~~CHAPTER VI~~

~~UTILIZATION REVIEW AND CONTROL~~

CHAPTER VI
TABLE OF CONTENTS

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REVIEW AND EVALUATION

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 of providers and by recipients. This function is handled by the Division of Program Compliance of the Department of Medical Assistance Services.

Provider and recipient utilization patterns to be reviewed are identified either from computerized exception reports or by referrals from agencies or individuals. Computerized exception reports for providers are developed by comparing an individual provider's billing activities with those of the provider peer group. Exception reports for recipients are developed by comparing individual recipient's medical services utilization with those of the recipient peer group. For recipients and providers who exceed the peer group averages by at least two standard deviations, an exception report for this activity is generated.

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

The use of statistical sampling is recognized as a valid basis for findings of fact in the context of Medicaid reimbursement. The Department utilizes a scientific random sample of paid claims for a 15-month audit period to calculate any excess payment. The number and amount of invalid dollars paid in the audit sample is compared to the total number and amount of dollars paid for the same time period, and the total amount of the overpayment is estimated from this sample.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to policy, 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 limit, suspend, or terminate the provider's participation agreement.

Providers selected for review will be contacted directly by DMAS personnel with detailed instructions. This will also apply when information is requested about a recipient or when a recipient is restricted to the physician and/or pharmacy of his choice because of misutilization of Medicaid services.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid

provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

CLIENT MEDICAL MANAGEMENT PROGRAM

The Department of Medical Assistance Services (DMAS) is required by 42 CFR 456.3, Subpart A, to implement a statewide surveillance and utilization control program.

Recipient Restriction

The Client Medical Management Program for recipients is a utilization control program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. Federal regulations in 42 CFR 431.54 (e) allow states to restrict recipients to designated providers when the recipients have utilized services at a frequency or amount that is not medically necessary. State regulations in VR 460-04-8.3 allow DMAS to institute procedures to control excessive and inappropriate utilization of services by Medicaid recipients. Restricted recipients are identified and managed by the Recipient Monitoring Unit in the Division of Program Compliance.

Under the Client Medical Management Program, Medicaid will pay for covered outpatient medical and pharmaceutical services only when they are provided by the designated providers, by physicians seen on written referral from the designated primary health care provider (including covering physicians), and in a medical emergency. A medical emergency means that a delay in obtaining treatment may cause death or lasting injury or harm to the recipient.

Prescriptions may be filled by a non-designated pharmacy only in urgent situations (e.g., insulin or cardiac medications) or when the designated pharmacy is closed, does not stock, or is unable to obtain the drug. Payment for covered outpatient services will be denied in all other instances, and the recipient may be billed for the services. The primary care providers bill Medicaid in the usual manner, but non-designated providers must follow special billing instructions (see Billing Instructions in Chapter V).

Recipients placed in the restriction program receive a letter explaining the recipient/provider relationships under medical management. They are given directions for completing and returning the Recipient/Primary Provider Agreement form to the Recipient Monitoring Unit. Recipients are asked to select a primary health care provider who will provide routine medical care and make medically necessary referrals to specialists. They must also select one pharmacy to fill their prescriptions. The recipient and the provider must mutually agree upon the relationship and sign the agreement form. If the recipient does not select a primary health care provider and pharmacy, designated providers will be selected by the Recipient Monitoring Unit.

Restriction is for 18 months. The restricted recipient receives an individual Medicaid card with the names and DMAS provider numbers of the designated primary health care provider and designated pharmacy printed on it. The recipient or designated provider may initiate a request for a change of a designated provider by contacting the Recipient Monitoring Unit. All changes must be preauthorized by DMAS.

Provider Restriction

Federal regulations in 42 CFR 431.54 (f) allow states to restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally recognized standards of health care. State regulations in VR 460-04-8.3 allow DMAS to restrict providers' participation as designated providers for restricted recipients when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.

Any pharmacy enrolled as a community pharmacy billing on the Daily Drug Claim Ledger may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.

Any physician enrolled as an individual practitioner may serve as a designated primary care provider except when:

- The physician's practice is limited to the delivery of emergency room services; or
- The physician has been notified by DMAS that he or she may not serve as a designated provider.

Provider restriction is for 18 months. Providers may appeal any proposed restriction in accordance with the Code of Virginia, Section 9-6.14:11 et seq., as discussed in Chapter II of this manual. Restriction is not implemented pending the result of a timely appeal request.

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 signature or the signature of his 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 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 Compliance
Department of Medical Assistance Services
600 E. 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
Supreme Court Building
101 North Eighth Street
Richmond, Virginia 23219

Recipient Fraud

Investigations of allegations of recipient fraud are the responsibility of the Medicaid Recipient Fraud Unit, Division of Program Compliance, of the Department of Medical Assistance Services. Recipient records are available to personnel from that unit for investigative purposes. Referrals should be made to:

Recipient Fraud and Recovery Unit
Division of Program Compliance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219