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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 of the Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

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

COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts utilization 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 recipient and provider that exceeds the peer group averages by at least two standard deviations.

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

The use of Statistical sampling and extrapolation may be used in a review. The Department may use a scientific random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the

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provision of poor quality services or of any of the above problems, Medicaid may restrict limit, suspend, 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 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 DMAS 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 Cost Settlement & Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
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

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RECIPIENT FRAUD

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

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

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Section
Division of Cost Settlement & Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
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 Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See the "Exhibits" section 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. A Voicemail receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Cost Settlement & Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

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Telephone: 804-786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT WAIVER SERVICES UTILIZATION REVIEW GENERAL REQUIREMENTS

DMAS conducts utilization review to assure that the services provided are appropriate and comply with the policies and procedures for the provision of Individual and Family Developmental Disabilities Support Waiver (IFDDS Waiver) services. For the general requirements, DMAS uses the following procedures:

1. DMAS will conduct an on-site review of service delivery;
2. Utilization Review (UR) is comprised of desk audits, on-site record review and may include observation of service delivery, as well as face-to-face or telephone interviews with the individual or family or significant other(s), or both. The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of individuals served, types of services rendered, numbers of private providers, etc;
3. Billing records are matched to service delivery documentation. Any infractions will be cited in the Utilization Review written report and may result in billing overpayments, voids to continued billing;
4. Utilization Reviews will be unannounced;
5. Providers may be asked to bring program and billing records to the provider's central location;
6. Upon completion of on-site activities for a routine UR, DMAS staff will be available to meet with designated staff to conduct an exit conference. The purpose of the Exit Conference is for DMAS to provide a general overview of the UR findings, preliminary actions required, and recommendations that may help the provider correct problems in documentation or billing practices;
7. Following the review, a written report of the findings is sent to the provider;
8. If a billing adjustment is needed, it will be outlined in the report to the provider, as will the timeline for submitting the adjustment; and

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9. Findings identified in the written report are subject to a request from the provider for reconsideration. The procedures for submitting a request are specified in the cover letter that accompanies the written UR report and must be submitted within 30 days of receipt of the letter.

If there are findings that are related to licensing procedures, a letter stating these findings will be submitted to the appropriate licensing or approving agency.

REVIEW OF SUPPORT COORDINATION AND DD WAIVER SERVICES

In addition to the general UR requirements, DMAS also reviews for specific requirements for the provision of Targeted Case Management (DD Support Coordination) and DD Waiver Services. These requirements are: eligibility for services; that the services are based on comprehensive and ongoing assessment and planning; that services are delivered, reviewed, and modified; that the provider is qualified; and that the services are consistent with billing limitations. Specific requirements for each area follow.

Eligibility for Services

- A. The individual meets the following criteria:
 1. Is eligible for Medicaid;
 2. There must be documentation in the support coordination record that the individual is six (6) years of age and older;
 3. There must be documentation in the support coordination record that the individual has a related condition as defined in 42 C.F.R 435.1009 and does not have a diagnosis of mental retardation.
- B. There individual meets functional criteria. For individuals receiving the DD Waiver, the ICF/MR Level of Functioning Survey (LOF) must be in the support coordination record, have been completed no more than six months prior to the start of Waiver services, and document that the individual meets the dependency level in two or more of the categories. This must be reviewed and completed annually and reflect the current status of the individual.
- C. The individual continues to meet eligibility for services.
 1. It should be clearly documented in the support coordination record that the individual's eligibility and need for continuation of any DD Waiver service is reviewed at least annually; and
 2. The support coordination record must contain an ICF/MR Level of Functioning (LOF) Survey that was administered on an annual basis by DMAS staff. The individual must meet the indicated dependency level in 2 or more of the categories on the LOF.

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D. There is basis for initiating DD Support Coordination (Targeted Case Management) services.

1. There must be documentation of eligibility for the DD Waiver in the record of an individual receiving DD Support Coordination services;
2. There must be documentation that the individual requires and receives active support coordination services; and
3. DD Support Coordination services must not duplicate any other Medicaid service provided under the *Virginia State Plan for Medical Assistance* or under any Waiver other than the DD Waiver.

E. There is basis for initiating DD Waiver services.

1. The support coordination record for an individual receiving DD Waiver services must indicate that the individual meets both diagnostic and functional eligibility as described above; and
2. Documentation must be evident that the individual is receiving DD Support Coordination services during any month in which DD Waiver services are provided. As with any DD Support Coordination individual, Support Coordination Supporting Documentation must be available in the record.

DD Waiver Services are Based on Comprehensive and Ongoing Assessment and Planning

A. A Consumer Service Plan is completed and reviewed.

1. The support coordination record must include a Consumer Service Plan (CSP) that organizes the services and supports that are provided to the individual. The four essential components to a CSP include a) a Social Assessment, b) primary goals and outcomes desired by the individual, c) supporting documentation for each DD Waiver Service (including support coordination), and d) a signature page or documentation of agreement by those participating in the development and implementation of the CSP; and
2. There must be evidence that the CSP is reviewed by the support coordinator and updated annually and whenever changes or service modifications occur.

B. There is comprehensive and current assessment information.

1. There must be a Social Assessment in the support coordination record, completed no earlier than one year prior to the start date of services and updated annually. This assessment must include a review of the current situation and the individual's strengths and desires within the following areas:

- Physical/Mental Health, Personal Safety, and Behavior Issues;

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- Financial, Insurance, Transportation, other Resources;
 - Home and Daily Living;
 - Education and Vocation;
 - Leisure and Recreation;
 - Relationships and Social Supports;
 - Legal Issues and Guardianship; and
 - Individual Empowerment, Advocacy, and Volunteerism.
2. There should be documentation in the support coordination record that demonstrates individuals receiving DD Waiver services are receiving any necessary medical care. Medical examinations of children should follow the schedule of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) administered by DMAS; and
 3. The functional assessment information used to develop the plan of care must be available in the individual's service provider record and reflect an individualized approach to gathering additional information about the individual's personal preferences, interests, strengths, and attributes.
- C. The individual and others, as appropriate, are involved in the planning process.
1. Documentation must indicate that the individual (or legally responsible relative, when appropriate) provided consent to exchange information. The support coordination record of an individual must contain a signed consent form completed prior to the initiation of Waiver services (see "Exhibits" at the end of Chapter IV);
 2. Documentation must indicate that the individual (or legal guardian, when appropriate) of DD Waiver services was informed of all feasible alternatives under the DD Waiver and given the choice between institutional care or Community Waiver services. The support coordination record must contain a copy of the DMAS form entitled "Documentation of Consumer Choice between Institutional Care or Home and Community Based Services." This is required at the initiation of DD Waiver services (see "Exhibits" at the end of Chapter IV);
 3. Documentation must be in the support coordination record that the individual has been presented with all feasible alternatives of available agency and consumer-directed services for which he or she is eligible under the DD Waiver (this can be done on the recipient choice form);
 4. Documentation must indicate that the individual (or legally responsible relative) was informed of all DD Waiver providers in the community and had the option of choosing from among qualified providers. It must be clear that the choice of providers was offered no more than six months prior to the initiation of any Waiver services, whenever new services were added, when changes occur in providers, or when requests are made by the individual. The choice must be documented in writing, prior to the start of services, by having the individual (or parent or guardian when appropriate) sign a list of available providers and designate the selected provider. While it is the responsibility of service providers to indicate their

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availability to each support coordinator where they may potentially provide services, it is suggested that the support coordinator review the updated roster of approved providers distributed by DMAS;

5. Documentation must indicate that the individual (or family caregiver) was involved in the development of the supporting documentation. At a minimum, the individual's (and family's) input and satisfaction with the plan should be documented by signature(s) on the CSP in addition to the support coordinator's signature;
 6. Documentation must indicate that the individual (or family caregiver) was informed of any changes in services, provided the opportunity for input, and agreed to the changes before they were implemented. Documentation of this involvement (either in the service plan itself or in the case notes) should accompany any changes to the CSP; and
 7. For any termination or decrease of support coordination or Waiver service, the support coordination record must contain written notification to the individual of the pending action and the right to appeal. Reference Chapter IV, "Consumer's Right to Appeal and Fair Hearing" for specific requirements.
- D. The support coordinator receives and reviews any supporting documentation.
1. All supporting documentation must be completed prior to the initiation of services and must be based on current information and reflect the individual's desires, input, and other assessment information and agreed to by the team;
 2. The supporting documentation must clearly describe the activities of the individual and staff, reflecting training and supports, as appropriate for the individual and congruent with the type and amount of service units authorized by DMAS. The supporting documentation must justify service components such as day support intensity levels, etc.;
 3. The supporting documentation must include activities and strategies that are meaningful and address the individual's primary goals. The supporting documentation must satisfy the specific Medicaid criteria and service limitations for each individual service as described in Chapter IV; and
 4. The schedule of services must be consistent with the service units prior authorized by DMAS.
- E. Documentation of all planned services. The CSP is completed annually by the support coordinator or as needed. It should list all current DD Waiver and non-waiver services.

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Services are Delivered, Reviewed, and Modified

- A. Services occur as planned or are adjusted to accommodate the individual's needs and requests.
 1. There must be ongoing documentation in the record of each service provider regarding the services to the individual and available for review by the support coordinator, DMAS, and the individual or family or both. Documentation can include case notes, various modes of measurable data collection, attendance records, notes regarding significant incidents, monthly summaries, and progress notes;
 2. The record must document a minimum of one face-to-face contact with the support coordinator within each 90-day period. There must be evidence that the support coordinator assessed the individual's satisfaction with services (through observation and interviews with the individual and significant others), determined any unmet needs, evaluated the individual's status, and assisted with adjustments in the services and supports as appropriate. Missed face-to-face contacts with no documented reason, particularly patterns of missed contacts, may result in the entire quarter being disallowed for Medicaid reimbursement; and
 3. Each service provider's record (including support coordination) must contain documentation that corresponds to the CSP objectives and indicates that services have been provided according to the plan. While this data may take many forms, it should be meaningful for the individual and show that his or her goals being addressed.
- B. Services are reviewed at least quarterly or as needed.
 1. There must be documentation that the support coordinator reviewed on a quarterly basis all services provided (including support coordination services). Support Coordination quarterly reviews must be completed by the last day of the month in which they are due, with a grace period of up to the last day of the month. However, the original quarterly due dates should always resume if this grace period must be utilized;
 2. There must be evidence that quarterly reviews for DD Waiver services are completed at the end of each quarter and as determined by the effective date of the start of the CSP. However, the original quarterly due dates should always resume if this grace period must be utilized; and
 3. The quarterly review for each service, including support coordination, will be reviewed to determine if it addresses a) the results of the services; b) any significant events; c) the individual's and, when appropriate, the family's satisfaction with the services and other input; and d) changes in the goals or strategies when they are ineffective or upon the individual's request.

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C. A comprehensive review of each service occurs annually.

1. The record will be reviewed to determine if the annual review includes a combination of record review, observation of service delivery, and interviews with the individual and family to determine if the services provided are effective and match the individual's needs and desires for support; and
2. Every service must have a supporting documentation developed at the time of the annual CSP review (no longer than 365 days/366 days in a leap year). There is no grace period. There must be documentation of individual and family involvement in the review and development of the new CSP.

The Provider is Qualified

A. There is documentation of the needed license, certification, vendor agreement, or approval.

1. It is the responsibility of the service provider to maintain documentation, readily available for review, which verifies the provider's qualifications; and
2. Provider qualifications and expectations are outlined in Chapter II of this manual.

B. Certain additional requirements are met.

1. A support coordinator must not be a direct service provider for the same individual;
2. Providers of Crisis Stabilization services must document that they employ or utilize mental health professionals, licensed mental health professionals, or other personnel competent to provide clinical/behavioral services and related activities to individuals with developmental disabilities who are experiencing serious psychiatric or behavioral problems. The face-to-face assessments and reassessments must be conducted by a qualified professional, as defined in Chapter II;
3. DMAS-enrolled Personal Care/Respite agencies providing agency-directed Personal Care or Respite services must employ or subcontract with an directly supervise a licensed RN or LPN who will provide ongoing supervision of all personal or respite assistants; and
4. The CD Services Facilitator must be a licensed RN or have RN consulting services available. The CD Services Facilitator may not also be the case manager or direct service provider for a given individual or be the individual or the primary caregiver of the individual receiving services.

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The Services Delivered Are Consistent With Billing Limitations

- A. Services are authorized or preauthorized as appropriate.
1. All DD Waiver providers must have a current DMAS Participation Agreement that lists all services for which the provider is eligible to provide and bill; and
 2. All DD Waiver providers must have a copy of the current notification letter authorizing their services. It is not necessary for a provider of multiple services to an individual to maintain the notification letter in each separate service record. CD Services Facilitation does not require authorization prior to service initiation; and
 3. Terminations of single Waiver services should be reflected on the supporting documentation and CSP. Terminations of all Waiver services should be reflected on a completed DMAS-122, submitted to DSS and DMAS.
- B. There is documentation that services were provided as billed.
1. Billing for Support coordination (targeted case management) services must be supported by a minimum of one direct or by individual-related contact, activity, or communication and must be documented each month relevant to the Consumer Service Plan (CSP) during any month for which a claim for support coordination is submitted. Written work is excluded; and
 2. Billing for Day Support and Supported Employment-Group Model services must be supported by attendance documentation that verifies individual participation in the service in accordance with the CSP and for a total number of hours that is equal to or greater than the number of hours/units billed each day in a month. The documentation must include, at a minimum, the date services were rendered, the number of hours/units provided with specific time frames and type of service, and an attendance log (or similar document); and
 3. Billing for Supported Employment, Individual Placement services must be supported by documentation of actual interventions or collateral contacts by the provider, not for the amount of time the individual is in the supported employment situation. A log or similar document, which shows the date, hours, and type of service rendered, in accordance with the CSP must be maintained;
 4. In-Home Residential Services are billed for actual service hours. Documentation must include dates, times, and services that were provided in accordance with the CSP;
 5. Billing for Respite Care, Personal Care services, Therapeutic Consultation, Crisis Stabilization, Attendant Care services, Consumer-Directed Respite Care services, Adult Companion Care, Family/Caregiver Training, and Skilled Nursing services must be supported by documentation of the dates and times of actual service delivery. The format used for documentation of service hours should be reviewed

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by DMAS staff prior to use to ensure that all required components are present. Billing for Consumer-Directed services is supported by employee time sheets that are signed by the individual and employee;

6. Billing for Environmental Modifications and Assistive Technology must be supported by bills from contractors, rehabilitation engineers (if required), and equipment purchase receipts. Additional documentation must be in the individual's file that demonstrates a licensed professional (i.e., Occupational Therapist) determined what Environmental Modifications are needed and for what purpose;
7. Providers billing for Personal Emergency Response Systems (PERS) services, must maintain a data record for each PERS individual at no additional cost to DMAS. The record shall contain the following:
 - a) Delivery date and installation of the PERS;
 - b) Enrollee/caregiver signature verifying receipt of PERS device;
 - c) Verification by a test that the PERS device is operational, monthly or more frequently as needed;
 - d) Updated and current individual responder and contact information, as provided by the individual or the individual's care provider; and
 - e) A case log documenting individual system utilization and individual or responder contacts/communication.

The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

The PERS provider shall document and furnish a written report to the support coordinator each emergency signal that results in action being taken on behalf of the recipient. This shall exclude test signals or activations made in error.

8. It is not permissible to automatically bill each month at the maximum amount authorized on the notification letter. For all services, if the amount billed for a given service in the month audited does not correspond to documented hours/units of services delivered, the entire quarter is audited. If that quarter's billing does not correspond to service delivery records, subsequent quarters may be audited.
9. All billing errors identified by DMAS staff are reported to the provider for correction. Billing errors identified during a formal Utilization Review are also reported to the provider reviewed.
10. All billing must be supported by the required documentation as outlined throughout this manual. As a result of reviews conducted by DMAS, infractions will be cited

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in the written report of findings and may entail a request for billing retractions or a void to continued billing. Plan of Correction may be requested when review issues cited are pervasive, repetitive, or of a serious nature. The following is a non-comprehensive list of circumstances most likely resulting in billing overpayments or voids when identified during utilization or more informal service reviews:

- a) Absence of current CSP;
- b) Services not delivered as described in the CSP;
- c) Services rendered to an ineligible individual;
- d) Support coordination face-to-face contacts that are not completed in a timely manner (every 90 days);
- e) Any periods of services billed for which there is an absence of or inadequate documentation to substantiate the service rendered (amounts, type, absence of data, assessment information, etc.);
- f) Any periods of services billed during which the staff were not qualified, the provider had not fulfilled the terms of the Participation Agreement, and/or the required license/certification/approval had been revoked;
- g) Any identified billing errors, such as inaccuracies in service amounts, incorrect or absent deductions of patient-pay amount, incorrect dates of service, duplication of services, etc.; and
- h) There is no documentation reflecting the need for a service or for that level of service, (e.g., High Intensity Day Support, specialized supervision).

C. If the individual has a patient-pay, a provider is designated to collect the following:

A copy of the DMAS-122 (Patient Information) form, completed and returned from DSS, should be in the individual's record at each provider. The provider designated as the collector of patient pay must be documented on the DMAS-122 prior to distribution to providers. Each provider agency (regardless of any patient pay responsibility) must receive from the support coordinator and keep on file a current copy of the DMAS-122.

A current DMAS-122 must be maintained in the records. The DMAS-122 is updated by the local DSS, annually, and by the support coordinator if the individual experiences any of the following changes: new address, a different support coordination agency, income, interruption in DD Waiver services for more than 30 days, discharge from all DD Waiver services, or death. The support coordinator must forward the DMAS-122 to notify DSS when such changes occur. The support coordinator should document communications with DSS regarding the need for and receipt of the DMAS-122.

D. If a patient-pay is required, the billing indicates the correct amount.

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If there is a patient-pay amount, the CMS-1500 (12-90), the billing invoice required by DMAS, must indicate that the amount billed was decreased by the designated amount.

E. Designated DD Waiver services are not used when available from the primary source.

1. Day Support and Supported Employment service providers, or the individual's support coordinator, must document before the onset of service delivery that these services are not available through the Department of Rehabilitative Services (DRS) or, for individuals under 22 years, by the local school system; and
2. There should be documentation that it was determined that the equipment or supplies provided to a individual under Assistive Technology services are not available under the *State Plan for Medical Assistance*. This may be documented in the individual's record by noting the results of reviewing the "Durable Medical Equipment and Supplies" list for a given item or the results of a phone inquiry to the DMAS Helpline about the item's availability through the *State Plan*, or both. There must be documentation for any equipment, supplies, and technology not purchased from a DME provider showing that it was not available from a DME provider.

RECONSIDERATIONS AND APPEALS

Payment to providers may be denied when the provider has failed to comply with established federal and State regulations or policy guidelines.

The provider has the right to request reconsideration of service denials. The request for reconsideration and all supporting documentation, must be submitted within 30 days of receipt of the Utilization Review (UR) to:

Supervisor, Behavioral Health and Developmental Disabilities Unit
 Long-Term Care and Quality Assurance Division
 Department of Medical Assistance Services
 600 East Broad Street, Suite 13006
 Richmond, Virginia 23219

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

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

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

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