CHAPTER VI

UTILIZATION REVIEW AND CONTROL

Table of Contents

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 individuals. 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 Participation Agreement, contracts, state and federal regulations, Medicaid Memos and Provider Manual requirements for services rendered are met in order to receive payment from DMAS and its contractors. Under the Participation Agreement/contract with DMAS, Magellan of Virginia and the Medicaid Managed Care Organizations (MCOs) 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.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider receives reimbursement only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any service that an LEA seeks reimbursement for, via paid interim claim, or inclusion of the costs related to provision of the service(s) in the LEA’s Direct Medical Services Cost Report, Specialized Transportation Cost Report, or Administrative Activities Claim, that cannot be verified at the time of review cannot be considered a valid claim for services provided and is subject to retraction or adjustment.

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.

Submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in 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, Medicaid Memos, their provider agreement with DMAS or its contractor, 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 (interim claim and Certified Public Expenditure letter) that all information provided to DMAS and its contractors is true, accurate, and complete. If the provider attests to having all required licenses, they must be able to furnish such documentation. Although claims may be prepared and submitted by an employee or contracted business partner, 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:

Department of Medical Assistance Services
Division of Program Integrity
Supervisor, Provider Review Unit
600 East Broad Street
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:

Office of the Attorney General
Director, Medicaid Fraud Control Unit
202 North Ninth Street
Richmond, Virginia 23219

Member Fraud

Allegations about fraud or abuse by Medicaid enrolled individuals are investigated by the Recipient 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. The sanction period may only be revoked or shortened by court order.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (LDSS) or to the DMAS Recipient Audit Unit via 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: recipientfraud@dmas.virginia.gov or forwarded to:

Department of Medical Assistance Services
Division of Program Integrity
Recipient Audit Unit
600 East Broad Street
Richmond, Virginia 23219

LEA GENERAL DOCUMENTATION REQUIREMENTS

Local Education Agency (LEA) providers and their associated direct service providers must follow the documentation requirements outlined in the LEA Provider Manual, which is accessible through the MES Provider Portal (https://vamedicaid.dmas.virginia.gov/). Documentation must also be in accordance with the requirements of the applicable licensing board, and applicable Virginia statutes and regulations for the professional discipline involved.

Records of services must be retained for not less than six years after the last date of service. Documentation in those records must be complete, accurate, readily accessible and systematically organized to facilitate retrieval and compilation of information upon request of DMAS. 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.

These general service documentation requirements apply to all types of school-based services documentation and must be maintained and made accessible at the request of DMAS.

Student's Medicaid Identification Number

Documentation supporting the provision of direct medical/health care services must clearly identify the recipient of services using the student's full name and Medicaid or FAMIS ID number.

The Student's Need for Services

To qualify for Medicaid reimbursement, a qualified healthcare provider, acting within the scope of their license under Virginia law, must make the determination that the service is necessary in order to correct or ameliorate a health* condition. Evaluations performed for the purpose of determining the student's need for services also qualify for reimbursement.

*The term "health" as used in this manual is inclusive of all covered services.

Examples of ways to document the need for services include, but are not limited to:

- Reference to a standing order, as defined by the Virginia Department of Health, for a school-based health service determined by a licensed prescribing healthcare provider;
- Reference to a school health treatment protocol, established by a licensed, supervising healthcare provider, that includes a school-based health service;
- A student-specific order for a school-based health service signed by a licensed healthcare provider;
- A student-specific plan of care, treatment plan, individualized health plan (IHP), behavioral intervention plan (BIP) or emergency action plan (EAP) (hereafter referred to collectively as plan of care or POC) that includes a school-based health service signed by a qualified provider acting within the scope of their license; or
- The results of a school-based services screening or evaluation process recommending a school-based service signed by a qualified provider acting within the scope of their license.

Unplanned Services

Documentation of services claimed, signed by the qualified provider rendering the service, is sufficient to establish medical necessity for unplanned services that involve unplanned nursing services or unplanned behavioral health-related services. In these circumstances, nursing and behavioral health services may be reimbursed without a child-specific order when the qualified provider determines that an unplanned service is necessary.

Services provided by persons working under the clinical supervision of a qualified provider

For services rendered by providers under supervision as required under licensing rules, the progress or service log must also contain:

- Supervisor confirmation that services provided by persons under their direction were carried out according to the documented plan of care. Confirmation must include the supervisor's signature; and
- Supervisor signature confirmation of a supervisory visit *at least* every 90 days for purposes of ensuring that services are being carried out according to the plan of care.

Services provided pursuant to an IEP

If the service is being provided pursuant to a student's IEP, the treatment goals outlined in the plan of care must align with goals as outlined in the IEP.

Signatures

All documentation requiring a provider signature must use a signature format including the first initial or first name, last name and title of the provider, and date of the signature (month/day/year). Signature formats used must ensure that the signature is legible. For required documentation that supports interim claiming of a service, the signature must be dated prior to the date of claim submission.

Electronic Signatures

Providers must follow DMAS guidelines set forth regarding electronic signatures. DMAS requirements for electronic signatures are listed in the DMAS Physician/Practitioner Manual, Chapter VI.

SERVICE-SPECIFIC DOCUMENTATION REQUIREMENTS

Medical Evaluations

In addition to the general documentation requirements stated previously in this chapter, documentation of medical evaluations must also include the following:

- Source of referral for medical evaluation;
- Positive and negative examination findings;
- Diagnostic tests ordered and the results of the tests, if applicable;
- Diagnostic impressions; and
- Recommendations for further services or treatment.

Physical Therapy, Occupational Therapy, Speech-Language Pathology and Audiological Services

In addition to the general documentation requirements listed above, the record must also include the following:

- Documentation of service-specific evaluation results that include:
    - Reason for the evaluation;
    - Medical/treating diagnoses;
    - Current findings;

- Current functional status (strengths and deficits); and
- Summary of previous treatment and results.
- Signature of the DMAS qualified provider that completed the evaluation. (For signature requirements, see “Signatures” section above.)

- A POC that includes:
  - The specific medical diagnosis or identifying clinical issue to be addressed by the service expressed using applicable ICD diagnosis code(s);
  - Type (PT, OT, SLP or Audiology) and frequency of service required to address the issue;
  - Long-term goals that:
    - Are expressed in terms of desired, measurable functional outcomes;
    - Specify interventions, treatments, modalities or methods to be used to achieve the goal;
    - Include a timeframe for achieving the goal that is no longer than one year from the implementation date of the POC.
  - Discharge goal(s).
  - Date of POC implementation; and
  - Signature of the DMAS qualified provider as confirmation that they developed the POC. (For signature requirements, see “Signatures” section above.)

  A POC is valid for up to 12 months from date of implementation; however, the POC must be revised when there are significant changes in the student's condition and/or functional status that necessitate changes to their treatment goals, or frequency or duration of services. Such changes may be documented with a new POC or as an addendum to an existing POC.

  When POC changes are due solely to the child’s participation in summer session (i.e., extended school year) those changes may be reflected in an addendum to the student’s POC. A new POC is not required. In these cases, the provider may revert to the primary POC at the end of summer session, when the new school year begins.

- Student progress or service logs are required for each claimed session and must:
  - Clearly identify the provider/therapist rendering the service;
  - Include progress or response to the procedure, intervention or treatment applied;
  - Include any change in the identifying issue or treatment plan, if applicable.

- If a service is discontinued, a discharge summary must include:
  - A summary of the student’s progress relative to treatment goals;
  - The reason for discharge;
  - The student’s functional status at discharge compared to admission status;
  - The student’s status relative to established long-term goals met or not met;

- The recommendations for any follow-up care; and
- Signature of the qualified provider completing the discharge summary. (For signature requirements, see "Signatures" section above.)

A discharge summary must also be completed if a qualified provider determines that services provided pursuant to the student's IEP are not clinically needed, but the IEP team or school policy requires/determines that services will continue. In this case, the continued services are not reimbursable by Medicaid.

- Documentation of hearing screens performed by an audiologist or SLP must include:
  - Reason for the hearing screening
  - Tests performed
  - Results
  - Recommendations, if applicable

Nursing Services

In addition to the general documentation requirements stated previously in this chapter, documentation in support of nursing services and services supervised by a licensed nurse must include one of the following (with the exception of services described above that involve unplanned nursing services and can be reimbursed without a student-specific order):

- A student-specific written order from a DMAS-enrolled physician, nurse practitioner or physician assistant*;
- Reference to a standing order from a licensed prescribing healthcare provider; or
- Reference to a school health treatment protocol established by a licensed, supervising healthcare provider, that includes a school-based health service.

* If services are provided based on an active written order from a physician, physician assistant or nurse practitioner, the order must be recertified on an annual basis.

Nursing services must also include:

- For services provided pursuant to a student-specific order, the record must also include:
  - The original written order(s) from a physician, physician assistant or nurse practitioner upon which the RN developed the POC.
  - A written POC that includes:
    - The specific medical condition or conditions, including applicable ICD diagnosis code(s) to be addressed by nursing services;
    - Goals or objectives for each nursing service included;
    - Medication, treatment and/or procedures required by the nurse for each goal addressed;
    - Dose (as applicable for medications) and frequency of service;

- Date of POC implementation; and
- Signature of the qualified nurse as confirmation that they developed the POC. (For signature requirements, see “Signatures” section above.)

- Documentation for nursing services must include:
  - Medical/treating diagnoses;
  - Date (month/day/year), time of day, and amount of time (total number of minutes) of the nursing service entered by the responsible licensed nurse;
  - Nursing service rendered;
  - Student’s response to treatment;
    - N = Normal
    - V = Variance from normal or standard. Note: If the student’s response is a variance from normal or standard, the responsible licensed nurse must document a written explanation of the variance.
  - If variance, care coordination activities directly related to the variance noted including notifying parents, calling the physician or notifying emergency medical services, as applicable;
  - Any prescribed drugs which are part of the POC, including dosage, route of administration and frequency;
  - Any changes from the physician, physician assistant or nurse practitioner written order;
  - Identification of the nurse rendering the service; and
  - Signature of a licensed RN as confirmation that services rendered by themselves or persons under their direction were carried out according to the POC. (For signature requirements, see “Signatures” section above.)

<u>Behavioral Health Services other than Adaptive Behavior Treatment Services</u>

Documentation of behavioral health screening assessments (including screenings for emotional, behavioral and developmental issues) performed by a licensed provider must include:

- Reason for the screening;
- Screening instruments used, if applicable;
- Results; and
- Recommendations, if applicable

In addition to the documentation requirements for all LEA providers outlined in the beginning of this chapter, documentation supporting ongoing behavioral health services ***other than adaptive behavior treatment services*** must also include the following:

- An evaluation* that includes:
  - The specific diagnosis or presenting clinical issue that is the reason the evaluation is needed, expressed using applicable ICD diagnosis code(s);

- Description of how the diagnosed condition impacts functioning in the school setting;
- Situational factors that may impact the diagnosis, presenting issue or functional status of the student (e.g., foster care, bereavement);
- Medical, psychosocial, educational, family history pertinent to the diagnosis, presenting issue or functional status of the student;
- Current and previous behavioral health services or treatment; and
- Recommendations or referrals made as a result of the evaluation.

If the evaluation includes standardized psychological testing, also include:

- Source(s) of information;
- Tests administered*;
- Interpretation of test data and other clinical information;
- Diagnostic or clinical impressions based on the evaluation.
- Signature of the DMAS qualified provider that completed the evaluation. (For signature requirements, see “Signatures” section above.)

* The evaluation may take place over multiple days. For billing purposes, the date of service is the date of completion of the evaluation.

- A plan of care (plan for treatment) that includes:
  - Diagnosis or presenting clinical issue that is the reason the service is needed;
  - Individual-specific goals related to the presenting issue or functional status;
  - Type of service or treatment (e.g., group counseling);
  - Estimated length of time that treatment will be needed;
  - Frequency of the treatments/duration of the treatment; and
  - Documentation of family/caregiver participation in the plan for treatment (if applicable; e.g., if family counseling is included in the POC).

- Documentation to support each individual, group or family counseling session or behavioral health intervention must include:
  - Clear identification of the individual providing the counseling
  - Length of the session;
  - Level of student participation;
  - Type of session (i.e., group, individual, family, unplanned, crisis);
  - For group sessions, indicate the total number of student participants (include all students, not just Medicaid students) in the group;
  - For family sessions, indicate the total number of family members participating, including the student;
  - How the activities of the session relate to the student-specific goals;
  - Progress or lack thereof toward the goals;
  - Plan for the next session; and
  - Signature of the provider. (For signature requirements, see “Signatures” section above.)

Adaptive Behavior Treatment Services

In addition to the documentation requirements for all LEA providers outlined in the beginning of this chapter, documentation to support planned adaptive behavior treatment services must include:

- An adaptive behavior evaluation that includes:
  - The specific diagnosis or presenting clinical issue that is the reason the evaluation is needed, expressed using applicable ICD diagnosis code(s);
  - Detailed behavior history related to the diagnosis or presenting issue;
  - Findings; and
  - Recommendations.

- Documentation supporting the adaptive behavior evaluation must include descriptions of the following activities if completed as part of the evaluation:
  - Observations of student behavior;
  - Assessment procedures and instruments used (Functional Behavior Assessment (FBA) or other standardized and non-standardized assessments);
  - Interviews with caregivers, teachers, parents, etc. to identify and describe deficient adaptive behaviors, maladaptive behaviors, and other impaired functioning secondary to deficient adaptive or maladaptive behaviors.
  - Signature of the DMAS qualified provider that completed the evaluation. (For signature requirements, see “Signatures” section above.)

- A plan of care/intervention plan that includes:
  - The specific diagnosis or presenting clinical issue that is the reason the POC/BIP is needed, expressed using applicable ICD diagnosis code(s);
  - Specific skill(s) and treatment goal(s) for the intervention planned based on results of the documented assessment;
  - Interventions planned for achieving each goal; and
  - Baseline data used to determine the student's skill performance prior to intervention.
  - Date of plan implementation.
  - Signature of the DMAS qualified provider that developed the plan of care. (For signature requirements, see “Signatures” section above.)

Documentation for each individual or group intervention session (i.e., visit) that includes:

- Documentation of the activities performed, length of activities with start and stop times;
- Documentation of performance in relation to each treatment goal, including data collected;
- Modifications to the goals, procedures, protocols or activities as applicable;
- Signature of the direct service provider; and

- If the intervention is performed by an unlicensed person, the signature of the supervising licensed psychologist, licensed behavior analyst or licensed assistant behavior analyst must co-sign the document and meet all signature requirements. (For signature requirements, see “Signatures” section above.)

Unplanned Behavioral Health Services

Unplanned behavioral health services are covered by DMAS when provided by a DMAS qualified provider acting within the scope of practice of their license. A student-specific plan of care may exist for these situations in cases where a student has a known behavioral health concern/need and intervention is indicated to be “as needed.” However, a plan of care is not required for an unplanned behavioral health service.

- Documentation to support unplanned services must include:
  - Clear identification of the individual providing the counseling or intervention
  - Length of the session/intervention service;
  - Level of student participation;
  - Type of session (e.g., unplanned service;
  - Description of specific intervention(s) employed;
  - Plan or recommendations; and
  - Signature of the provider. (For signature requirements, see “Signatures” section above.)

Personal Care Assistance

In addition to the general documentation requirements for all LEA providers outlined in the beginning of this chapter, documentation for personal care services must also include the following:

- A POC that includes:
  - The specific medical diagnosis or identifying clinical issue to be addressed by the service expressed using applicable ICD diagnosis code(s).
  - Type of intervention, treatment or modality to be used, and frequency of service required to address the issue. If the intervention involves administration of medications, include the dose and frequency of medication administration.
  - Measurable long-term goal(s).
  - Date of POC implementation.
  - Signature of the supervising qualified provider as confirmation that they developed the POC. (For signature requirements, see “Signatures” section above.)

  If two or more disciplines are utilizing personal care assistant services as a part of their service plan, each discipline must develop a separate, discipline-specific plan

of care signed by each DMAS qualified provider supervising the service within the scope of their license.

- A log of personal care assistant services that includes:
  - Clear identification of the staff person rendering the service;
  - Date (month/day/year) and amount of time (total number of minutes) of the service;
  - Procedures performed;
  - Student's response to procedures including description of response if varied from normal.

Specialized Transportation Included in an IEP

LEAs that claim cost reimbursement for specialized transportation must maintain documentation supporting each trip made. Trip is defined as the one-way transport of a covered student from (to) their home or another designated "originating site" to (from) the location where a covered service is provided. Documentation of each trip must include:

- Trip service date;
- The names of all students in attendance on the vehicle for that trip;
- Signature and date of the Driver or Bus Attendant on that trip; and
- Medicaid or FAMIS ID numbers of any students enrolled in Medicaid or FAMIS.

Due to the cost reporting requirements for seeking reimbursement for specialized transportation, LEAs must maintain supporting documentation for all trips and all students riding in the vehicle on each trip for the entire period for which reimbursement is sought related to each specially equipped transportation vehicle (i.e., the vehicle "attendance" records). LEAs do not need to separately track the days or trips when each student received a DMAS-covered service in school. For additional details, see the LEA Specialized Transportation Cost Reporting Instructions published on the DMAS website: https://www.dmas.virginia.gov/for-providers/school-based-services/.

QUALITY MANAGEMENT REVIEW

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

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

Medicaid/FAMIS records of students currently receiving DMAS reimbursable services as well as a sample of closed Medicaid/FAMIS records may be reviewed. DMAS or its

contractors may also conduct an on-site investigation as follow-up to any complaints received.

Periodic, unannounced, quality management reviews of documents supporting the provision of services according state and federal requirements will be made. Reviews may include but are not limited to:

- The plan of care or plan for treatment;
- Documentation of the qualifications of the direct providers of services;
- Progress notes or service logs documenting the dates that services were provided;
- The documentation in the student's service record that supports medical necessity and authorization for services; and
- That required documentation, as described in this manual, has been signed and dated according to DMAS requirements.

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

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