CHAPTER VI

UTILIZATION REVIEW AND CONTROL

MANUAL TITLE: PSYCHIATRIC SERVICES MANUAL

CHAPTER 6, UTILIZATION REVIEW AND CONTROL REVISION DATE: 12/7/2023

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INTRODUCTION

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 by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) or its designated contractor(s) conducts periodic utilization reviews on all programs. In addition, DMAS or its designated contractor(s) conducts compliance reviews on providers that are found to provide services that are not within the established Federal or State codes, DMAS guidelines, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that Participation Agreement, contracts, state and federal regulations, Medicaid Memos and Provider Manual requirements for services rendered are met in order to receive payment from DMAS and its contractors. Under the Participation Agreement/contract with DMAS, Magellan of Virginia and the Medicaid Managed Care Organizations (MCOs) the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives or its designated contractor(s), 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 procedures conducted by DMAS. The MCOs conduct audits for services provided to Members enrolled in Managed Care. Providers shall contact the specific MCO for information about the utilization review and control procedures conducted by the MCO.

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.

COMPLIANCE REVIEWS

DMAS or its designated contractor(s) routinely conduct compliance reviews to ensure that the services provided to Medicaid individuals 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 individuals are 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 peer group.

To ensure a thorough and fair review, trained professionals review all cases using available resources, including appropriate consultants, and perform on-site or desk reviews.

Overpayments will be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by DMAS, the Behavioral Health Services Administrator (BHSA) or the MCOs if they are found to have billed these entities contrary to law or manual requirements, 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, DMAS, the BHSA or the MCOs may restrict or terminate the provider's participation in the program.

DMAS contracts with Health Management Systems, Inc. (HMS) to perform audits of FFS Mental Health Services in-state and out-of-state providers that participate in the Virginia Medicaid program. DMAS will also continue to audit mental health services as well. Providers that have been audited by HMS and have questions directly pertaining to their audit may contact HMS at: VABH@HMS.com

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/herself 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, understanding, and adhering to applicable state and federal regulations, Medicaid Memos, their provider agreement with DMAS or its contractor, 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/her signature or the signature of his/her authorized agent on each invoice that all information provided to DMAS and its contractors is true, accurate, and complete. If provider attests to having all required licensed as required they must be able to furnish such documentation. Although claims may be prepared and submitted by an employee or contracted business partner, 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:

Department of Medical Assistance Services
Division of Program Integrity
Supervisor, Provider Review Unit
600 East Broad Street
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:

Office of the Attorney General
Director, Medicaid Fraud Control Unit
202 North Ninth Street
Richmond, Virginia 23219

Member Fraud

Allegations about fraud or abuse by Medicaid enrolled individuals are investigated by the Recipient Audit Unit of the DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, 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 twelve months beginning with the month of fraud conviction. The sanction period may only be revoked or shortened by court order.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (LDSS) or to the DMAS Recipient Audit Unit via the RAU Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the RAU email address: recipientfraud@dmas.virginia.gov or forwarded to:

Department of Medical Assistance Services
Division of Program Integrity
Recipient Audit Unit
600 East Broad Street
Richmond, Virginia 23219

PATIENT UTILIZATION AND MANAGEMENT SAFETY PROGRAMS (PUMS)

The DMAS contracted MCOs must have a Patient Utilization Management & Safety Program (PUMS) for MCO enrolled members which is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and care coordination program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the MCO must refer members to appropriate services based upon the member's unique situation.

Once a Member meets the placement requirements for PUMS, the MCO may limit a member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO may limit a member to providers and pharmacies that are credentialed in their network.

If the member changes MCOs while the member is enrolled in a PUMS, the receiving MCO must re-evaluate the member within thirty (30) calendar days to ensure the member meets the minimum criteria above for continued placement in the health plan's PUMS.

UTILIZATION REVIEW – GENERAL REQUIREMENTS

Utilization reviews of enrolled providers are conducted by DMAS, the designated contractor or the MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

Utilization reviews are comprised of desk audits, on-site record review, and may include observation of service delivery and review of all provider policies and procedures and human resource files. Dependent upon the setting, the utilization review may also include a tour of the program. Staff will visit on-site or contact the provider to request records. Utilization Review may also include face-to-face or telephone interviews with the individual, family, or significant other(s), or all. In order to conduct an on-site review, providers may also be asked to bring program and billing records to a central location within their organization. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

DMAS and the MCOs shall recover expenditures made for covered services when providers' documentation does not conform to standards specified in all applicable regulations. 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.

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider’s care. Such documentation shall fully disclose the extent of services provided in order to support provider’s claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered or within one business day from the time the services were rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

The review will include, but is not limited to, the examination of the following areas / items:

- If a provider lacks a full or conditional license or a provider enrollment agreement does not list each of the services provided and the locations where the provider is offering services, then during a utilization review the provider will be subject to retraction for all unlisted service and/or locations.
- Health care entities with provisional licenses shall not be reimbursed by Medicaid.

- An assessment of whether the provider is following The U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009).
- An assessment of whether the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.).
- The appropriateness of the admission to service and for the level of care, and medical or clinical necessity of the delivered service.
- A copy of the provider's license/certification, staff licenses, and qualifications to ensure that the services were provided by appropriately qualified individuals and licensed facilities.
- Verification that the delivered services as documented are consistent with the documentation in the individual's record, invoices submitted, and specified service limitations.
- The reviewer determines that all documentation is specific to the individual and their unique treatment needs. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient services and may not be adequate recordkeeping mechanisms for these services.
- The reviewer determines whether all required aspects of treatment (as set forth in the service definitions) are being provided, and also determines whether there is any inappropriate overlap or duplication of services.
- The reviewer determines whether all required activities (as set forth in the appropriate sections of this manual and related regulations) have been performed.
- The reviewer determines whether inappropriate items have been billed.
- The reviewer determines whether the amount billed matches the documented amount of time provided to the individual.

Services must meet the requirements set forth in the Virginia Administrative Code (12 VAC 30) and in the Virginia State Plan for Medical Assistance Services and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

Upon completion of on-site activities for a routine utilization review, the MCO, DMAS, or its designated contractor(s) may be available to meet with provider staff for an Exit

Conference. The purpose of the Exit Conference is to provide a general overview of the utilization review procedures and expected timetables.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be noted. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting medical record documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, DMAS or its designated contractor(s) will contact the provider to conduct an Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the provider.

If a billing adjustment is needed, it will be specified in the final audit findings report.

If the provider disagrees with the final audit findings report, they may appeal the findings. Refer to Chapter II for information on the provider appeal process.

MEDICAL RECORDS AND RETENTION

The provider 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 Medicaid covered services must be retained for not less than five years after the date of service or 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 482.24 for additional requirements.

The provider 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. All medical record entries must be fully signed,

and dated (month, day, and year) including the title (professional designation) of the author. Documentation should be clear and legible.

DOCUMENTATION AND UTILIZATION REVIEW REQUIRMENTS FOR PSYCHIATRIC SERVICES

Documentation Requirements for Supervision

When plans of care and psychotherapy or counseling services are provided by one of the following: "Residents" under supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10) or licensed substance abuse treatment practitioner (18VAC115-60-10) approved by the Virginia Board of Counseling; "Residents in psychology" under supervision of a licensed clinical psychologist approved by the Virginia Board of Psychology (18VAC125-20-10); "Supervisees in social work" under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work (18VAC140-20-10), to support the billing of these services, the licensed supervisor must ensure that:

- Therapy or counseling sessions rendered by a Resident or Supervisee must be provided under the direct, personal supervision of a qualified, Medicaid enrolled provider.
- The therapy session documentation must contain at a minimum the dated signature of the Resident or Supervisee rendering the service but also include the dated signature of the qualified, Medicaid enrolled, licensed supervising provider.
- Each therapy session must contain the dated co-signature of the supervising provider within one business day from the date the service was rendered indicating that they have reviewed the documentation. The direct supervisor can be the licensed program supervisor/manager for the agency.

INPATIENT ACUTE CARE

General Acute Care Hospital Audits

The audits for General Acute Care Hospitals for an admission related to a psychiatric diagnosis shall consist of the following:

1. The general hospital's Utilization Management Plan to determine compliance with the regulations found in 42 CFR §§ 456.100 through 456.145.

2. List of current Utilization Management Committee members and physician advisors to determine that the Committee's composition is as prescribed in the 42 CFR §§ 456.105 through 456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and lists of attendees to determine that the Committee is meeting according to its utilization management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR §§ 456.141 through 456.145.

5. Topic of one ongoing Medical Care Evaluation Study to determine if the hospital is in compliance with the 42 CFR § 456.145.

6. From a list of randomly selected paid claims, the hospital must provide a copy of the physician admission certification, recertification if applicable, and written plan of care for each selected stay to determine the hospital's compliance with 42 CFR §§ 456.60 and 456.80. If any of the required documentation does not meet the requirements found in the 42 CFR §§ 456.60 through 456.80, reimbursement may be retracted.

7. The hospital may appeal in accordance with the *Administrative Process Act* (§§ 2.2- 4000 et seq., of the Code of Virginia) and the provider appeal regulations (12VAC 30–20–500 et. seq.) any adverse decision resulting from such audits, which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.

In addition to general documentation requirements, all medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This includes, but is not limited to, orders, progress notes, procedure notes, patient assessments, history and physicals, treatment interventions, and any other service or treatment provided.

Free-Standing Psychiatric Hospital Audits

In each case for which payment for free-standing psychiatric hospital services is made under the State Plan:

1. A physician must certify at the time of admission, or at the time the hospital is notified of an individual’s retroactive eligibility status, that the individual requires or required inpatient services in a free-standing psychiatric hospital

consistent with 42 CFR Section 456.160.

2. The physician, or physician assistant, or nurse practitioner, acting within the scope of practice as defined by state law and under the supervision of a physician, must recertify, at least every 60 days that the individual continues to require inpatient services in a free-standing psychiatric hospital.
3. Before admission to a free-standing psychiatric hospital or before authorization for payment, the attending physician must perform a medical evaluation of the individual and appropriate professional personnel must complete a psychiatric and social evaluation as cited in 42CFR 456.170.
4. Before admission to a free-standing psychiatric hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each individual as cited in 42CFR 441.155 and 456.180. The plan shall also include a list of services provided under written contractual arrangement with the free-standing psychiatric hospital that will be furnished to the individual through the free-standing psychiatric hospital's referral to an employed or contracted provider, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought.

The audits for free-standing psychiatric hospitals shall consist of a review of the following:

a. The free-standing psychiatric hospital's Utilization Management Plan to determine compliance with the regulations found in 42 CFR Sections 456.200 through 456.245.

b. List of current Utilization Management Committee members and physician advisors to determine that the Committee's composition is as prescribed in 42 CFR Sections 456.205 through 456.206.

c. Verification of Utilization Management Committee meetings, including dates and list of attendees to determine that the Committee is meeting according to their Utilization Management meeting requirements.

d. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR Sections 456.241 through 456.245.

e. Topic of one on-going Medical Care Evaluation Study to determine that the hospital is in compliance with 42 CFR Section 456.245.

f. From a list of randomly selected paid claims, the free-standing psychiatric hospital must provide a copy of the certification for services; a copy of the physician admission certification for services, independent team certification if applicable; a copy of the required medical, psychiatric, and social evaluations; and the plan of care for each selected stay to determine the hospital's

compliance with the *Code of Virginia* Sections 16.1-335 through 16.1-348 and 42 CRF Sections 441.152, 456.160, and Sections 456.180 through 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may be retracted.

g. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a free-standing psychiatric hospital consistent with 42 CFR Section 456.160.

h. The physician, or physician assistant, or nurse practitioner, acting within the scope of practice as defined by state law and under the supervision of a physician, must recertify, at least every 60 days that the individual continues to require inpatient services in a free-standing psychiatric hospital.

i. Validation of documentation received during the preauthorization process.

j. All required provision of services must be fully documented in the medical record.

k. Compliance with restraint and seclusion regulations will be reviewed (42 CFR §§ 483.350 – 483.376).

For services provided under arrangement, the free-standing psychiatric hospital shall not receive a per diem reimbursement for any day that:

- The initial or comprehensive written plan of care fails to include within three business days of the initiation of the service provided under arrangement all services that the individual needs while at the free-standing psychiatric hospital and that will be furnished to the individual through the free-standing psychiatric hospital's referral to an employed or contracted provider of services under arrangement;

- The comprehensive plan of care fails to include within three business days of the initiation of the service the prescribed frequency of such service or includes a frequency that was exceeded;

- The comprehensive plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;

- The referral to the service provided under arrangement was not present in the patient's free-standing psychiatric hospital record;

- The service provided under arrangement was not supported in that provider's records by a documented referral from the free-standing psychiatric hospital;

- The medical records from the provider of services under arrangement (i.e., admission and discharge documents, plans of care, progress notes, treatment summaries, and documentation of medical results and findings) (i) were not present in the patient's free-standing psychiatric hospital record or

had not been requested in writing by the free-standing psychiatric hospital within seven days of completion of the service or services provided under arrangement or (ii) had been requested in writing within seven days of completion of the service or services, but had not been received within 30 days of the request, and had not been re- requested; or

- The free-standing psychiatric hospital did not have a fully executed contract or an employee relationship with the provider of services under arrangement in advance of the provision of such services. For emergency services, the free-standing psychiatric hospital shall have a fully executed contract with the emergency services hospital provider prior to submission of the provider's claim for payment.

For services provided under arrangement, the provider of services under arrangement shall be required to reimburse DMAS or its designee for the cost of any such service billed prior to receiving a referral from the free-standing psychiatric hospital or in excess of the amounts in the referral.

Absence of any of the required documentation for either free-standing psychiatric hospitals or acute care hospitals may result in retraction of payment. Services not documented in the individual's record as having been provided will be determined not to have been provided, and may result in retraction of payment.

Utilization Review Process

DMAS or its contractors conduct utilization review audits on providers of inpatient psychiatric services for Medicaid individuals within free-standing psychiatric hospitals and acute care psychiatric hospitals. These audits are conducted to determine that the provider is in compliance with the regulations found in 42 CFR, Section 456.150 and 42 CFR, Section 456.50-456.145. These audits can be performed either on-site or as a desk audit. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

Criteria for Reimbursement

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

Medicaid criteria for reimbursement of inpatient psychiatric services are found throughout the provider manual and include, but are not limited to:

- A Pre-Admission Screening Report, signed by the required team members, with a recommendation to admit the individual to inpatient services and an indication of why community resources do not meet the individual's needs;

- Certificate of need or independent team certification for admission that is completed and dated prior to admission and the request for authorization;
- Provision of all ordered services in the individual's written plan of care by qualified professionals;
- Written Plan of Care completed by specified professionals and addressing the components listed in Chapter IV of this manual;
- Timely review of the written Plan of Care;
- Dated signatures of qualified service providers on all medical documentation; and
- Medical records sufficient to document fully and accurately the nature, scope and details of the health care provided.

OUTPATIENT PSYCHIATRIC SERVICES

DMAS or its contractor will conduct periodic, utilization review on-site or as desk reviews of individuals currently receiving psychiatric services, including Mental Health Clinic Services. DMAS or its contractor may also review a sample of closed medical records. DMAS or its contractor may also conduct an on-site investigation as follow-up to any complaints received.

Documentation Requirements:

Providers of outpatient psychiatric services are expected to document the requirements outlined in this manual, as well as the following:

- Assessment to include the following:
  - Precipitating events/reason for treatment/stressors/functional impairments;
  - Behavioral health/treatment history/outcomes;
  - Medical history/medication current and history;
  - Social/Family history;
  - Educational/Developmental history;
  - Legal/Carceral history;
  - Ability/desire of the family/caretakers to participate in treatment;
  - Psychiatric diagnosis or have evidence of diagnosis within the past year
- Plan(s) of Care (POC), and review of the plan of care signed and dated by the LMHP. An initial plan of care is required to be completed at the start of services. The POC may be incorporated in the Psychiatric Diagnostic Interview.
- Medical Evaluation (evidence of coordination with the primary care physician (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. The provider is expected to have the results of a medical evaluation in the individual's medical record or indicate that the individual's condition either does not warrant an evaluation or an evaluation was recommended and for what reasons.

- Results of a Diagnostic Evaluation done within the past year.
- Documentation of a psychiatric diagnosis that is current, within the past year.
- Progress Notes for each unit must :
    - be individual-specific;
    - describe how the activities of the session relate to the individual specific goals;
    - describe the therapeutic intervention;
    - include the length of the session including the start and end time for the service;
    - include the setting in which the service was rendered;
    - include the level of participation in treatment;
    - include the modalities of treatment and the type of session [group, individual, medication management];
    - document the progress or lack thereof toward the goals;
    - document the plan for the next treatment; and
    - contain the dated signatures of the providers.

- Evidence of discharge planning and discharge summary, if applicable.