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CHAPTER VI
UTILIZATION REVIEW AND CONTROL

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CHAPTER VI UTILIZATION REVIEW AND CONTROL

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 recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic reviews on all programs to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455.

Providers and recipients are identified for review by

- Systems 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. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.
- Referrals and complaints from agencies or individuals. Referrals and complaints of inappropriate utilization of Medicaid services are investigated to determine if a Quality Management Review is necessary. The case may be referred to DMAS' Provider Review Unit or the Attorney General's Office for further review.

Reviews are conducted by

- The reviewer, who is either a Health Care Compliance Specialist (HCCS), trained professional employed by DMAS or a Contractor of DMAS, reviews all cases

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using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

On-site review process:

- Upon arrival at the facility, the reviewer will supply the provider with a list of the records to be reviewed. The provider must supply the reviewer with the records as requested. The reviewer will begin the review at the facility.
- At completion of the on-site portion of the review, the reviewer will conduct an Exit Conference. This conference is a brief summary of the onsite findings.
- Upon return to DMAS the reviewer will complete the review. Completion of this review includes a summary letter to the provider. This letter includes technical assistance, areas of citation and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the Fiscal Division at DMAS. The provider will receive another letter outlining the repayment requirements will be received from this Division.

Desk review process:

- The reviewer will mail, via United States Post Office certified mail, a list of the records to be reviewed. The provider must supply the reviewer with the records as requested. The records must be received by DMAS by the date instructed. Upon receipt of the documents the reviewer will review the records received. The reviewer may contact the provider for clarification of any document received.
- Upon completion of the review the reviewer will send a summary letter to the provider via certified mail. This letter includes technical assistance, areas of citation and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the Fiscal Division at DMAS. Another letter outlining the repayment requirements will be received from this Division.

Overpayments

- Overpayments may also be calculated based upon review of all claims submitted during a specified time period.
- Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain records or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or

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some other person. It includes any act that constitutes fraud under applicable federal or State law.

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

Provider Fraud

The provider is responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
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:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations about fraud or abuse by recipients are investigated by the Division of Program Integrity of the Department of Medical Assistance Services. The Division 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 Division also investigates incidences of card sharing

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and prescription forgeries.

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

Referrals should be made to:

Program Integrity Division
 Cost Settlement and Audit
 Department of Medical Assistance Services
 600 East Broad Street
 Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Division of Program Integrity (PI) of the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voicemail receives after-hours referrals. Written referrals should be mailed to:

Program Integrity Division
 Department of Medical Assistance Services
 600 East Broad Street
 Richmond, Virginia 23219
 Telephone: (804) 786-6548
 CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

REFERRALS TO THE VIRGINIA MEDICAID HEALTHY RETURNS DISEASE STATE MANAGEMENT (DSM) PROGRAM

Effective January 13, 2006 DMAS rolled out the expanded Virginia Medicaid Healthy

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Returns Disease State Management (DSM) Program which is a disease state management program designed to help patients better understand and manage coronary artery disease, congestive heart failure, asthma, and diabetes through prevention, education, lifestyle changes, and adherence to prescribed plans of care (POCs). The purpose of the program is not to offer medical advice, but rather to support provider staff in reinforcing patients' POCs, DMAS has contracted with Health Management Corporation (HMC) to administer the program.

Providers are encouraged to review their Fee-for-Service Medicaid patients with identified conditions and refer appropriate patients to the program. Providers can call 1-866-836-4008 toll-free to recommend a patient for enrollment. Provider participation in this program will help DMAS continue to offer quality medical services through the Medicaid program while conserving limited Medicaid funds.

More information regarding this program may be found on the DMAS website at www.dmas.virginia.gov.

MEDALLION

MEDALLION is a mandatory Primary Care Case Management program that enables Medicaid recipients to select their personal Primary Care Physician (PCP) who will be responsible for providing and/or coordinating the services necessary to meet all of their health care needs. MEDALLION promotes the physician/patient relationship, preventive care and patient education while reducing the inappropriate use of medical services. The PCP serves as a gatekeeper for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide a referral for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. To provide services to a MEDALLION recipient, a referral from the recipient's PCP is required. Before rendering services, either direct the patient back to his or her PCP to request a referral or contact the PCP to inquire whether a referral is forthcoming. Refer to Supplement A – MEDALLION, in this manual for further details on the program.

DME PROVIDER RESPONSIBILITIES AND EXPECTATIONS FOR DME AND SUPPLIES

The Durable Medical Equipment and Supplies provider may not bill for items or services that have not been provided to the recipient and documented as received by the recipient.

To receive reimbursement, the DME provider must:

- Verify the recipient's Medicaid eligibility;
 - Determine whether the item is covered and if so, does it requires preauthorization;
- Deliver only the item(s) ordered by the physician and approved by DMAS;

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- Deliver only the quantities ordered by the physician on the CMN and approved by DMAS;
- Deliver only the item(s) for the periods of service covered by the physician's order and approved by DMAS;
- Maintain a copy of the physician's orders (CMN) and all verifiable supporting documentation for all durable medical equipment/supplies ordered. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided that there is no change in the eligibility of the recipient or PCP;
- Document and justify the description of services (labor, repairs, maintenance of equipment);
- Document and justify the medical necessity of all items and supplies as described in Chapter IV of this manual; and
- Once medical necessity (i.e. incontinence) is established the decision to use tab diapers or pull ups shall be left to the recipient/caregiver and shall be documented by the provider on the CMN; and
- Document all equipment and supplies provided to a recipient in accordance with the physician's orders. The delivery ticket/proof of deliver must document the information described below.

Proof of Delivery

Delivery tickets must contain:

- The recipient's name and date of birth
- A detailed description of the item being delivered. The product name and brand.
- The serial number or product number of the durable medical equipment or supplies
- The quantity that was delivered
- The signature of the recipient or their designee. The relationship of the designee. The designee's signature shall be legible. If it is not legible, the supplier must note the name of the designee on the delivery slip.
- Providers or anyone else having a financial interest in the delivery of an item shall not sign or accept an item on behalf of a beneficiary

Refills or repeat orders:

- Providers shall contact the recipient prior to dispensing repeat orders or refills to assure that the item is still needed, the amount is still appropriate and the recipient still resides at the same location. The provider must contact the resident prior to each delivery. This contact should not take place sooner than 7 days prior to the delivery/ship date and must be documented in the recipient record.

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- Providers shall not delivery refills sooner than 5 days prior to the end of usage. For example, they may not deliver all cases of diapers for a two month period on one date.

Shipping:

- If a commercial shipping service is used, the provider's records must reference, in addition to the above information, the delivery services' package identification number, and a copy of the delivery ticket from the delivery service (this may be a printed from an on-line record on the delivery service's website). The delivery service's identification number must be on the provider's delivery ticket. It is recognized that commercial delivery services may not obtain a signature of the receiving party. Therefore, this documentation will substitute for the recipient's signature above as proof of delivery.
- Providers may use a return postage-paid delivery invoice from the recipient or designee as a form of proof of delivery. The descriptive information concerning the item(s) delivered, as described above, as well as the required signature/date from either the recipient or designee should be included on this invoice as well.

Billing and Delivery:

- Providers shall not bill for dates of service prior to delivery. The provider must confirm receipt (shipping service record showing the item was delivered is acceptable) prior to billing.

Discharges from a facility:

- Equipment and supplies delivered for home use for recipients being discharged from a hospital or nursing facility may be delivered to the facility but the claim date of service may not begin prior to the date of discharge from the hospital or nursing facility

DME providers must provide all of the same DME services/items to the Medicaid recipient as provided to the general population, in accordance with the established Medicaid reimbursement rate. As per the provider agreement, a Medicaid-enrolled provider must accept Medicaid payment as payment in full.

DME providers are responsible for knowing which items require preauthorization and the limitation on the provision of certain items as described in the "Medicaid DME and Supplies Listing" in Appendix B. Since the Medicaid Program has established guidelines regarding which items require preauthorization and the limitations that may be imposed on certain items, providers can reasonably be expected to know for which items Medicaid will pay.

The DME provider must provide equipment and supplies as prescribed by the physician on the CMN. If the recipient is enrolled in MEDALLION, the ordering physician must

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be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP. The PCP referral is valid as long as the CMN is effective, provided there is no change in the eligibility of the recipient or PCP. The CMN shall not be changed, altered, or amended after the attending physician signature date. If changes in the ordered DME or supplies are necessary, as indicated by the recipient's condition, the DME provider must obtain a new CMN. All CMNs must be signed and dated by the attending physician within 60 days from the time ordered supplies are furnished by the DME provider. (12 VAC 30-50-165)

The DME provider must not bill DMAS prior to the date of the physician's signature when the signature is not obtained within 60 days of the first day (CMN begin date) of service. The DME provider will be reimbursed only for services that are provided in accordance with published policies and procedures. If reimbursement is denied for one of these reasons, the DME provider may not bill the Medicaid recipient for the items/service that were provided. (12 VAC 30-50-165)

The DME provider must not provide items or extended quantities of items which require preauthorization prior to obtaining the written preauthorization from DMAS. Therefore, the liability for the charges for denied items or services which the provider supplied prior to obtaining the required written authorization rests with the DME provider. A provider cannot bill a recipient for Medicaid-covered services if the provider is denied reimbursement due to his or her failure to obtain preauthorization or to perform other required administrative functions. (12 VAC 30-50-165)

As per the provider agreement, a DME provider may only bill a Medicaid recipient for non-covered services. The DME provider is responsible for determining if an item is covered, whether or not it requires preauthorization, and for verifying Medicaid eligibility. If the DME provider does not follow the established procedure for obtaining authorization for any item, and the request is denied, the provider may not bill the recipient for that item. (12 VAC 30-50-165)

The DME provider must advise the Medicaid recipient in writing of any fiscal liability (potential or actual) for items delivered prior to the receipt of authorization by the preauthorization contractor. If all established guidelines are followed by the provider, and the request is denied, the DME provider may seek reimbursement from the recipient. The provider may not require the recipient to make a deposit or "pay in advance" for any item that is covered and requires preauthorization. If the provider fails to follow established procedures for authorization or fails to notify the recipient of any fiscal liability and the item requested is determined not to be medically justified or does not meet criteria for reimbursement, the DME provider may not bill the Medicaid recipient. (12 VAC 30-50-165)

DME providers shall retain copies of the CMN and all applicable supporting documentation on file for post payment audit reviews. Durable medical equipment and supplies that are not ordered on the CMN for which reimbursement has been made by Medicaid will be retracted. Supporting documentation is allowed to justify the medical need for durable medical equipment and supplies. Supporting documentation does not replace the requirement for a properly completed CMN. The dates of the supporting

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documentation must coincide with the dates of service on the CMN and the medical practitioner providing the supporting documentation must be identified by name and title. DME providers shall not create or revise CMNs or supporting documentation for durable medical equipment and supplies provided after the post payment audit review has been initiated. (12VAC 30-60-75)

Some items in the “Appendix B: Durable Medical Equipment and Supplies Listing” do not have a fee and indicate that a fee is determined by individual consideration (I.C.). In those cases the provider submits for preauthorization and provides documentation of their cost. This cost may be an estimate or a quote. The reimbursement amount is determined by adding 30% to the providers cost for the item. Upon receipt of the manufacturer’s invoice the cost is less than reported on preauthorization, the provider must only bill 30% over the cost of that item. Likewise, if the cost is more than estimates, the provider may submit a change request to the preauthorization contractor for consideration (See Appendix D for more preauthorization information). Documentation of the actual cost of the item billed must be in the recipient’s record.

DMAS RESPONSIBILITY – QUALITY MANAGEMENT REVIEW FOR DME AND SUPPLIES

DMAS will conduct either a desk review or an on-site review for enrolled DME providers. Such post payment review audits may be unannounced. Medical records of recipients currently receiving DME as well as a sample of closed records may be reviewed. DMAS may also conduct an on-site investigation of any complaints that are received.

DMAS staff may visit recipients and conduct a professional review (covering physical, emotional, social, and cognitive factors) with respect to all of the following:

- Care being provided by the DME provider;
- Adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each recipient;
- Necessity and desirability of the continued service to the recipient;
- Feasibility of meeting the recipient's health needs in alternate care arrangements;
- Verification of the existence of all documentation required by Medicaid, regardless of whether or not the item has been preauthorized; and
- Determination if the item billed was received by the recipient.

Services not specifically documented in the recipient’s DME medical record as having been rendered or received, as described under Proof of Delivery, shall be deemed not to have been rendered, and no reimbursement shall be provided. Supporting documentation is allowed to justify the medical need for DME and supplies, but supporting documentation does not replace the requirement for a properly completed CMN. (12 VAC 30-60-75)

Following post payment review, a report will be written detailing the findings of the analysts during the utilization review. Based on the review team's report and recommendations, DMAS may take corrective action. (12 VAC 30-60-75) Actions taken

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and the level of management involved will be based on the severity of the cited deficiencies which adversely affect the health and safety of the recipients, the quality of life of the recipients, or utilization control regulations.

If DMAS requests a corrective action plan, the DME provider must submit the plan of action within 30 days of the receipt of the utilization review findings report, to the Quality and Utilization Management Supervisor.

Subsequent contact may be made to the provider for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance. DMAS will deny or retract payment from the DME provider if any of the following occur:

- No current, fully completed CMN/DMAS-352 (physician's order), appropriately signed and dated by the physician. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION PCP, or there must be a referral for the service from the MEDALLION PCP;
- Documentation does not verify that the item was provided to and received by the recipient;
- Lack of medical documentation, signed by the physician, to justify the DME and supplies; or
- Item is non-covered or does not meet DMAS criteria for reimbursement.

(12 VAC 30-60-75)

PROVIDER APPEAL PROCESS FOR DENIAL OF REIMBURSEMENT

Payment to the DME provider may be denied when the provider has failed to comply with established DMAS law, regulation, or policy guidelines as a result of utilization review. (12 VAC 30-60-75)

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

Program Manager
Program Integrity Division
Attention: DME
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

DMAS will review the documentation submitted and provide the DME provider with a

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written response to the request for reconsideration. If the denial is upheld, the provider has the right to appeal the reconsideration decision by requesting an informal fact finding conference within 30 days of the provider's receipt of the reconsideration decision. The provider must submit a detailed statement of the factual and legal basis for each item under appeal. The notice of appeal and supporting documentation must be sent to:

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

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

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

NOTE: During the appeal process, the provider may not remove the equipment or supplies in question from the recipient's home.

RECIPIENT APPEALS

Any denial of a service decision made by DMAS staff may be appealed to the Department of Medical Assistance Services. This decision must be appealed in writing by the recipient or his or her legally appointed representative. If possible, please include a copy of the denial with the appeal request. All appeals must be filed within 30 days of the date of the final decision notification. Appeals should be directed to:

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