CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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TABLE OF CONTENTS

	Page
Review and Evaluation	1
Purpose of Utilization Review	1
Assessment and Authorization of Services	2
Admission Certification for Assisted Living Services	2
Ongoing Monitoring for Assisted Living Services	3
Responsibilities of the Assisted Living Facility for Monitoring of Recipient Services	3
Responsibilities of the Licensed Health Care Professional for Monitoring of Recipient Services	4
Responsibilities of the Public Case Manager for Monitoring of Recipient Services	4
Ongoing Monitoring for Assisted Living Services by VDSS Division of Licensing Programs	5
Ongoing Monitoring by DMAS for Assisted Living Services	5
Appeals of Level of Care Decisions	6
Financial Review and Verification	6
Exit Conference	7
Request for Corrective Action	8
Fraudulent Claims	8
Provider Fraud	8
Recipient Fraud	9

CHAPTER VI

UTILIZATION REVIEW AND CONTROL

REVIEW AND EVALUATION

Under the provisions of federal regulations in 42 CFR 441, Subpart-G (§§ 441.300 - 441.310), DMAS must provide for the continuing review and evaluation of the care and services paid through Medicaid, including review of the utilization of the services of providers and by recipients.

The Department of Social Services' (VDSS') Division of Licensing Programs is responsible for monitoring each assisted living facility's adherence to licensure standards which provide the basis for Department of Medical Assistance Services (DMAS) provider participation standards. In addition, DMAS will periodically conduct audits of services billed to DMAS and interview recipients to ensure that services are being provided and billed in accordance with DMAS policies and procedures. A facility's non-compliance with DMAS policies and procedures will result in a written request from DMAS for a corrective action plan which details the steps the facility will take and the length of time permitted to achieve full compliance with DMAS regulations, policies, and procedures. (See Chapter II: "Provider Participation Requirements" for details.) DMAS will review the corrective action plan for approval.

Providers will be required to reimburse DMAS if they are found to have billed DMAS contrary to policy or failed to maintain records to support their claims. DMAS may limit, suspend, or terminate the provider's contract with DMAS due to the provision of poor quality services or of any of the above problems.

PURPOSE OF UTILIZATION REVIEW

The purpose of utilization review is to determine whether services are needed, or continue to be needed, and the amount and kind of services required. Utilization review is mandated to ensure that the health, safety, and welfare of the recipient are protected and addresses quality of care, appropriateness of care, level of care, and cost-effectiveness. The recipient's plan of care, known as the Individualized Service Plan (ISP), is the fundamental tool by which DMAS will ensure the health and welfare of publicly funded individuals residing in ALFs.

Through the assessment and authorization process, DMAS ensures that individuals are placed appropriately in assisted living facilities. Through the ongoing monitoring of the recipient's plan of care by the licensed health care professionals, public case managers, and the facility staff, DMAS ensures that all services continue to be needed and the appropriate amount and kind of services are provided. Onsite visits by DMAS ensure that the recipient participates in and is satisfied with the care provided and that the ALF has the proper documentation to support the claims for services.

ASSESSMENT AND AUTHORIZATION OF SERVICES

Utilization review or prior authorization for assisted living services is a two-step process which ensures that appropriate placement is made. First, services will be offered only to individuals who have been certified eligible for assisted living services by an assessor responsible for completing the Uniform Assessment Instrument (UAI) and authorizing admissions to the ALF. Second, the assisted living provider must submit admission certification information to DMAS to indicate what services will be provided to the individual, as documented on the ISP. All authorizations and individualized service plans for assisted living services are subject to the approval of DMAS prior to Medicaid payment.

Only DMAS approved assessors and case managers can perform assessment and authorization services. DMAS reviews all submitted documentation upon receipt to ensure accuracy and that the UAI and Long-Term Care Preadmission Screening Authorization form (DMAS-96) are completed in their entirety. DMAS will return to the assessment agency any documentation that is incomplete.

Providers of publicly funded assisted living services must have written authorization from DMAS in order to bill for assisted living. Each assisted living services provider must have an "authorization to bill" letter for each assisted living recipient for whom DMAS has been or will be billed for services.

Admission Certification for Assisted Living Services

Only providers licensed by VDSS for assisted living and enrolled with DMAS as an assisted living provider can provide publicly funded assisted living services. It is the assisted living provider's responsibility to determine whether the facility can adequately provide service to an individual prior to accepting a referral for service. The services that the facility will provide the individual must be documented on the ISP. The provider will submit this ISP, along with the Long-Term Care Preadmission Screening Authorization form (DMAS-96), to DMAS for authorization to bill DMAS for assisted living services. DMAS will return to the assisted living facility any documentation that is incomplete.

At a minimum, this process requires that the ALF submit the following documents:

- A copy of the Medicaid Long-Term Care Preadmission Screening Authorization form (DMAS-96) from the initial assessment for eligible individuals who were already residing in the ALF as of August 1, 1996, or from the pre-admission screening for those who have been admitted since that date, and

- A copy of the completed Individualized Service Plan (ISP) signed and dated by the ALF representative. The information on the ISP must include:

    - The facility's name and seven-digit Medicaid provider identification number, and

- The recipient's name and 12-digit Medicaid identification number, and the start of care/admission date.
- The start of care/admission date to the ALF or the new level of care. (Start of care dates cannot predate August 1, 1996).
- This ISP must include the services that are needed by the individual recipient as well as address how those service needs will be met.

Admission Certification Packages must be addressed and mailed for processing to:

Assisted Living Admission Certification
Facility and Home Based Services Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

ONGOING MONITORING FOR ASSISTED LIVING SERVICES

Ongoing monitoring for assisted living services is provided by a variety of sources, including but not limited to: the assisted living facility, the licensed health care professional, and the public case managers.

Responsibilities of the Assisted Living Facility for Monitoring of Recipient Services

The assisted living facility must comply with the standards and regulations of the VDSS Division of Licensing Programs. The assisted living facility must know the criteria for the levels of care in an ALF and is responsible for arranging for the discharge of the resident whenever a resident does not meet, either upon admission or at any later time, the criteria for level of care for which the ALF is licensed.

The ALF is responsible for monitoring the ongoing provision of services to each recipient. This includes:

- The quality of care provided by the ALF;
- The functional and medical needs of the individual and any modification necessary to the ISP due to a change in these needs; and
- The individual's need for support in addition to care provided by the facility. This includes an overall assessment of the individual's safety and welfare in the facility.

The ALF staff is responsible for following the ISP, notifying the licensed health care professional of any change in condition or support or problem that arises, and documenting the performance of duties in the recipient's record. The ALF staff must document in the recipient's record the specific services delivered to the recipient and the recipient's

response. ALF staff comments must include observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to the services rendered.

Responsibilities of the Licensed Health Care Professional for Monitoring of Recipient Services

Each ALF must retain a licensed health care professional, either by direct employment or on a contractual basis, to provide health care oversight to its assisted living residents. The licensed health care professional, acting within the scope of the requirements of his or her profession, must be on-site at least quarterly and more often, if indicated, based on his or her professional judgment of the seriousness of a resident's needs or the stability of a resident's condition for regular assisted living residents**. On-site visits by the licensed health care professional are required at least monthly for intensive assisted living residents.**

The licensed health care professional must participate in the development and monitoring of the resident's ISP. It is the ALF's responsibility to ensure that this licensed health care professional is onsite and follows the policies and procedures in the VDSS and DMAS regulations. In addition, DMAS will monitor this requirement and return the ISP to facilities when it is not clear whether the licensed health care professional participated in the development of the plan for services as required. Incomplete documentation may cause a delay in or denial of DMAS approval of payment for assisted living services.

Responsibilities of the Public Case Manager for Monitoring of Recipient Services

There are two types of Medicaid-funded case management services for assisted living residents which provide a formal monitoring process for ensuring that placement is appropriate and public funds payment is still warranted: 1) twelve-month reassessment only; or 2) ongoing targeted ALF case management.

The purpose of the twelve-month reassessment is the re-evaluation of the service need and utilization review. The outcome of this review is communicated to DMAS, as well as the LDSS eligibility staff, the facility, and the resident. Based upon this review, the case manager may authorize the same level of care, a different level of care, or the need for discharge.

The purpose of ongoing Medicaid-funded targeted case management services is to assist the ALF with residents who require coordination of multiple services, who are not able and do not have other support available to assist in coordination of and access to services or problem resolution, and who need a level of coordination that is beyond what the ALF can reasonably be expected to provide. The case manager will develop a plan of care that addresses the needs on the UAI that cannot be provided by the ALF. This case manager will monitor the services provided from his or her plan of care and ISP at least quarterly.

ONGOING MONITORING FOR ASSISTED LIVING SERVICES BY VDSS DIVISION OF LICENSING PROGRAMS

The purpose of the VDSS Division of Licensing Programs is to promote the safety, health, and well-being of children and adults in day and residential programs. This includes the licensing and ongoing monitoring of ALFs. The Division's goal is preventive consumer protection through enabling good care.

Licensing services are delivered from eight field offices across the state. Each ALF is assigned a Licensing Specialist who visits twice annually to monitor the care being provided and to evaluate the facility's compliance with state standards. Licensing Specialists provide consultation and technical assistance to providers and help connect facilities with other community resources.

In addition, all facility complaints are investigated, even if they are anonymous. When care issues and noncompliance with regulations are found, unless there is an immediate risk to those in care, the facility is given the opportunity to present a plan for making needed corrections within a specified time frame. Uncorrected compliance issues from routine monitoring or from complaint investigations can result in sanctions or penalties such as reducing capacity, restricting or prohibiting new admissions, denying renewal of a license, or revoking a license that has been issued.

The Division of Licensing Programs also promotes protection and provides support to ALFs through a newsletter, technical assistance materials, and provider training and workshops.

ONGOING MONITORING BY DMAS FOR ASSISTED LIVING SERVICES

DMAS staff conduct utilization review of admission certification documentation submitted by the provider which shows the recipient's needs and available social supports, and analysts conduct on-site reviews of the ALF's recipient records and interview ALF staff and recipients in the ALF, either in person, via telephone call, or a written communication.

During the on-site review, the analyst will be available to offer technical assistance and consultation to the ALF regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and assistance. Any issues which, if uncorrected, might result in termination of the provider contract will be presented to the ALF in writing. In addition, the analyst will closely monitor the following information during the on-site utilization review process:

- All current and prior UAIs and authorization forms (Long-Term Care Preadmission Screening Authorization form [DMAS-96]) must be in the recipient's record;

- The ISP must be in the recipient's record and must be current, appropriate to the recipient's needs, and have the appropriate participation of the licensed health care professional;

- All written communication related to the provision of care between the facility and the assessor, case manager, licensed health care professional, DMAS, VDSS, the recipient, or other related parties. Staff notes must be in the recipient's record promptly after contact is made with the recipient. Any relevant contacts not documented and present in the recipient's record will be considered as not having been made and may result in retraction of payment; and

- Log verifying dates the recipient was actually in the ALF.

Appeals of Level of Care Decisions

Any change in the level of care decision made by the utilization review team may be appealed to the Department of Medical Assistance Services. This decision may only be appealed by the recipient or responsible party. All appeals must be filed within 30 days of the receipt of notification of the final decision. However, for Medicaid to continue payment until the appeal decision is rendered, the appeal must be filed within 10 days. Recovery of any Medicaid payment of the care provided during the appeal process will be the responsibility of the recipient or his or her responsible party if the decision is sustained. Appeals should be directed to:

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

Once the appeal is received by the Division of Recipient Appeals, the recipient or the responsible party is notified as to whether the appeal is valid or not. If the appeal is valid, a hearing date is scheduled (usually in the locality of the facility), and the hearing is conducted by a DMAS Hearing Officer accompanied by a court reporter who provides a transcript of the hearing. Following the hearing, a summary of the case, the Hearing Officer's evaluation, and the Hearing Officer's recommendation are sent to the recipient or responsible party for review. If the recipient or responsible party disagrees with the Hearing Officer's decision, the information will be sent to the DMAS Administrative Law Judge for the final evaluation.

Unless waived by the recipient, all appeals will be heard within 90 days of the date the appeal was received in the Division of Recipient Appeals.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to assure that the ALF bills only for those services which have been provided and which are covered by the DMAS Assisted Living Services Program. Any paid ALF claims which cannot be verified at the time of utilization review cannot be considered valid for services provided.

Verification of days of service by each recipient will be maintained on a log which documents each day that the recipient is present in the facility. DMAS payment of the per

diem fee is limited to the days in which the recipient is physically present in the facility. Therefore, DMAS will not pay the facility for days the recipient is in the hospital or temporarily away from the facility.

The utilization review analyst will send a letter of utilization review findings to the ALF. Attached to the letter will be a billing problem form listing over-billed and incorrectly billed patient pay amounts found at the time of utilization review and the corrective action the ALF needs to take.

The ALF must submit an adjustment as indicated within 30 days of the receipt of this form. If an adjustment is not received within 30 days, a reminder will be sent to the ALF and an additional 30 days will be allowed for adjustment of overpaid funds. If at the end of this period no adjustment has been made, DMAS will initiate a demand letter that requires adjustment of overpaid funds be made within 21 days. Failure to respond to this demand letter will result in DMAS recovery of funds from future ALF remittances. Referral to the DMAS Post-Payment Review Section may be made.

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate pursuant to the Code of Virginia, § 32.1-313.1. Interest will not apply pending appeal.

Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

EXIT CONFERENCE

Following the DMAS analyst's review of the records and home visits, the analyst will meet with the appropriate ALF staff to discuss findings from the reviews. **The ALF must provide appropriate staff (as requested by the analyst) for this meeting.**

The exit conference may include information regarding the following: the number of records reviewed, recommendations regarding level of care change, recommendations regarding changes in ISPs, and any pertinent information regarding documentation, service verification issues, quality of care, or provision of services. The analyst will send a letter to the ALF verifying that the review was conducted and describing findings from the review.

The ALF must utilize the findings of the utilization review analyst to comply with regulations, policies, and procedures in the future. Records that have been reviewed must not be altered to meet the compliance issues.

During the review process, the analyst will be available to offer technical assistance and consultation to the ALF regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and assistance. Any issues regarding retraction or which might result in termination of the provider contract will be presented in writing within two weeks.

REQUEST FOR CORRECTIVE ACTION

Repeated failure to comply with DMAS regulations, policies, and procedures will result in a corrective action letter to the ALF. A corrective action letter cites to the ALF those areas which have been found to be out of compliance and requests that a corrective plan of action be submitted to DMAS within a specified time-period. This plan must address all the areas cited in the corrective action letter with time frames indicated within which corrective action will be taken. The ALF will be monitored closely during subsequent utilization reviews. If improvement is not made in areas cited, DMAS may move to terminate the ALF's contract.

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.

Submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony. DMAS 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
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 and 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 or civil litigation or by 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 Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-0156
FAX: (804) 225-4393