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CHAPTER VI  
UTILIZATION REVIEW AND CONTROL

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## **CHAPTER VI UTILIZATION REVIEW AND CONTROL**

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of care and services paid by 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 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 established 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 subject to periodic and unannounced utilization reviews, as well as 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's peer group. An exception profile report is generated for each 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 or its contractor, will review all cases using available resources, including appropriate consultants, and contractors, and make on-site reviews of medical records, as necessary.

Statistical sampling may be used in a review. The Department may use a 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.

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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 provision of poor quality services or of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

### Utilization Review Visits

Periodic, unannounced, utilization review will be conducted on-site or as desk reviews on each psychiatric or substance abuse treatment provider. DMAS, or its contractor, will review medical records and conduct an overall review of the provision of services.

Medical records of recipients currently receiving psychiatric and substance abuse (SA) services as well as a sample of closed medical records may be reviewed. DMAS, or its contractor, may also conduct an on-site investigation as follow-up to any complaints received.

### Documentation Criteria

Providers of outpatient psychiatric and SA services are expected to document the requirements outlined in Chapter IV, as well as the following:

- The recipient must participate and be compliant with treatment (e.g., some individuals with mental retardation [MR] or children may not have the ability to understand the treatment).
- The provider is expected to have the results of a medical evaluation in the recipient's medical record or indicate that the recipient's condition either does not warrant an evaluation or an evaluation was recommended and for what reasons.
- History;
- Functional limitations;
- Diagnostic Evaluation;
- Plans of Care and reviews of the plan;
- Progress notes; and
- Discharge plans and discharge summary.

Psychiatric and SA services that fail to meet Medicaid criteria are not reimbursable. Such non-reimbursable services will be denied upon preauthorization or at the time of the post-payment utilization review.

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Upon completion of an on-site review, the utilization review analyst(s) may meet with staff members as selected by the provider for an exit conference. The exit conference will provide an overview of the findings from the review, and based on the review team's report and recommendations, DMAS may take any corrective action necessary regarding retraction of payment. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services and utilization control regulations.

Upon completion of a desk review, DMAS, or its contractor, will respond to the provider in writing and cite any federal or state regulations and policy and procedures that were not followed. In addition, a letter outlining any retractions necessary as a result of not following federal or state regulations will be sent to the provider.

If DMAS requests corrective action plans, the mental health clinic provider must submit the plan, within 30 days of the receipt of notice, to the utilization review analyst(s) who conducted the review. Subsequent visits/desk reviews may be made for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

### **Reconsiderations and Appeals**

Payment to the psychiatric or substance abuse services provider may be denied when the provider has failed to comply with established DMAS law, regulation, or policy guidelines. (*Virginia State Plan for Medical Assistance*, Supplement 1 to Attachment 3.1-A&B, Section 7-D, 1-9).

The psychiatric or substance abuse services 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 of the denial, to:

DMAS  
Payment Processing Unit Supervisor  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

DMAS will review the documentation submitted and provide the psychiatric services provider with a written response to the request for reconsideration. If the denial is upheld, the provider has the right to a first-level informal appeal of the reconsideration decision, pursuant to Va. Code §2.2-4019. A provider may appeal an adverse decision by filing a written notice of appeal with the DMAS Appeals Division within 30 days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed and must be sent to:

Appeals Division  
Department of Medical Assistance Services  
600 East Broad Street, 11<sup>th</sup> Floor  
Richmond, VA 23219

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If the denial is upheld, in whole or in part, as a result of the first-level informal appeal, the provider has the right to file for a second-level formal appeal, pursuant to Va. Code § 2.2-4020. The provider must file a request for a formal appeal within 30 days of receipt of the first-level informal appeal decision. The notice must identify the issue being appealed and must be sent to:

Appeals Division  
 Department of Medical Assistance Services  
 600 East Broad Street, 11<sup>th</sup> Floor  
 Richmond, VA 23219

### **MEDICAL RECORDS AND RECORD RETENTION**

The facility or agency 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 psychiatric and substance abuse services must be retained for not less than five years after the date of 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 485.721 for additional requirements.*

Upon the transfer of ownership or closure of a service provider or facility, the current provider or facility is required to notify DMAS Provider Enrollment and the supervisor of the Hospital Utilization Review Unit in writing within 30 days of the effective date of the change. Information required concerning the change includes, but is not restricted to, the effective date of the change and who will have custody of the files/records.

Send notice to:

Department of Medical Assistance Services  
 Hospital Utilization Review Supervisor  
 600 E. Broad Street, Suite 1300  
 Richmond, Virginia 23219

And to:

Department of Medical Assistance Services  
 Provider Enrollment  
 600 E. Broad Street, Suite 1300  
 Richmond, Virginia 23219

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The facility or agency 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.

Each psychotherapy session must be written at the time the service is rendered and must be signed and dated by the therapist rendering the service. If the therapy session is rendered by a professional working towards licensure, and under the direct, personal supervision of a licensed professional (in accordance with professional licensing board requirements), the therapy session must contain not only the dated signature of the therapist rendering the service but also the dated signature of the supervising professional. Each therapy session must contain the co-signature of the supervising professional on the date the service was rendered indicating that he or she has reviewed the note.

All psychiatric medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. A required physician signature for DMAS purposes may include signatures, computer entry, or rubber-stamped signature initialed by the physician. These methods only apply to DMAS requirements. For more complete information, refer to the Medicaid *Physician Manual*. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the provider's administration with a signed statement to the effect that he or she is the only person who has the stamp and he or she is the only person who will use it. The physician must initial and completely date all rubber-stamped signatures at the time the rubber stamp is used.

## **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 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

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

Telephone: (804) 692-0480  
FAX: (804) 786-0414

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 regarding issuance of non-entitled benefits or fraud and abuse by non-providers 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 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 non-entitled benefits were issued, 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 *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 a period of 12 months beginning with the month of the fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit  
Division of Program Operations  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

Telephone: (804) 786-0156

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FAX: (804) 786-6229

## **REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM**

DMAS providers may refer Medicaid recipients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) in 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 and pharmacy in the client Medical Management program (CMM). (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. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit  
Division of Program Operations  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

Telephone: (804) 78-6548  
CMM Helpline: 1-888-323-0589  
FAX: (804) 786-5799

When making a referral, provide the name and Medicaid number of the recipient and a brief statement regarding 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.