

CHAPTER VI  
UTILIZATION REVIEW AND CONTROL

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## **INTRODUCTION**

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by 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 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. The MCOs conduct audits for services provided to Members enrolled in Managed Care. Providers shall contact the specific MCO for information about the utilization review and control procedures conducted by the MCO.

## **FINANCIAL REVIEW AND VERIFICATION**

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

## **COMPLIANCE REVIEWS**

DMAS or its designated contractor(s) routinely conduct compliance reviews to ensure that the services provided to Medicaid individuals 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 individuals are identified for review by system-generated exception reporting using various sampling methodologies or by referrals and complaints from

agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group.

To ensure a thorough and fair review, trained professionals review all cases using available resources, including appropriate consultants, and perform on-site or desk reviews.

Overpayments will be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by DMAS or the MCOs if they are found to have billed these entities contrary to law or manual requirements, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, DMAS or the MCOs may restrict or terminate the provider's participation in the program.

## **FRAUDULENT CLAIMS**

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

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

### Provider Fraud

The provider is responsible for reading, understanding, and adhering to applicable state and federal regulations, 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 that all information provided to DMAS and its contractors is true, accurate, and complete. If provider attests to having all required licensed as required 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@dmass.virginia.gov](mailto:recipientfraud@dmass.virginia.gov) or forwarded to:

Department of Medical Assistance Services  
Division of Program Integrity

Recipient Audit Unit  
600 East Broad Street  
Richmond, Virginia 23219

## **PATIENT UTILIZATION AND MANAGEMENT SAFETY PROGRAMS (PUMS)**

The DMAS contracted MCOs must have a Patient Utilization Management & Safety Program (PUMS) for MCO enrolled members which is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and care coordination program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the MCO must refer members to appropriate services based upon the member's unique situation.

Once a Member meets the placement requirements for PUMS, the MCO may limit a member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO may limit a member to providers and pharmacies that are credentialed in their network.

If the member changes MCOs while the member is enrolled in a PUMS, the receiving MCO must re-evaluate the member within thirty (30) calendar days to ensure the member meets the minimum criteria above for continued placement in the health plan's PUMS.

## **UTILIZATION REVIEW – GENERAL REQUIREMENTS**

Utilization reviews of enrolled providers are conducted by DMAS, the designated contractor or the MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

Utilization reviews are comprised of desk audits, on-site record review, and may include observation of service delivery and review of all provider policies and procedures and human resource files. Dependent upon the setting, the utilization review may also include a tour of the program. Staff will visit on-site or contact the provider to request records. Utilization Review may also include face-to-face or telephone interviews with the individual, family, or significant other(s), or all. In order to conduct an on-site review, providers may also be asked to bring program and billing records to a central location

within their organization. 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.

DMAS and the MCOs shall recover expenditures made for covered services when providers' documentation does not conform to standards specified in all applicable regulations. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider's care. Such documentation shall fully disclose the extent of services provided in order to support provider's claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered or within one business day from the time the services were rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

The review will include, but is not limited to, the examination of the following areas / items:

- If a provider lacks a full or conditional license or a provider enrollment agreement does not list each of the services provided and the locations where the provider is offering services, then during a utilization review the provider will be subject to retraction for all unlisted service and/or locations.
- Health care entities with provisional licenses shall not be reimbursed by Medicaid.
- An assessment of whether the provider is following The U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009).
- An assessment of whether the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.).
- The appropriateness of the admission to service and for the level of care, and medical or clinical necessity of the delivered service.
- A copy of the provider's license/certification, staff licenses, and qualifications to ensure that the services were provided by appropriately qualified individuals and licensed facilities.
- Verification that the delivered services as documented are consistent with the documentation in the individual's record, invoices submitted, and specified service limitations.
- The reviewer determines that all documentation is specific to the individual and their unique treatment needs. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products

offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient services and may not be adequate recordkeeping mechanisms for these services.

- The reviewer determines whether all required aspects of treatment (as set forth in the service definitions) are being provided, and also determines whether there is any inappropriate overlap or duplication of services.
- The reviewer determines whether all required activities (as set forth in the appropriate sections of this manual and related regulations) have been performed.
- The reviewer determines whether inappropriate items have been billed.
- The reviewer determines whether the amount billed matches the documented amount of time provided to the individual.

Services must meet the requirements set forth in the Virginia Administrative Code (12 VAC 30) and in the Virginia State Plan for Medical Assistance Services and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

Upon completion of on-site activities for a routine utilization review, the MCO, DMAS, or its designated contractor(s) may be available to meet with provider staff for an Exit Conference. The purpose of the Exit Conference is to provide a general overview of the utilization review procedures and expected timetables.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be noted. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting medical record documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, DMAS or its designated contractor(s) will contact the provider to conduct an Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the provider.

If a billing adjustment is needed, it will be specified in the final audit findings report.

If the provider disagrees with the final audit findings report, they may appeal the findings. Refer to Chapter II for information on the provider appeal process.



## **MEDICAL RECORDS AND RETENTION**

The provider 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 Medicaid covered services must be retained for not less than five years after the date of service or 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 482.24 for additional requirements.

The provider 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. All medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. Documentation should be clear and legible.

## **BABYCARE REQUIREMENTS**

### Eligibility

Recipients must be eligible for Fee-for-Service (FFS) Medicaid, FAMIS, FAMIS Plus, FAMIS MOMS, or FAMIS Prenatal Coverage on the date of service. Medicaid and FAMIS MOMS members must be either pregnant or within 12 months postpartum (up to the last day of the calendar month in which the postpartum year ends. (The 12-month postpartum continuous coverage applies to pregnant full benefit Medicaid and FAMIS MOMS members. It is not limited to pregnancy coverage groups). FAMIS Prenatal Coverage members are eligible up to the end of the month following their sixtieth day post-partum. Infant members are eligible for BabyCare case management up to their second birthday.

### Member's Consent for BabyCare Services

Individuals cannot be forced to receive BabyCare services for which they might be eligible. The member/member's primary caregiver must agree to be open for services and refusal of services will not negatively impact the member's benefits.

Note: DMAS requires the completion of the Letter of Agreement (DMAS-55) or equivalent to support the member's or member's primary caregiver willingness to be open for BabyCare services. The documentation should be kept in the member's medical record.

#### Member Choice and Involvement in the Planning Process

Documentation must indicate that the member was given a choice of available BabyCare Service providers. Documentation must indicate that the member or member's caregiver was involved in the assessment, Service Plan development and any changes to the Service Plan.

#### Screening Requirements

DMAS will reimburse providers, as defined in Chapter II of this manual, for administering the *Behavioral Health Risks Screening Tool* DMAS 16-P (Provider) and DMAS 16-S (Self-Instrument). The completed screening tool and outcome including referrals must be documented in the member's medical record. This tool replaces the BabyCare Maternity Risk Screen (DMAS 16) and the BabyCare Infant Risk Screen (DMAS 17).

Note: Practitioner's may document in the infant's medical record for completion of a screening of the infant's mother, that a "risk assessment" has been performed. To maintain the confidentiality of the mother's screen, keep the screening tool and results in a separate file.

#### Universal Referral Form

DMAS has approved the use of the *Virginia Home Visiting Consortium's Universal Referral Form* as a template for use as a referral mechanism to BabyCare. BabyCare providers may adapt the form and change it to meet their community's needs. Note: Referrals to BabyCare are not a reimbursable service. DMAS has removed the requirement for a "Risk Screen" to be completed to initiate a referral to BabyCare. This change was made to reduce any potential barriers for an at-risk pregnant or infant enrollee to be referred for BabyCare services.

#### Case Management Documentation Requirements

BabyCare providers must maintain records for each member which includes, at a minimum, the following information:

- Evidence that the member or member's primary caregiver has agreed to be open to services (via Letter of Agreement DMAS 55 or equivalent);
- Identification of the member on each entry by full name and Medicaid/FAMIS ID number;
- Documentation must be clear and legible;

- Signatures and complete dates are required for all documentation or entries and must include, at a minimum, the first initial and last name and credentials;
- Written documentation verifying the qualifications of the nurse or social worker providing the services must be maintained and available for review;
- All contacts and attempted contacts (face-to-face, telephonic and collateral) signed and dated by the individual providing the service;
- Evidence of coordinating care with the member's primary care provider (PCP);
- A timeline for obtaining needed services as well as a timeline for reevaluation of the Service Plan (via DMAS 52 or equivalent);
- All interventions to include the nature and content of services received and which goals the intervention is addressing;
- Documentation of the need for, and occurrences of, coordination with other case managers;
- Copies of all required forms, or equivalents, as specified within this chapter;
- If the nurse or social worker was not able to complete the initial face-to-face assessment (via DMAS 50 (M)aternal or (I)nfant) within the first 30 calendar days from date of referral, there must be specific documentation of the reason the face-to-face contact did not occur;
- Documentation must be evident that the member is receiving services as identified in the Service Plan during any month in which billing for services occurs; and
- The Service Plan must address needs identified in the case manager's assessment and be reviewed and updated as necessary to reflect changes in the member's service needs.

Services may not duplicate any other covered service provided under the Medicaid or FAMIS State Plans or other Medical Assistance programs. If the BabyCare case manager is involved in the direct provision of medical or prenatal care services, the documentation must clearly differentiate the case management services from other service provisions.

High Risk Case Management Service authorization Request Form (DMAS 50 M/I)

During the initial face-to-face meeting, the nurse or social worker completes a comprehensive assessment and documents this on the BabyCare Service authorization Request form (DMAS 50 [M]aternal or [I]nfant) and notes this as entry in member's medical record.

The following documentation is required to be completed on the assessment for service authorization of case management services:

- Member's name;
- Medicaid/FAMIS ID number;
- Member's date of birth;
- Pregnant member's obstetric history (Gravida, para, AB elective, AB Spontaneous);
- Pregnant member's estimated date of delivery;
- Date that case management services began;
- Provider's National Provider Identifier (NPI);
- Provider's Agency Name;
- At least one risk must be checked to indicate at-risk pregnancy or infant;
- Signature and date of case manager completing the assessment.

### Service Plan

The nurse or social worker uses the information obtained from the assessment to create a Service Plan with the member or member's caregiver. The Service Plan is an individualized description of what services and resources are needed to meet the service needs of the member and a plan to access those resources. The Service Plan includes active participation of the member or member's caregiver in developing and working towards specified goals. The provider may use the DMAS 52 or equivalent documentation that include the following:

1. The member's identifying information;
2. A list of identified needs/problems identified during the assessment process including medical, social, and educational needs. Resolved problems and/or issues the member does not wish to address may be documented in the member's record;
3. A plan for interventions addressing the identified problems. This includes all necessary referrals; and
4. A plan for follow-up.

After the member is enrolled in case management services, the nurse or social worker conducts periodic reassessments as needed and must update the service plan as necessary.

### Closing to Case Management Services

The provider must send a letter to the member and the member's primary care provider or referring provider stating that the member's case is being closed.

The provider is no longer required to submit notification of the closure of the member's case to DMAS. Upon closure of case to BabyCare case management, DMAS requires that the provider document the following in the member's medical record, including the following:

- Documentation of Part C referral if infant appears to not be developing as expected or who have a medical condition that can delay normal development.
- Documentation of the *Behavioral Health Risks Screening for Women of Childbearing Age* administration and outcome, as applicable.
- The referrals that were initiated upon closure to case management for purposes of discharge planning.
- Signature of case manager and date completed.

## **EXPANDED PARENTAL SERVICES**

### Member Education Classes

A written record must be kept for each member which includes:

- The member's name and Medicaid/FAMIS ID number;
- The course being provided;
- The instructor teaching the course; and
- Verification through the member's signature of the dates of each course session attended.

### Nutrition Services

The provider of nutrition services must develop a written dietary assessment for each member which includes, at a minimum, the following information: height and weight measurements (including pregravid weight), laboratory values, dietary habits, socioeconomic status, complications of pregnancy involving a nutrition component, and a nutrition care plan for follow-up and referral based on individual needs. Nutrition counseling must be provided based on the assessment and care plan. Documentation of participation in food assistance programs such as WIC or the Supplemental Nutrition Assistance Program (SNAP) should also be included. It is also acceptable to maintain laboratory values in the laboratory section of the member's record.

Documentation for the nutrition follow-up visits must include progress notes which document how the concerns found in the initial assessment have been addressed.

### Blood Glucose Monitors

The physician must follow the guidelines for ordering blood glucose monitors which is detailed in the DMAS Durable Medical Equipment (DME) Provider manual available online at [www.dmas.virginia.gov](http://www.dmas.virginia.gov). When a physician determines that a pregnant enrollee is at risk due to her diabetes and authorizes the use of a blood glucose monitor, Virginia Administrative Code requires that a referral to a nutritionist be completed. The ordering physician must indicate in the member's medical record that a referral for nutrition counseling was initiated.

### Homemaker Services

A written record must be kept which includes the following:

- A referral from the primary care provider supervising the member's prenatal and/or postpartum care which states that the member is confined to bed for a specific period of time;
- An assessment performed by the supervisor of the homemaker service that states what services are required for the normal functioning of the bed-bound member's household. The assessment should reflect inquiries into such elements as: the number and age of persons in the household, availability of assistance by relatives/friends, needs as perceived by the bed-bound member, etc.;
- A Service Plan developed based on the needs assessment that states specific services needed and the frequency of services;
- All documentation for the extension of services, if necessary;
- Services rendered and length of the visit by the homemaker; and
- Signatures by the homemaker and the member verifying services received for each date of service.

Homemaker services rendered must be reviewed monthly by the supervisor and documented in the record. Flow sheets may be utilized by the homemaker and/or the supervisor for documentation purposes.