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 care and services paid by Medicaid, including review of utilization of the services by providers and by recipients. Federal regulations of 42 CFR §§ 455 – 456 set forth requirements for detection and investigation of Medicaid fraud and abuse to maintain program integrity and require implementation of a statewide program of utilization control to ensure high quality care as well as the appropriate provision of services. This chapter provides information on utilization review and control requirements handled by the Department of Medical Assistance Services (DMAS).

OVERVIEW TO UTILIZATION REVIEW ACTIVITIES

DMAS conducts utilization review to ensure that the care meets quality standards. Medicaid requires that effective utilization review be maintained on a continuing basis to ensure the medical necessity of the services for which Medicaid provides reimbursement and to promote the most efficient use of available health facilities and services. Participating Medicaid providers are responsible for ensuring that requirements, such as record documentation for services rendered, as well as Federal and State codes is met in order to receive reimbursement 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 request. The provider incurs the cost associated with providing these records to the requesting authority.

Providers and recipients are identified for review either from systems-generated reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Provider reviews are initiated on a regular basis to meet federal requirements as indicated in the code of Federal Regulations (CFR). Random sampling may be used to determine areas for on-site reviews, as well as computerized exception reports which look at utilization patterns for providers and recipients. Exception reports developed for providers and recipients compare billing activities and utilization patterns with those of their respective peers.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources including consultants and contractors. These audits

will be conducted as desk and/or on-site audits. DMAS will notify the provider by written request for clinical records. Failure to comply with the request for records will be determined as an overpayment for the billed service. DMAS staff will send the provider a written request for recipient records. Facilities must have these records available for the reviewer the date and time specified on the Request for Records letter. If a facility fails to comply with the request for records for the on-site audit, an overpayment to DMAS will be required. DMAS staff will not issue extensions for on-site audits.

Providers will be required to refund payments made by DMAS if they are found to have billed DMAS contrary to federal and state regulation or statute, failed to maintain any record or adequate documentation to support their claims, failed to provide valid information to obtain prior authorization, or billed for medically unnecessary services. Due to the provision of poor quality services or of any of the above problems, DMAS may limit, suspend, or terminate the provider's participation agreement.

Corrective actions for recipients include education on the appropriate use of health care, restriction to designated providers for utilization control, recovery of misspent funds, and referral for further investigation of allegations of fraudulent activities. Loss of Medicaid/FAMIS coverage can result from a conviction of Medicaid/FAMIS fraud.

MEDICAID SERVICES PROVIDED BY SCHOOLS

Recipient Eligibility

- Recipients of DMAS covered school services must be eligible for Medicaid or Family Access to Medical Insurance Security (FAMIS) on the date of service. Children receiving Early Periodic Screening Diagnosis and Treatment (EPSDT) screening services provided by the school system may not be enrolled in a Medicaid managed care organization (MCO) on the date of service.

- Recipients of DMAS services provided by schools must be under the age of 23.

- With the exception of EPSDT screening services, recipients must have the need for medical services documented in the Individualized Education Program (IEP).

General Documentation Requirements

The Provider Agreement requires that the records fully disclose the extent of services provided to individuals receiving Medicaid services. Records must be made available to authorized state and federal personnel in the form and manner requested. Family Education Rights and Privacy Act (34 CFR §99.31) and IDEA (34 CFR §300.154 [d] 2 [iv] A) require that schools obtain parental/guardian consent for DMAS to review any Medicaid/FAMIS documentation.

Providers must follow both the general documentation requirements for all providers and

the documentation requirements for specific services as outlined in this chapter. In general, the recipient's record should contain the following elements:

- A current IEP which documents the medical necessity for services and includes the most recent assessments and evaluations by licensed IEP providers.
- With the exception of EPSDT screening services, each recipient of Medicaid/FAMIS services provided by schools must have an IEP which demonstrates medical necessity.
- With the exception of EPSDT screening services, Medical Evaluations and Transportation, each recipient of Medicaid/FAMIS services provided by schools must have a Plan of Care (POC).
- POCs on DMAS or DOE approved forms for ongoing services which includes, at a minimum, the following:
  - The medical/treating diagnosis to be addressed by the service;
  - Type, amount and frequency of service;
  - Anticipated duration of service;
  - Short-term and long-term goals; and
  - Signature, title and date of licensed practitioner completing the plan of care.

  The IEP may serve as the plan of care and as a mechanism for the authorization of services as long as:

    - There is evidence of a licensed practitioner of the healing arts initiating the services;
    - The IEP identifies the services; and, the IEP identifies the estimated time frame that the services will be medically necessary.
- Progress notes for ongoing services;
- Evidence of the recipient's involvement and understanding of diagnosis and prognosis;
- The record must identify the patient name on each page;
- Entries must be signed and dated by the responsible provider of services. Care rendered by personnel under the supervision of an approved licensed professional, in accordance with Medicaid policy, must be signed by the responsible licensed professional meeting the 30 calendar day supervision requirement which is detailed in this manual;
- The record must contain a preliminary medical diagnosis and the elements of the history and physical examination upon which the diagnosis is based;
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record;

- The record must indicate the progress being made, any change in the diagnosis or treatment, and the response to treatment. Progress notes must be written as required for the provider type;
- Discharge summaries which document a summary of the recipient's progress and recommendations for future care.

Services not specifically documented in the recipient's medical record as having been rendered will be deemed not to have been rendered, and no payment will be provided.

The school must maintain records on all recipients in accordance with accepted medical professional standards and practice. Records must be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieval and compilation of information.

All record documentation must be signed with at least the first initial, last name, and title of the provider and be dated with complete dates (month, day, and year). A required licensed practitioner of the healing arts signature for DMAS purposes may include signatures, written initials or computer entry. Only a medical doctor (MD) may use a rubber stamp and must be initialed by the MD. However, these methods do not override other requirements that are not for DMAS purposes. If a MD chooses to use a rubber stamp on documentation requiring his or her signature, the MD whose signature the stamp represents must provide the school administration with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. The MD must initial and completely date all rubber-stamped signatures.

Current medical records and those of discharged recipients must be completed promptly. All information pertaining to a recipient's Medicaid/FAMIS covered school services must be centralized in the recipient's record. Each licensed practitioner's entry into the record must be signed and dated by the practitioner making the entry.

The school must recognize the confidentiality of medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern records' use and removal and the conditions for the release of information. The recipient/responsible party's written consent is required for the release of information not authorized by law.

Records 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, quality management review, or administrative action. The school 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.

NOTE: All forms mentioned in this chapter may be located at the Department of

Education, Medicaid and School Services website at:
http://www.doe.virginia.gov/VDOE/Instruction/Sped/medicaidmain.html

SPECIFIC DOCUMENTATION REQUIREMENTS

EPSDT Services and Medical Evaluation Services

In addition to the general documentation requirements stated previously in this chapter, the record must include the following:

- Positive and negative examination findings;
- Diagnostic tests ordered and the results of the tests;
- Diagnoses;
- An indication of whether further treatment is needed;
- Referrals, including the name of the referring physician; and
- Any recommended IEP changes.

Physical Therapy, Occupational Therapy and Speech-Language Pathology Services

In addition to the documentation requirements for all school providers outlined in the beginning of this chapter, documentation for physical therapy, occupational therapy and speech-language pathology services must also include the following:

1. Assessments/Evaluations

   Therapist assessment/evaluation must include all of the following, but is not limited to:

   - Medical/treating diagnoses;
   - Current findings;
   - Current functional status (strengths and deficits);
   - Summary of previous rehabilitative treatment and results; and
   - Extent to which the recipient/responsible party is aware of the diagnosis and prognosis.

   Some of the assessment data may be found in the IEP.

   An evaluation or re-evaluation must be completed by a licensed therapist when a recipient is admitted to a service, when there is significant change in a recipient's condition (for example, a long illness or hospitalization, etc.), when ordered by a physician, physician assistant or nurse practitioner, or when a recipient is readmitted to a service.

A licensed practitioner is required to order the assessment/evaluation by using the MED-6 form.

2. Plan of Care/IEP (MED-8)

   A POC/IEP specifically designed for the recipient by the licensed practitioner of the healing arts must be available for all recipients. Providers must use the MED-8 form or the IEP for this purpose. The POC/IEP must include measurable goals (long and short-term) which describe the anticipated level of functional improvement together with time frames for improvement and/or goal achievement. Included are therapeutic interventions to be addressed by the therapist and identification of a discharge plan. The POC must be personally signed and dated by the licensed practitioner.

   Any changes in the recipient's condition must be noted with subsequent revisions in the POC. This includes revisions, additions and deletions of the long-term goals, and any changes to the frequency or duration of services. Providers must use the “Plan of Care Addendum” (MED-12) to document changes to the POC/IEP.

3. Progress Notes (MED-9)

   The licensed practitioner or the therapy assistant must write progress notes for each visit. Documentation in progress notes must be in accordance with the POC/IEP. Progress notes must be signed and dated by the licensed practitioner or the therapy assistant (with evidence of supervision by the licensed therapist every 30 calendar days) providing the treatment. The supervisory 30 day on-site review is required when the LPTA, COTA, or speech language pathology assistants are providing treatment. NOTE: Evidence of the supervisory visit must be supported by documentation of the visit, not just the licensed therapist’s signature. Documentation must demonstrate that all treatment is rendered to the recipient in accordance with the POC with specific attention to frequency, individual and/or group therapy, duration, modality, recipient response to treatment, revision to short-term goals and identification of the treating therapist. If appropriate, the summary of treatment rendered and results achieved during previous periods of services is included. Providers must use the appropriate therapy progress note (MED-9 PT, OT, SLP or Audiology) form for this purpose.

4. Discharge Summary

   The discharge summary must be completed within 30 calendar days of discharge and must include all of the following, but is not limited to:

   - The reason for discharge;
   - The recipient's functional status at discharge compared to admission status;
   - The recipient's status relative to established long-term goals met or not met;
   - The recommendations for any follow-up care;
   - The recipient's discharge destination; and
   - The full signature, title and date by the qualified therapist who developed the plan.

NOTE: A discharge order by the licensed practitioner is required prior to the discontinuation of therapy services.

Skilled Nursing Services

Skilled nursing services documentation must be in accordance with the Virginia Board of Nursing, the Department of Health Professions, the Department of Education statutes, regulations and standards relating to school health and the Medicaid School Division Manual. In addition to the documentation requirements for all school providers outlined in the beginning of this chapter, documentation for skilled nursing services must also include the following:

- The plan of care (MED-10);
- The student log (MED-11);
- Dates and times of services entered by the responsible licensed nurse;
- Treatment and actual nursing services rendered;
- Current diagnosis and elements of the history and examination which form the basis of diagnosis;
- Any prescribed drugs which are part of the POC, including quantities, dosage and frequency;
- Notes to indicate progress made by the recipient;
- Any changes from the physician, physician assistant or nurse practitioner written order;
- The recipient's response to treatment;
- Actions related to skilled nursing services, such as notifying primary care

provider and/or caregiver of pertinent medical information, contacting Emergency Medical Services, etc.; and

- RN documentation of on-site supervision, at a minimum every 30 calendar days, of any nursing procedures performed by an LPN.

Skilled Nursing Evaluations

An evaluation or re-evaluation must be completed by a registered nurse when a recipient is admitted to a service, when there is significant change in a recipient's condition (for example, a long illness or hospitalization, etc.), when ordered by a physician, physician assistant or nurse practitioner, or when a recipient is readmitted to a service.

The Plan of Care (MED-10)

All skilled nursing services will be directly and specifically related to an active, written plan of care. The POC is to be part of the nursing record and is the documentation for the services. The POC is based on a physician's, physician assistant's or nurse practitioner's written order for skilled nursing services. The RN is to establish, sign and date the POC. The signing of the POC must predate the actual delivery of services. The POC is to be periodically renewed or updated by the physician, physician assistant or nurse practitioner. This may be done at the beginning of each school year or at anytime the physician's, physician assistant's or nurse practitioner's orders are changed. The services shall be specific and provide effective treatment for the child's condition in accordance with accepted standards of skilled nursing practice. Once the POC is completed by the RN, a copy of the POC must be given to the child's Primary Care Physician.

The POC must include the following:

- The medical condition or conditions to be addressed by skilled nursing services;
- Goals for skilled nursing services;
- Time tables for accomplishing such stated goals;
- Actual skilled nursing services to be delivered; and
- Whether the services will be delivered by a RN or LPN.

NOTE: When designing nursing plans, please note that if a service can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a licensed nurse, then the service is not defined by DMAS as a skilled nursing service. Services such as Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) care are not nursing services and will not be approved as nursing services by DMAS unless a concurrent nursing service is being provided to the individual. The total amount of approved nursing hours may include both nursing and personal care time if the personal care tasks are incidental to the nursing care.

Psychiatric Services

In addition to the documentation requirements for all school providers outlined in the beginning of this chapter, documentation for psychiatric and psychological services must also include the following:

- History including school/educational history, medical history, family history and previous psychological treatment to include:
  - The onset of the diagnosis and functional limitations;
  - Family dynamics; ability/desire of the family/caretakers to participate and follow through with treatment;
  - Reasons that may require consideration (foster care, dysfunctional family);
  - Previous treatment and outcomes;
  - Medications, current and history of;
  - Medical history if relative to current treatment;
  - Treatment received through other programs (Department of Rehabilitative Services, day treatment, Special Education, Community Services Board, or the Department of Mental Health, Mental Retardation and Substance Abuse Services clinics.
- Functional limitations;
- Plan(s) of care and review of the plan of care signed and dated by the qualified provider. (POC for psychological services may be found on the Diagnostic Clinical Interview form [MED-16] and the Psychological Evaluation form [MED-17]);
- Medical evaluation (evidence of coordination with the PCP, if applicable, or documentation that it is not applicable). The purpose of the evaluation is to rule out any underlying medical condition as causing the symptoms, and to ensure that any underlying medical conditions are being treated.
- Results of a diagnostic evaluation done within the past year (MED-17). The chief complaint should relate to the psychiatric diagnosis that is current, within the past year.
- Global Assessment of Functioning (GAF) (Diagnostic Clinical Interview Form);
- Therapy progress notes (MED-18) for each session (must describe how the activities of the session relate to the client-specific goals, the length of the session, the level of participation in treatment, the modalities of treatment, the type of session [group, individual], the progress or lack thereof toward the goals, and the plan for the next treatment and must contain dated the signatures of the providers);

- Evidence of discharge planning; and
- On an annual basis, a summary report of the counseling/therapy sessions conducted for each student seen during the year for psychological counseling as a related service should be completed. This summary should include the reason for referral, a summary of the treatment (i.e., when counseling started, number of sessions, general issues or treatment plan, response to treatment, general outcomes, etc.), diagnostic impression at time of discharge or annual report, and recommendations.

Plan of Care (Diagnostic Clinical Interview form [MED-16] and the Psychological Evaluation form [MED-17]);

- Focus of the POC must be related to the diagnosis;
- Must indicate client-specific goals related to symptoms and behaviors;
- Must indicate treatment modalities used and documentation specific to the appropriateness of the modalities (why the modality was chosen for this individual - all modalities will be considered with appropriate documentation);
- Must indicate estimated length that treatment will be needed;
- Must indicate frequency of the treatments/duration of the treatment;
- Must indicate documentation of the family/caregiver participation;
- Qualified provider must sign and date the plan of care;
- The POC must be reviewed by the provider every 90 calendar days from the date of the provider's signature. The review should include the following:
  - Has there been a relapse?
  - Has there been a significant change in the environment?
  - Is the individual at risk for moving to a higher level of care?
  - Positive/negative changes relative to the symptoms.
  - Documented review of the POC by a qualified licensed practioner of the healing arts.

Audiology Services

In addition to the documentation requirements for all school providers outlined in the beginning of this chapter, documentation for audiology services must also include the following:

1. Any assessments and/or evaluations;

2. A plan of care (MED-8) specifically designed for the recipient who is receiving therapy services, which includes: any measurable goals (long and short-term); the anticipated level of functional improvement together with time frames for improvement and/or goal achievement; any therapeutic interventions to be addressed by the audiologist; and identification of a discharge plan. Any changes in the recipient's condition must be noted with subsequent revisions in the POC (MED-12);

3. All progress notes (MED-9-Audiology); and
4. A discharge summary (MED-13) signed and dated by the audiologist within 30 calendar days of discharge which includes: the reason for discharge; the recipient’s functional status at discharge compared to admission status; the status of any established goals; and any recommendations for follow-up care.

Personal Care Services

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

- POC (MED- 14);
- Personal care aide progress notes/service log (MED-15), including the following information: date and time and of service; amount of time or service; services performed; recipient’s response; initials of personal care aide on each service rendered; and signature of personal care aide upon sign off of service log; and documentation of supervisory visits;

- The supervising RN, PT, OT, ST, Psychiatrist or Psychologist must document supervisory visits with the recipient and personal care aide at a minimum of every 30 calendar days The purpose of these visits is to ensure the quality and appropriateness of the personal care services being provided. Based on continuing evaluations of the aide’s performance and the recipient’s needs, the licensed RN, PT, OT, ST, Psychiatrist or Psychologist shall identify any gaps in the aide’s ability to function competently and shall provide training as indicated; and

- Documentation of training provided to the personal care aide by the specific discipline.

Transportation

Documentation requirements for special education transportation include:

- Must be in the child's IEP;
- Each trip must be documented in the Special Transportation Bus Log (MED-20);
- Each trip must be documented by school personnel;
- Documentation must include Student's name, Medicaid number, DOS, Type of encounter: To/From; and
- Staff documenting trip must observe student's arrival or departure on the bus.

CRITERIA FOR REIMBURSEMENT

School services that fail to meet DMAS criteria are not reimbursable. Such non-reimbursable services will be denied at the time of DMAS utilization review activities. DMAS criteria for general reimbursement of general Medicaid/FAMIS services provided by schools are found throughout the provider manual and include, but are not limited to, the following:

- A qualified practitioner of the healing arts (as defined in Chapter II) must be part of the IEP team or an MD order as required by skilled nursing services or personal care services supervised by an RN;
- Medical record requirements per program must be followed as defined in Chapter VI;
- A POC must be completed and signed by the licensed practitioner of the healing arts prior to the provision of services which includes the assessment and identification of deficits and outcome recipient goals;
- Services must be provided by qualified licensed practitioner of the healing arts as defined in Chapter II;
- The service must address the identified goals;
- Additional services are expected to significantly improve or maintain functional ability or health care status;
- Progress toward goals should be made within a reasonable period of time or the treatment will result in effective maintenance or management of the child's health condition to prevent the child's functioning from deteriorating;

- Documentation must be available for services rendered and/or reimbursed;
- Renewal of the IEP and/or POC must be completed at least once per school year; and
- Evaluation/re-evaluation that is provider program generated (due to internal school district requirements) does not meet criteria for Medicaid reimbursement.

RECONSIDERATIONS AND APPEALS

At the conclusion of the audit, DMAS will submit a letter to the provider with the results of the audit. If retractions are necessary, the provider will be notified of the amount. DMAS may request a plan of action if deemed necessary to ensure future compliance with the requirements listed earlier in this section. If the provider does not agree with the results of the audit, the provider has the right to request reconsideration and state why the retraction should not be made. All requests for reconsideration must be in writing and must be received by DMAS within 30 days of the date on the Audit Result letter. Mail all reconsideration requests to:

DMAS
Specialized Services Unit, Manager
Division of Maternal and Child Health Services
600 E. Broad Street, Suite 1300
Richmond, VA 23219

DMAS will review the documentation submitted and provide the school 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 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, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
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 written notification of the informal fact finding decision. The notice of appeal and supporting documentation shall be sent to:

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

REFERRING RECIPIENTS TO CLIENT MEDICAL MANAGEMENT

DMAS providers may refer Medicaid patients 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/or pharmacy in the Client Medical Management Program (CMM). 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) 786-6548
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.

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 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
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Telephone: (804) 692-0480

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 and/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 and/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 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 12 months beginning with the month of the fraud conviction. The sanction period may only be revoked or shortened by court order.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Telephone: (804) 786-0156