the Medicaid agency to implement a statewide surveillance and utilization control program and 42 CFR 455.1 through 455.16 require the Medicaid agency to conduct investigations of abuse by providers.

2. Federal regulations at 42 CFR 431.54 (f) allow states to restrict providers' participation in the Medicaid program if the agency finds that providers of items or services under the State Plan have provided items or services at a frequency or amount not medically necessary in accordance with utilization guidelines established by the state, or have provided items or services of a quality that do not meet professionally recognized standards of health care.

C. Identification of ~~Client Medical Management Program~~ CMM Program participants. DMAS shall identify providers for review through computerized reports such as but not limited to ~~Provider SURS or AEA~~ JSURS, Oracle, VAMMIS, or by written referrals from agencies, health care professionals, or other individuals.

D. Provider evaluation for restriction.

1. DMAS shall review providers to determine if health care services are being provided at a frequency or amount that is not medically necessary or that are not of a quality to meet professionally recognized standards of health care. Evaluation of utilization patterns can include but is not limited to review by the department ~~staff~~ of medical records or computerized reports generated by the department reflecting claims submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab or diagnostic procedures, hospital admissions, and referrals.

2. DMAS may restrict providers if any one or more of the following conditions is identified in a significant number or proportion of cases. These conditions include but shall not be limited to the following:

a. Visits billed at a frequency or level exceeding that which is medically necessary;

b. Diagnostic tests billed in excess of what is medically necessary;

c. Diagnostic tests billed which are unrelated to the diagnosis;

d. Medications prescribed or prescriptions dispensed in excess of recommended dosages;

e. Medications prescribed or prescriptions dispensed unrelated to the diagnosis.

f. The provider's license to practice in any state has been revoked or suspended.

~~g. Excessive transportation services rendered such that unnecessary costs to the Virginia Medicaid Program ensue from the accumulation of services.~~

E. Provider restriction procedures.

1. DMAS shall advise affected providers by written notice of the proposed restriction under the ~~Client Medical Management Program~~ CMM Program. Written notice shall include an explanation of the basis for the decision, request for additional documentation, if any, and notification of the provider's right to appeal the proposed action.

2. DMAS shall restrict providers from being the designated provider, a referral provider, or a covering provider for ~~recipients~~ individuals in the ~~Client Medical Management Program~~ CMM Program for 24 months.

3. DMAS shall notify the Centers for Medicare and Medicaid Services (CMS) and the general public of the restriction and its duration.

4. DMAS shall not implement provider restriction if a valid appeal is noted.

F. Review of provider restriction status.

1. DMAS shall review a restricted provider's claims history record prior to the end of the restriction period to determine restriction termination or continuation (See subsection D of this section). DMAS shall extend provider restriction for 24 months in one or more of the following situations:

a. Where abuse by the provider is identified.

b. Where the practices which led to restriction continue.

2. In cases where the provider has submitted an insufficient number of claims during the restriction period to enable DMAS to conduct a claims history review, DMAS shall continue restriction until a reviewable six-month claims history is available for evaluation.

3. If DMAS continues restriction following the review, the provider shall be notified of the agency's proposed action, the basis for the action, and appeal rights. (See subsection E of this section).

4. If the provider continues a pattern of inappropriate health care services, DMAS may make a referral to the appropriate peer review group or regulatory agency for recommendation and action as appropriate.

G. Provider appeals.

1. Providers shall have the right to appeal any adverse action taken by the department under these regulations.

2. Provider appeals shall be held pursuant to the provisions of Article 3 (§ 2.2-4018 et seq.) of the Administrative Process Act.