COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **Emily McClellan**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **Abrar Azamuddin**
Assistant Attorney General
Office of the Attorney General

DATE: **June 5, 2019**

SUBJECT: **Final Regulations Regarding Utilization Review, 12 VAC 30-60-5 & 12 VAC 30-141-570**

I am in receipt of the attached regulations to adopt regulations concerning utilization review. You have asked the Office of the Attorney General to review and determine if Department of Medical Assistance Services has the statutory authority to promulgate these regulations and if they comport with applicable state law.

Virginia Code § 32.1-325 authorizes the Board of Medical Assistance Services to promulgate regulations as may be necessary to carry out the provisions of the state plan. Virginia Code § 32.1-324 authorizes the Director of the Department of Medical Assistances with the Board's authority when it is not in session. It is this Office's view that the Director has the authority to promulgate the final regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and Executive Order 14 (2018), and has not exceeded that authority.

Please note that Virginia Code § 2.2-4013(B) requires that all changes to the proposed regulation be highlighted in the final regulations. If you have any questions or need additional information about these regulations, please contact me at 786-6004.

cc: Kim F. Piner, Esq.
Attachment

Final Text

Action: Utilization Review Changes

Stage: Final 1/30/19 3:28 PM [latest]

12VAC30-60-5. ~~Applicability of utilization~~ Utilization review ~~requirements~~.

A. ~~These utilization~~ The requirements in this section shall apply to all Medicaid covered services and all Medicaid providers unless otherwise specified.

1. Providers shall be required to maintain documentation detailing all required information about the individuals who are in the provider's care. Such documentation shall fully disclose the extent of services provided in order to support the provider's claims for reimbursement for services rendered. All provider documentation about individuals in the provider's care shall be written, signed, and dated [~~at the time the services are rendered~~] .

2. Medicaid providers shall provide all requested records to DMAS or its designee immediately upon demand or upon a timeframe specified in writing by DMAS or its designee.

3. Notwithstanding any other DMAS regulation, claims selected for utilization review shall not be corrected or re-billed.

B. DMAS or its designee shall perform utilization reviews of all [fee-for-service] Medicaid services.

1. A utilization review is initiated when DMAS or its designee:

a. Issues a written notice;

b. Requests [~~onsite~~] access to records; [or]

[~~c. Issues a preliminary findings letter; or~~]

[~~d.~~ c.] Commences a claims analysis.

2. After a utilization review is initiated, DMAS or its designee shall issue a preliminary findings letter. The preliminary findings letter shall include a date by which the provider may submit any additional documentation. DMAS or its designee shall only consider documentation identified and submitted by the provider prior to the specified deadline. DMAS or its designee shall only consider documentation that was created contemporaneously with the date of service.

3. Following a review of documentation submitted according to subdivision 2 of this subsection, if any, DMAS or its designee shall issue a final overpayment letter.

4. Providers who are determined not to be in compliance with DMAS requirements shall be [~~subject to §§ 32.1-312 and 32.1-313 of the Code of Virginia, 12VAC30-80-130, and 12VAC30-90-250 through 12VAC30-90-257 for the repayment of any overpayments to DMAS that are~~ required to pay the overpayment amount] identified in the final overpayment letter.

~~B.~~ C. Some Medicaid ~~covered~~ services require an approved service authorization prior to service delivery in order for reimbursement to occur. ~~1.~~ To obtain service authorization, all providers' information supplied to the Department of Medical

Assistance Services (DMAS), service authorization contractor, or the behavioral health service authorization contractor shall be fully substantiated throughout individuals' medical records. ~~2. Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in providers' care. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. This documentation shall be written, signed, and dated at the time the services are rendered unless specified otherwise.~~

~~C. DMAS, or its designee, shall perform reviews of the utilization of all Medicaid covered services pursuant to 42 CFR 440.260 and 42 CFR Part 456.~~

~~D. DMAS shall recover expenditures made for covered services when providers' documentation does not comport with standards specified in all applicable regulations.~~

~~E. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.~~

~~F.~~ D. Utilization review requirements specific to the community mental health services~~, as set out~~ in 12VAC30-50-130 and 12VAC30-50-226~~,~~ shall be as follows:

1. To apply to be reimbursed as a Medicaid provider, the required Department of Behavioral Health and Developmental Services (DBHDS) license shall be either a full, annual, triennial, or conditional license. Providers must be enrolled with DMAS or the [~~BHSA~~ behavioral health service authorization contractor] to be reimbursed. Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS requires, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.

2. Health care entities with provisional licenses shall not be reimbursed as Medicaid providers of community mental health services.

3. Payments shall not be permitted to health care entities that either hold provisional licenses or fail to enter into a Medicaid Provider Enrollment Agreement for a service prior to rendering that service.

4. The behavioral health service authorization contractor shall apply a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual Criteria, or an equivalent standard authorized in advance by DMAS. Services that fail to meet medical necessity criteria shall be denied service authorization.

12VAC30-141-570. Utilization control - State Children's Health Insurance Program.

A. Each ~~MCHIP~~ managed care health insurance program shall implement a utilization review system as determined by contract with DMAS, or administered by DMAS.

B. For the fee-for-service program, DMAS shall use the utilization controls already established and operational in the State Plan for Medical Assistance, including those specified in 12VAC30-60-5.

C. DMAS may collect and review comprehensive data to monitor utilization after receipt of services.