CHAPTER VI

UTILIZATION REVIEW AND CONTROL

CHAPTER VI
TABLE OF CONTENTS

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 the care and services paid through Medicaid, including review of utilization of the services by providers and by members. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic reviews on all programs to ensure that the services provided to Medicaid members are medically necessary and appropriate and are provided by the appropriate provider. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or members.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment 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 reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

INDIVIDUALS ENROLLED IN MANAGED CARE (MEDALLION 3.0 & CCC PLUS)

Most individuals enrolled in the Medicaid program have their services furnished through contracted managed care organizations (MCOs) and their network of providers. Durable medical equipment (DME) providers serving individuals enrolled within an MCO shall reference their MCO provider agreement regarding Utilization Review and Control. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations. For those who are enrolled in Medicaid and continue to receive care under Medicaid fee-for-service, the provider is responsible for adhering to state and federal regulations, as well as this manual.

COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid members 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 members are identified for review by

- Systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or members. Exception reports developed for providers compare a member provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.
- Referrals and complaints from agencies or members. Referrals and complaints of inappropriate utilization of Medicaid services are investigated to determine if a Quality Management Review is necessary. The case may be referred to DMAS' Provider Review Unit or the Attorney General's Office for further review.

Reviews are conducted by:

- The reviewer, who is either a Health Care Compliance Specialist (HCCS), trained professional employed by DMAS or a Contractor of DMAS, reviews all cases using available resources, including appropriate consultants, and makes on-site reviews of medical records as necessary.

On-site review process:

- Upon arrival at the facility, the reviewer will supply the provider with a list of the records to be reviewed. The provider must supply the reviewer with the records as requested. The reviewer will begin the review at the facility.
- At completion of the on-site portion of the review, the reviewer will conduct an Exit Conference. This conference is a brief summary of the onsite findings.
- Upon return to DMAS the reviewer will complete the review. Completion of this review includes a summary letter to the provider. This letter includes technical assistance, areas of citation and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the Provider Reimbursement Division at DMAS. The provider will receive another letter from this Division outlining the repayment requirements.

Desk review process:

- The reviewer will mail, via United States Post Office certified mail, a list of the records to be reviewed. The provider must supply the reviewer with the records as requested. The records must be received by DMAS by the date instructed. Upon receipt of the documents the reviewer will review the records received. The reviewer may contact the provider for clarification of any document received.
- Upon completion of the review the reviewer will send a summary letter to the provider via certified mail. This letter includes technical assistance, areas of citation and, if applicable, documentation of overpayment.

- If overpayment occurs, a copy of the letter will be forwarded to the Fiscal Division at DMAS. The provider will receive another letter from Provider Reimbursement Division outlining the repayment requirements.

Overpayments:

- Providers may be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain records 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 restrict or terminate the provider's participation in the program.

DOCUMENTATION REQUIREMENTS FOR ALL DME

Medical documentation must provide DMAS with a clear understanding of the individual's needs. The following applies to the medical justification necessary for **all DME services** regardless of whether or not service authorization (SA) is required. The documentation is necessary to identify:

- The medical need for the requested DME;
- The diagnosis related to the reason for the DME request;
- The individual's functional limitation and its relationship to the requested DME;
- How the DME service will treat the individual's medical condition;
- The quantity needed and the medical reason the requested amount is needed;
- *The frequency of use (holds more weight for expendable supplies – see "note" below);
- The estimated length of use of the equipment (holds more weight for DME especially related to rental vs. purchase);
- Any conjunctive treatment related to the use of the DME or supplies;
- How the needs were previously met and identifying changes that have occurred which necessitate the DME;
- Other alternatives tried or explored and a description of the success or failure of these alternatives;
- How the DME service is required in the individual's home environment; and
- The individual or caregiver's ability, willingness, and motivation to use the DME.

NOTE: ***Frequency of use is part of the practitioner's order and describes how often a supply is used by the individual and provides the justification for the quantity ordered per month. Frequency of use should be documented by how often the individual uses the supplies ordered. For example, an individual needs incontinent briefs and must be changed seven (7) times per day. Seven times per day is the frequency of use. The frequency of use is multiplied by 31 days and should justify the quantity ordered per month on the CMN/DMAS-352. This documentation can be noted by the day, the week or the month depending on the type of supply and the individual's needs. Some items may be used once per week or twice per month so if an item is needed less than monthly the provider should document accordingly. Frequency of use holds more weight for expendable supplies but can be required for DME. (Frequency of use means – how often something is used. Quantity means – total. The provider will need to know how often the supply is used to determine quantity).

Instructions for Completing the CMN/DMAS-352

Section I - Individual Data

Section I contains demographic information for the individual and the servicing provider. This section is the **only** section of the CMN/DMAS-352 that can be changed after the practitioner has signed the CMN/DMAS-352. This information is considered technical information that will not affect the practitioner's order.

Section II – Individual Clinical Information

Section II contains the individual's information. There are eight questions that should be answered, if applicable, to the DME/supplies being requested. If the answer is "yes" to any of the questions, additional information should be provided on the CMN/DMAS-352 or in supporting documentation signed and dated by the practitioner. To the right of the eight questions is a box for description/additional information. This section can be used to provide medical justification for the item/s being ordered. Below the eight questions are two additional questions to respond to when appropriate.

The first question must be answered on the CMN/DMAS-352 or in the supporting documentation. If the item is not suitable for use in the home the item would not be covered under DME. If the individual/caregiver is unwilling or unable to use the item it would not be covered.

The second question is the date the individual was last examined by the practitioner and must be completed on the CMN/DMAS-352 or in the supporting documentation. The individual must have seen the ordering practitioner within the last 2 years; however, some DME/supplies have stricter criteria. See the criteria for the ordered items for the

guidelines in Chapter IV of this manual.

The last part of Section II is for the individual's diagnoses. The diagnoses should be related to the reason for the DME/supplies request. The ICD code is optional. The clinical diagnosis narrative is required. The date of onset should be noted if available.

Section III – Specific Physician Ordered DME and Supplies

Section III is to be completed for all DME/supplies ordered for the individual, to include each component of the DME and supplies. Page two of the CMN allows for additional orders that won't fit on the first page of the CMN.

The begin service date on the CMN/DMAS-352 is optional. If the provider enters a begin service date, the CMN/DMAS-352 must be signed and dated by the practitioner within 60 days of the begin service date in order for the CMNDMAS-352 to start from the begin service date. Refer to the following examples:

- If the begin service date is 01/01/2015 and the practitioner signs and dates the CMN/DMAS-352 on 02/03/2015, the CMN/DMAS-352 meets the 60 day requirement. If the individual is 21 years of age and older the CMN is good from 01/01/2015 to 12/31/2015, if all other requirements are met. If the individual is under 21 years old the CMN/DMAS-352 is good from 01/01/20015 to 06/30/2009, if all other requirements are met.
- If the begin service date is 01/01/2015 and the practitioner signs and dates the CMN/DMAS-352 on 03/14/2015, the CMN/DMAS-352 does not meet the 60 day signature requirement. If this individual is 21 year of age and older the CMNDMAS-352 is good from 03/14/2015 to 12/31/2015, if all other requirements are met. For an individual under 21 years of age the CMN/DMAS-352 is good from 03/14/2015 to 06/30/2015, if all other requirements are met.
- If **no** begin service date is provided on the CMN/DMAS-352 the date of the practitioner's signature is the start date of the CMN/DMAS-352. If the CMN/DMAS-352 is signed by the practitioner on 02/01/2015 and the individual is 21 of age and older the CMN/DMAS-352 is good from 02/01/2015 to 01/31/2016 if all other requirements are met. If the individual is under 21 years of age the CMN/DMAS-352 is good from 02/01/2015 to 07/31/2015, if all other requirements are met.

The HCPCS code column on the CMN/DMAS-352 is optional. However, the provider is responsible for using the correct HCPCS code for service authorization (if required) and billing. The DME provider can contact the manufacturer of the DME/supplies or visit the Noridian site at https://www.dmepdac.com/dmecsapp/do/search for coding assistance.

Coding accuracy may be reviewed at post payment audit.

The item ordered description is a required field to be completed on the CMN/DMAS-352. If this section is not completed the CMN/DMAS-352 is invalid for this item. If the item is an E1399 (miscellaneous), the description of the item should not be miscellaneous DME, the provider should specify the DME item/supply.

The length of time needed should be documented on the CMN/DMAS-352 or in the supporting documentation signed and dated by the practitioner. The length of time the item is needed must be evaluated for durable items when determining whether the item is purchased or rented.

The quantity ordered column is a required field on the CMN/DMAS-352 and is part of the practitioner's order. For expendable supplies the provider must designate supplies needed for one month. If an item is not needed every month the provider may designate an alternate time frame. For example, if an individual needs a supply once every two months the provider may document 1 every 2 months or 1/2M in the quantity section. If this section is left blank the order is not complete and the CMN/DMAS-352 would be invalid for that item.

The Quantity/Frequency of use/Justification/Comments column provides a space for this documentation but can also be documented on the supporting documentation signed and dated by the practitioner. Frequency of use must be documented for expendable supplies to justify the quantity but can also be required for durable medical equipment Frequency of use is a required part of the practitioner's order and describes how often a supply is used by the individual and provides the justification for the quantity ordered per month. Frequency of use must be documented and can be determined by how often the individual uses the supplies ordered. For example, the individual needs incontinent briefs and is changed 7 times per day. Seven times per day is the frequency of use. The frequency of use is multiplied by 31 days and should justify the quantity ordered per month on the CMN/DMAS-352.

Documentation can be noted by the day, the week or the month depending on the type of supply and the individual's needs. Some items may be used once per week or twice per month so if an item is needed less than monthly the provider should document accordingly. Frequency of use holds more weight for expendable supplies but can be required for DME. (Frequency of use means – how often something is used. Quantity means – total. The provider will need to know how often the supply is used to determine quantity).

.

Section IV – Practitioner Certification

Section IV is for practitioner certification. The practitioner shall print his/her full name in the first blank. The second blank is for the practitioner signature. The third blank is for the date of the signature and should contain the full date (day/month/year). Note: An attached practitioner prescription will **not** be accepted in lieu of the practitioner's signature and date on the CMN. If orders for DME/supplies are written on both pages of the CMN, the practitioner must sign and fully date both pages on the CMN. The complete practitioner Medicaid provider number (NPI) and phone number are optional.

NOTE: The practitioner signature and full date is required on the CMN. If either the signature or full date or both is missing the **entire** CMN is **invalid** and a new CMN must be obtained. The purpose of the practitioner certification is to certify that the ordered DME/supplies are a part of the treatment plan and, in the opinion of the practitioner, are medically necessary.

Documentation for Repair of Rented or Purchased DME

The provider shall document the following:

- What equipment the individual is currently using and why that equipment is no longer appropriate for the individual. This description shall include the reason why repairs could not be done or why the option to repair the equipment was not cost effective.
- The provider shall include a breakdown of what items need to be repaired and include the cost to repair the items to justify why the purchase of new equipment would be more cost effective.
- If the item is no longer appropriate due to a change in medical condition, limitations and symptoms, or if the equipment was provided inappropriately, the provider shall give justification to describe the circumstances.
- The provider must demonstrate short term need versus long term need

DOCUMENTATION REQUIREMENTS FOR SPECIFIC DME ITEMS

In addition to the Medical Necessity guidelines described previously in this chapter, and the previously described documentation requirements for all DME, additional specific medical justification and/or documentation requirements are in place for the following DME:

Hospital Beds

Describe all of the following: How the bed will be used to treat a medical condition;

how needs have and are currently being met; the functional abilities/disabilities; other alternatives tried; and why a non-hospital bed would not meet the individual's medical needs.

Any Hospital Bed submitted under E1399, the provider must submit the following:

- Submit Invoice with requested items circled or marked to the service authorization contractor.
- Submit Manufacturer's description and picture of the E1399 item requested to the service authorization contractor. (Can use a manufacturer's spec sheet or brochure.)

The following must be documented on the CMN/DMAS-352 or in supporting documentation, along with medical necessity for all Hospital Beds submitted under E1399:

- Will the home support the electricity requirements of the bed?
- Will the home support the weight of the bed?
- Need to list what other beds have been ruled out and why.
- Why is a standard hospital semi/total electric bed with support surface not sufficient?
- Does the bed already include a mattress?

Patient Lifts

Describe all of the following: the individual's weight; identify the caregiver and his or her ability to use the lift; the individual's functional limitations; how needs were previously met and what has changed in the individual's condition to require the lift; and the home accessibility for the lift.

Individual Bath Chairs

Describe all of the following: the individual's medical condition and the need for the bath chair; the individual's weight; identify the caregiver and his or her ability to use the equipment; the individual's functional limitations; how needs were previously met, what has changed in the individual's condition to require the bath chair; and the bathroom's accessibility for the bath chair.

Documentation Requirements for A**ll** Wheelchairs

The provider **must** document **all** of the following in addition to the minimum documentation requirements:

- Document the diagnosis or condition requiring the wheelchair, and how the requested wheelchair treats that diagnosis/condition;
- Describe how any additional components added to the wheelchair will treat the diagnosis/condition;
- Describe the distance (in feet) the individual can functionally ambulate with or without an assistive device;
- Describe upper and lower extremity strength/weakness;
- Identify how the individual's needs have been met/unmet previously and what changes have occurred to now require a mobility device, or if current mobility device is not meeting need and why;
- Describe cost effective alternatives tried and ruled out;
- Describe home accessibility for the mobility device and how the requested device is needed within the individual's home;
- If the individual currently owns a wheelchair, describe the type of wheelchair, condition of the wheelchair (describe damage/cost to repair), and any special features included on the wheelchair.

In addition to CMN/DMAS-352, documentation for wheelchairs can be in the form of a letter of medical necessity (LMN), office notes, written documentation on the CMN/DMAS-352 or other supporting documentation that is signed and dated by the practitioner.

Note: All items related to wheelchairs, including correct quantities, hardware, upgraded foam, labor, any item that is an upcharge, etc., must be ordered on the CMN/DMAS-352 and justified either on the CMN/DMAS-352 or in attached, supporting, verifiable documentation, regardless of whether or not the item requires service authorization. All supporting documentation must be individual-specific and must be signed and dated by the practitioner.

Documentation Requirements for Power Wheelchairs

1. Fully completed CMN/DMAS-352, to include the minimum documentation requirements, signed and dated by the practitioner.
2. A specialty evaluation (face to face) will be required for all individuals receiving a Group 2 single power or multi-power option PWC, and Group 3, 4 or 5 PWC, or a push rim activated power assist device for a manual wheelchair. The evaluation must be performed by a health care professional with experience in fitting

wheelchairs and making recommendations based on the individual's need (specifically, practitioner, physical therapist, occupational therapist, or rehabilitation engineer in coordination with the physical therapist or occupational therapist). The physical therapy and/or occupational therapy evaluation is a covered rehabilitation program service that may be billed to DMAS. DMAS requires the assessment to be performed by a physical therapist or occupational therapist, especially for wheelchairs with specialized seating and positioning components and features, or for wheelchairs operated via specialty electronics. All evaluations should include but are not limited to the following;

- Range of motion and semi-quantitative assessment of strength in the extremities
- Quantitative limitations to passive range of motion in the extremities
- Detailed description of the individual's condition to include related diagnosis and history
- Presence or absence of increased muscle tone or spasms
- Describe head and trunk control in relation to the specific components/type of wheelchair requested
- Describe how the equipment benefits the individual in performing activities of daily living (ADLs)
- Detailed list, description and justification of wheelchair base and accessories
- Detailed description of the individual's long-term prognosis
- Size, weight and measurements of the individual
- Description of the medical condition necessitating use of a wheelchair
- Extent of the individual's ability to ambulate. If the individual can ambulate, what are the limitations to this ambulation and does it require an assistive device? If a device is currently being used, indicate the device and why the device no longer meets the individual's needs. Indicate other alternatives tried and ruled out.

3. Home Assessment – The provider must perform an on-site evaluation of the patient's home prior to delivery. A written report must be kept in the individual's clinical record. The home assessment must verify the following:
    - The wheelchair is accessible in the home setting
    - The individual can adequately maneuver the wheelchair in the home, taking into consideration:
        - Physical layout;
        - Doorway width(s);
        - Doorway thresholds; and,
        - Surfaces

4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the individual.
5. Manufacturer information to include price, make, model of wheelchair and all accessories for the wheelchairs reimbursed as Individual Consideration (IC).

Documentation Requirements for Wound Care Supplies

Describe all of the following:

- The total number of wounds;
- The location;
- Stage;
- Size;
- Depth;
- Drainage;
- Color of each wound;
- Who is providing the wound care (individual, caregiver, home health nurse);
- Frequency of the wound care; and
- The complete practitioner's order for the wound care

Additional documentation requirements for specific items may be found in the "Medicaid DME and Supplies Listing" in Appendix B and in the following pages describing specific coverage criteria and as described in Chapter IV of this manual.

Documentation Requirements for Communication Devices

The speech-language pathology documentation must show that the individual's ability to use the device is improving and that the individual is motivated to continue to use the device. If the communication device(s) supplied for the required two-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in the DME Listing in addition to the initial two-month rental period for these items.

The CMN/DMAS-352, speech/language evaluation, and/or other verifiable supporting documentation must include all the following:

- The complete practitioner's prescription for the augmentative communication device, including an itemization of the components (i.e., special switches, special mounting devices, etc.) required by the individual;

- Documentation describing the individual's medical condition/diagnosis, including a description of the individual's disease, general prognosis, and prognosis for intelligible speech;
- Documentation if the condition permanent, temporary, or changing;
- Documentation to demonstrate if the medical condition will result in an increased or decreased need for a device in the future;
- A description of how the individual communicates medical needs now and how communication needs are currently unmet\met;
- Is the individual cognitively/physically able and motivated to use an augmentative communication device? Documentation must include an assessment of the individual's gross and fine motor skills, e.g., hand use skill, including finger dexterity;
- A description of related impairments including audio/visual, perceptual, and/or memory, that would limit his or her ability to use a device, or that would require the use of a specific augmentative communication device;
- A description of the plan to provide ongoing speech-language therapy and support in the use of the communication device in the individual's home and community; a list of other devices that have been tried by the individual (describe the success/failure); a description of how the requested device better meets the individual's medical needs than more cost-effective devices available;
- A description of the extent to which the individual and/or family/caregivers are able to properly program and utilize the device; and
- Specific information about the device including: the manufacturer's name, catalog number, product description, a photo (if available), and documentation of the provider's cost, less any discounts available.

<u>Documentation Requirements for Enteral Nutrition</u>

For individuals eligible for enteral nutrition, the DME provider must obtain and maintain all of the following documentation:

- The CMN/DMAS-352 is required for all nutritional supplements and supplies regardless of whether or not the individual is enrolled in a Medicaid home and community based waiver program.
- A complete description of the item(s) being supplied;
- A copy of the supplier's invoice or the dealer cost information to document the cost of the item(s) marked as Individual Consideration (IC) as listed in the Fee column of the Appendix B; any discount received must be indicated; and
- Delivery tickets for the items provided

The required medical justification can be included in the supporting documentation that is

signed and dated by the practitioner. The CMN/supporting documentation must include all of the following elements:

1. Height (or length for pediatric individuals);
2. Weight (if unobtainable, may provide mid-arm circumference and triceps skinfold test data). For initial assessments, indicate the individual's weight loss over time;
3. Formula tolerance (e.g., is the individual experiencing diarrhea, vomiting, and constipation?). This element is only required if the individual is already receiving a supplement;
4. Tube or stoma site assessment, as applicable;
5. Indication of whether the supplement is the primary or sole source of nutrition;
6. Route of administration;
7. The daily caloric order and the number of calories per package, can, etc.
8. Title, signature, and date of the qualified personnel completing the assessment; and
9. Practitioner signature and date in accordance with criteria for supporting documentation. See Chapter IV of this manual.

NOTE: If the practitioner is unable to obtain a current weight, the practitioner must document the reason why a weight was unable to be obtained and how the practitioner is able to monitor therapy status without an individual's weights documented.

Documentation Requirements for Home Infusion Therapy-Certificate of Medical Necessity

The CMN/DMAS-352 must be completed for intravenous (I.V.) therapy DME services. The provider may complete the CMN/DMAS-352, but the practitioner must fully date and sign the CMN/DMAS-352 within 60 days of the begin date of service.

DMAS will not reimburse the DME provider for any DME and supplies provided prior to the date of the practitioner's signature when the signature is not obtained within 60 days of the first date of service. Under the item/service and HCPCS code on the CMN/DMAS-352, list the proper code and therapy service as well as the estimated length of time needed. The I.V. Therapy Implementation Form (DMAS-354) must be completed, signed, and dated by the practitioner within 60 days of the therapy start date. Additionally, a copy of the doctor's order for discontinuing the therapy must also be attached to each CMN/DMAS-352 and I.V. Therapy Implementation form upon completion of the therapy.

The I.V. Therapy Implementation form must be initiated with the beginning of each drug

and therapy service provided. The I.V. Therapy Implementation Form (DMAS-354) may be completed by the provider, but must be signed and dated by the practitioner. **Do not attach either the I.V. therapy implementation form (dmas-354) or the CMN to claim requests**.

The Medicaid Program must ensure that only medically necessary I.V. therapy is provided to Medicaid individuals. For DME services, I.V. therapy providers must maintain records that contain the fully completed CMN/DMAS-352, signed and dated by the practitioner; the I.V. Therapy Implementation Form (DMAS-354), with the begin and end dates for each drug/therapy provided and signed and dated by the practitioner; and the order to discontinue the therapy (the official end date), signed and dated by the practitioner. These forms shall be furnished to DMAS staff or its contractors upon request. The absence of documentation to support I.V. therapy services may result in the retraction of reimbursement.

DMAS forms are located on the Medicaid Web Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Documentation Requirements for Reimbursement of Apnea Monitors and Diagnostic Studies

For the initial 120 days which do not require service authorization, there must be a CMN/DMAS-352 stating the individual's diagnosis that indicates the need for a monitor or a description of the individual's condition.

The following documentation is required for the continued use of an apnea monitor over 120 days (both 1 and 2):

1. A CMN/DMAS-352 and documentation outlining the condition of the individual related to apnea in the previous 120 days of monitoring, including all of the following:

    a) The dates and the number of occurrences of observed apnea;
    b) An interpretation of any related diagnostic tests;
        For example: an upper GI series for GE reflux; pneumograms or downloads for recording apnea monitors, that are interpreted and indicate the child had clinically significant apnea during the first 120 days and/or the condition is resolving;
    c) Download reports with clinical interpretation from recording monitors. The practitioner is encouraged to order a pneumogram for those children on non-recording apnea monitors in order to document the clinical status;
    d) Adequate and verifiable documentation of the oxygen flow rate for those individuals who continue on oxygen; and
    e) Adequate and verifiable documentation of the month of death of any sibling

who expired due to Sudden Infant Death Syndrome (SIDS) if the child was placed on the monitor for this reason.

2. A comprehensive history and record of physical examination, with appropriate work-up including specific pulmonary studies as indicated (i.e., sleep airway studies and fluoroscopy, transcutaneous oxygen, pulse oximetry, recording monitor download analysis, and carbon dioxide monitor findings or pneumogram studies).

The provider must submit a clinical description to DMAS staff of what happened during the first 120 days and why the monitor continues to be needed. This description is comprised of a history and physical, interpreted downloads or pneumograms that show a test history, indication of special considerations (need for oxygen, need to receive immunization stressors, or need to reach significant age for a sibling with SIDS), and a practitioner's assessment of what happened during the first 120 days of monitoring to warrant continued use. It is the responsibility of the individual's practitioner to interpret the data. It is the responsibility of the provider to obtain the interpretation from the practitioner and submit the interpretation to DMAS or its contractor.

Documentation for pneumograms, polysomnagrams, and multi-channel sleep studies must specify the number of signals, what signals are to be done, and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis.

Documentation on the CMN/DMAS-352 must specify the number of signals, what signals are to be done and whether or not interpretation is to be done. Documentation must also include the download findings and a wave form analysis. A summary report of the study and all other required documentation must be maintained at the provider's location.

Documentation Requirements for Oxygen

While there is no substitute for oxygen therapy, it is appropriate that each individual should receive optimum therapy before long-term home oxygen therapy is ordered. The practitioner must have examined the individual recently (within 30 days of the start of therapy).

The CMN/DMAS-352 must include all of the following:

- A diagnosis of the disease requiring home use of oxygen;
- The oxygen flow rate;
- An estimate of the frequency, duration of use (e.g., 2 liters per minute, 12 hours a day) and duration of need (e.g., six months or lifetime).

- Oxygen that is ordered PRN must include justification to determine the amount of oxygen that is reasonable and necessary for the individual; and
- Blood gas study results

The practitioner must also specify the type of oxygen delivery system to be used (i.e., gas, liquid, or concentrator). If the type of system is not specified, the provider must provide services in the most cost-effective manner to carry out the practitioner's order and meet the needs of the individual.

The practitioner must submit a new CMN/DMAS-352 whenever there is a revision to the oxygen requirements based on a change in condition and the subsequent need for oxygen therapy. In the absence of any revision, the CMN/DMAS-352 authorization is valid for a 12-month period for adults and six months for children. The practitioner may only certify the need for oxygen therapy if the individual has been examined by a practitioner within the past 12 months.

Laboratory Evidence/Studies

The CMN/DMAS-352 or supporting documentation signed and dated by the practitioner must also include the results of a blood gas study ordered and evaluated by the attending practitioner. This will usually be in the form of a measurement of the partial pressure of oxygen (PO_2) in arterial blood. A measurement of arterial oxygen saturation obtained by ear or pulse oximetry, however, will also be acceptable when ordered and conducted by a qualified provider or supplier of laboratory services and evaluated by the attending practitioner. The conditions under which the laboratory tests are performed must be specified in writing and submitted with the CMN/DMAS-352 or supporting documentation (i.e., at rest, while sleeping, while exercising, on room air, or if while on oxygen, the amount, body position during testing, and any similar information necessary for interpreting the evidence).

In situations when the arterial blood gas and the oximetry studies are both used to determine the medical need for home oxygen therapy and the results are conflicting, the arterial blood gas study is the preferred source for this determination.

A DME supplier is not considered a qualified provider or supplier of laboratory services for purposes of these blood gas study requirements. This prohibition does not extend to the results of an arterial blood gas test conducted by a hospital certified to do such tests. The preferred sources of laboratory evidence are existing practitioner and/or hospital records that reflect the individual's medical condition. If more than one arterial blood gas test is performed during the individual's hospital stay, the test result obtained closest to the hospital discharge date must be submitted. The attending practitioner's statement of recent

hospital test results is acceptable in lieu of copies of the actual hospital records.

A DME provider may be the provider of pulse oximetry services, in accordance with the established DMAS pulse oximetry criteria, for an individual with a progressive disease who may require oxygen at night. The overnight pulse oximetry study must be ordered by the practitioner, and the DME provider must send a copy of the pulse oximetry readings to the attending practitioner for interpretation. If the practitioner determines that oxygen therapy is medically indicated, the oximetry test results and the practitioner's order for oxygen therapy must be recorded on the CMN/DMAS-352 and/or in supporting documentation. DMAS will reimburse the DME provider for the oxygen therapy as ordered by the practitioner, and in accordance with the coverage criteria for oxygen therapy.

A repeat arterial blood gas or oximetry study will normally be necessary only when evidence indicates that an individual receiving oxygen has undergone a major change relevant to the home use of oxygen. For example, if there has been a significant increase in the amount of oxygen required (e.g., an increase to more than 4 liters per minute), a repeat blood gas or oximetry study may be necessary.

Documentation Requirements for Pulse Oximetry

The practitioner must document on the CMN/DMAS-352 or in supporting documentation that the individual's condition meets one of the above criteria and all of the following:

- Pulse oximetry readings are necessary on a daily basis in order for the individual to remain in the home;
- The individual does not have a condition which contraindicates the effective use of pulse oximetry (e.g., oxygen toxicity is a concern);
- Alternative treatments which have been attempted (e.g., periodic arterial blood gases); and
- Why periodic pulse oximetry readings (e.g., pulse oximetry reading submitted bimonthly showing SaO_2 trends over a specified period of time) would not meet the practitioner's need for monitoring.

In addition, the practitioner must specify the current oxygen flow rate and the assessment parameters: the setting at which the device should be set to alarm and the intervention response or corrective action to be taken (e.g., increase oxygen to 50%, increase oxygen to 2 L/min.).

MEDICAL RECORDS AND RECORD RETENTION

The provider must ensure the confidentiality of individual record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern

record use and removal and the conditions for the release of information. The individual or his/her authorized representative's written consent is required for the release of information not authorized by law. Current individual records and those of discharged individuals must be fully completed and in a timely manner. All clinical information pertaining to an individual must be centralized in the individual's record. All information should meet all established guidelines for the Health Insurance Portability and Accountability Act (HIPAA) compliance and security of records.

The provider must maintain records on all individuals who were provided DME supplies for a minimum of not less than six (6) years from the last date of service. For minors records must be retained for at least six (6) years after such minors have reached 21 years of age 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 DME record entries must be fully signed and dated (month, day, and year), including the title (professional designation) of the author.

ELECTRONIC SIGNATURES

The Department of Medical Assistance Services' (DMAS) clarified written policy regarding the use of electronic signatures for clinical documentation purposes. Provider failure to properly maintain or authenticate medical records (signed and dated entries) may result in the retraction of Medicaid payments.

An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and,
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Use of electronic signatures, for clinical documentation purposes, shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Providers must have written policies and procedures in effect regarding use of electronic signatures. In addition to complying with security policies and procedures, providers who use computer keys or codes of electronic signatures, must sign a statement assuring that they alone will have access to and use the key or codes, or computer password. The policies and procedures and statements of exclusive use must be maintained and available at the provider's location. Additionally, the use of electronic signatures must be consistent

with the applicable accrediting and licensing authorities and the provider's own internal policies. These requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

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 Medicaid 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 Virginia Medicaid 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 and all of their employees are responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. 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
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 addressed to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor

Richmond, Virginia 23219

Individual Fraud

Allegations about fraud or abuse by members are investigated by the Division of Program Integrity of the Department of Medical Assistance Services. The Division focuses primarily on determining whether members misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The Division also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, 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 individuals 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.

Referrals should be made to:

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

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

The DMAS Recipient Monitoring Unit (RMU) staff will review eligible individuals to determine if the utilization meets Client Medical Management (CMM) program regulatory criteria, 12 VAC 30-130-810 for restriction to either a physician or pharmacy, or both.

The RMU has three (3) methods of receiving a referral:

- The CMM helpline voice mail is available 24 hours daily; local (804) 786-6548; and 888-323-0589;
- Fax: (804) 371-8891; or
- In writing to :

  Department of Medical Assistance Services
  Division of Program Integrity
  Recipient Monitoring Unit

600 East Broad Street
Richmond, Virginia 23219

All referral should include the name and Medicaid number of the individual and a brief description of the utilization or abuse of Medicaid services. Contact information of the referring individual or provider is requested to acknowledge receipt of the referral.

DME PROVIDER RESPONSIBILITIES AND EXPECTATIONS FOR DME AND SUPPLIES

The Durable Medical Equipment and Supplies provider may not bill for items or services that have not been provided to the member and documented as received by the individual. To receive reimbursement, the DME provider must:

- Verify the individual's Medicaid eligibility, on a monthly basis;
- Determine whether the item is covered and if so, does it require service authorization;
- Deliver only the item(s) ordered by the physician and approved by DMAS or its contractor;
- Deliver only the quantities ordered by the physician on the CMN and approved by DMAS or its contractor;
- Deliver only the item(s) for the periods of service covered by the physician's order and approved by DMAS or its contractor;
- Maintain a copy of the physician's orders (CMN) and all verifiable supporting documentation for all durable medical equipment/supplies ordered;
- Document and justify the description of services (labor, repairs, maintenance of equipment);
- Document and justify the medical necessity of all items and supplies as described in Chapter IV of this manual; and
- Once medical necessity (i.e. incontinence) is established the decision to use tab diapers or pull ups shall be left to the individual or caregiver and shall be documented by the provider on the CMN/DMAS-352; and
- Document all equipment and supplies provided to an individual in accordance with the physician's orders. The delivery ticket/proof of deliver must document the information described below.

Miscellaneous HCPCS and Individual Consideration (IC)

Miscellaneous codes will not be recognized for the sole purpose of cost variances. If a HCPCS code is not listed in Appendix B, the provider can use an appropriate miscellaneous code for coverage consideration. In order for the service authorization contractor and the post payment contractor to determine the appropriate reimbursement for

miscellaneous and IC items, **all of the following must be provided** and kept on file in the member's record:

- A complete description of the item(s) being supplied;
- A copy of the supplier's invoice or the dealer cost information to document the cost of the item(s);
- Any discount received; and
- MSRP

The manufacturer's invoice, the dealer's price list showing the dealer's cost of the item, or a statement from the manufacturer detailing estimates of cost for specially designed item, are all acceptable documentation. The documentation must include the manufacturer's cost, any discounts provided to the provider, and the provider's ancillary cost of providing the DME and/or supplies to the member. The reimbursement amount is determined by adding 30% to the providers cost for the item.

If an estimate is used for specially constructed items, upon receipt of the manufacturer's invoice, if the cost is less than reported on service authorization, the provider must only bill 30% over the cost of that item. Likewise, if the cost is more than the original estimate, the provider may submit a change request to the service authorization contractor for consideration (See Appendix D of this manual for more service authorization information). Documentation of the actual cost of the item billed must be in the member's record.

Provider must make sure that the Invoice, CMN/DMAS-352 and delivery ticket are clearly documented for the auditors and service authorization contractor to discern. For example, if the provider has multiple lines of items on a CMN/DMAS-352, the provider should make sure the invoice and delivery ticket are clearly correlated to the items on the CMN/DMAS-352. This can be done by highlighting, numbering or another method that demonstrates which item correlates to the same item on the CMN/DMAS-352, invoice and/or delivery ticket.

Proof of Delivery

Delivery tickets must contain all of the following:

- The individual's name and Medicaid number **or** date of birth or a unique identifiers (for example, an individual's medical record number);
- A detailed description of the item being delivered. The product name and brand;
- The serial number or product number of the durable medical equipment or supplies if available, not required;

- The quantity that was delivered;
- The signature of the individual, caretaker, or their designee. The designee's signature on the delivery ticket shall be legible. If it is not legible, the supplier must note the name of the designee on the delivery ticket;
- Providers or anyone else having a financial interest in the delivery of an item shall not sign or accept an item on behalf of a Medicaid individual.

Refills or Repeat Orders

- Providers shall make affirmative contact with the individual/caregiver prior to dispensing repeat orders or refills to assure that the item is still needed, the amount is still appropriate and the individual still resides at the same location. The provider must contact the individual prior to each delivery. This contact should take place no sooner than 7 days prior to the delivery/ship date and must be documented in the individual's record. If no affirmative contact is made with the individual or caregiver the monthly refill should not be delivered until affirmative contact is made. Providers should make the individual/caregiver aware of this policy from the start of services and document this conversation in the member's record. Providers can use the mail for affirmative contact; however, if a mailing is being used for monthly contact the provider shall have in person contact (face to face, by phone, or via electronic means such as use of a provider's web based portal or ordering system) prior to annual recertification on the CMN/DMAS-352..
- Providers shall not deliver refills sooner than 5 days prior to the end of usage. For example, they may not deliver all cases of incontinent briefs for a two month period on one date.

Shipping:

- If a commercial shipping service is used, the provider's records must reference, in addition to the above information, the delivery services' package identification number, and a copy of the delivery ticket from the delivery service (this may be a printed from an on-line record on the delivery service's website). The delivery service's identification number must be on the provider's delivery ticket. It is recognized that commercial delivery services may not obtain a signature of the receiving party. Therefore, this documentation will substitute for the individual's signature above as proof of delivery.
- Providers may use a return postage-paid delivery invoice from the individual or designee as a form of proof of delivery. The descriptive information concerning the item(s) delivered, as described above, as well as the required signature/date from either the individual or designee should be included on this invoice as well.

Billing and Delivery:

- Providers shall not bill for dates of service prior to delivery. The provider must confirm receipt (shipping service record showing the item was delivered is acceptable) prior to billing.

For repeat orders only: Since DMAS allows the provider to ship repeat orders no sooner than 5 days prior to the end of usage, the provider will need to bill for the item on the date of the refill month and not the delivery date to avoid overlapping claims. This should be documented in the individual's record and only done for repeat monthly orders. For example: If an individual's first months delivery was on January 1st the refill for the 2nd month and all proceeding months should also be on the 1st of the month. For billing purposes the provider should bill delivery on the 1st of the month for this member even though they may have delivered up to 5 days prior to the 1st of the month.

Discharges from a Hospital or Nursing Facility

Equipment and supplies delivered for home use for individuals being discharged from a hospital or nursing facility DME may be delivered to the facility prior to discharge; however, the claim date of service may not begin prior to the date of discharge from the hospital or nursing facility.

General Information

Important: DME providers must provide all of the same DME services/items to the Medicaid individual as provided to the general population, in accordance with the established Medicaid reimbursement rate. As per the provider agreement, a Medicaid-enrolled provider must accept Medicaid payment as payment in full.

DME providers are responsible for knowing which items require service authorization and the limitation on the provision of certain items as described in the "Medicaid DME and Supplies Listing" in Appendix B of this manual. Since the Medicaid Program has established guidelines regarding which items require service authorization and the limitations that may be imposed on certain items, providers can reasonably be expected to know for which items Medicaid will pay.

The DME provider must provide equipment and supplies as prescribed by the physician on the CMN/DMAS-352. The CMN/DMAS-352 shall not be changed, altered, or amended after the attending physician signature date. If changes in the ordered DME or supplies are

necessary, as indicated by the individual's condition, the DME provider must obtain a new CMN/DMAS-352. All CMN/DMAS-352's must be signed and dated by the attending physician within 60 days from the time ordered supplies are furnished by the DME provider (CMN/DMAS-352 begin date). (12 VAC 30-50-165)

The DME provider must not bill DMAS prior to the date of the physician's signature when the signature is not obtained within 60 days of the first day (CMN/DMAS-352 begin date) of service. The DME provider will be reimbursed only for services that are provided in accordance with published policies and procedures. If reimbursement is denied for one of these reasons, the DME provider may not bill the Medicaid individual for the items/service that was provided. (12 VAC 30-50-165)

The DME provider must not provide items or extended quantities of items which require service authorization prior to obtaining the written service authorization from DMAS. Therefore, the liability for the charges for denied items or services which the provider supplied prior to obtaining the required written authorization rests with the DME provider. A provider cannot bill an individual for Medicaid-covered services if the provider is denied reimbursement due to his or her failure to obtain service authorization or to perform other required administrative functions. (12 VAC 30-50-165)

As per the Virginia Medicaid provider agreement, a DME provider may only bill a Medicaid individual for non-covered services. The DME provider is responsible for determining if an item is covered, whether or not it requires service authorization, and for verifying Medicaid eligibility. If the DME provider does not follow the established procedure for obtaining authorization for any item, and the request is denied, the provider may not bill the individual for that item. (12 VAC 30-50-165)

Communication with the Medicaid individual is important when an item is non-covered so the individual can make a decision as to if they want to purchase and "pay out-of-pocket" for the item(s).

The DME provider must advise the Medicaid individual in writing of any fiscal liability (potential or actual) for items delivered prior to the receipt of authorization by the service authorization contractor. If all established guidelines are followed by the provider, and the request is denied, the DME provider may seek reimbursement from the individual. The provider may not require the individual to make a deposit or "pay in advance" for any item that is covered and requires service authorization. If the provider fails to follow established procedures for authorization or fails to notify the individual of any fiscal liability and the item requested is determined not to be medically justified or does not meet criteria for reimbursement, the DME provider may not bill the Medicaid member. (12

VAC 30-50-165)

DME providers shall retain copies of the CMN/DMAS-352 and all applicable supporting documentation on file for post payment audit reviews. Durable medical equipment and supplies that are not ordered on the CMN/DMAS-352 for which reimbursement has been made by Medicaid will be retracted. Supporting documentation is allowed to justify the medical need for durable medical equipment and supplies. Supporting documentation does not replace the requirement for a properly completed CMN/DMAS-352. The dates of the supporting documentation must coincide with the dates of service on the CMN/DMAS-352 and the medical practitioner providing the supporting documentation must be identified by name and title. DME providers shall not create or revise CMN/DMAS-352's or supporting documentation for durable medical equipment and supplies provided before or after the post payment audit review has been initiated. (12VAC 30-60-75)

Some items in the "Appendix B: Durable Medical Equipment and Supplies Listing" of this manual do not have a fee and indicate that a fee is determined by individual consideration (I.C.). In those cases the provider submits for service authorization and provides documentation of their cost. This cost may be an estimate or a quote. The reimbursement amount is determined by adding 30% to the providers cost for the item. Upon receipt of the manufacturer's invoice, if the cost is less than reported on service authorization, the provider must only bill 30% over the cost of that item. Likewise, if the cost is more than the original estimates, the provider may submit a change request to the service authorization contractor for consideration (See Appendix D of this manual for more service authorization information). The actual cost of the item billed must be documented in the individual's record.

DMAS RESPONSIBILITY – QUALITY MANAGEMENT REVIEW (QMR) FOR DME AND SUPPLIES

DMAS or its contractor will conduct either a desk review or an on-site quality management review (QMR) for enrolled DME and Supply providers. Such post payment review audits may be unannounced. Medical records of individuals currently receiving DME and Supplies as well as a sample of closed records may be reviewed. DMAS may also conduct an on-site investigation of any complaints that are received.

DMAS staff or its contractors may visit Medicaid individuals in their homes and conduct a professional review (covering physical, emotional, social, and cognitive factors) with respect to all of the following:

- Care being provided to the Medicaid individual by the DME and Supplies provider;

- Adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each individual;
- Necessity and desirability of the continued service to the individual;
- Feasibility of meeting the individual's health needs in alternate care arrangements;
- Verification of the existence of all documentation required by Medicaid, regardless of whether or not the item has been preauthorized; and
- Determination if the item billed was received by the individual.

NOTE: Services/items not specifically documented in the individual's DME medical record as having been rendered or received, as described under Proof of Delivery, shall be deemed not to have been rendered, and no reimbursement shall be provided. Supporting documentation is allowed to justify the medical need for DME and supplies, but supporting documentation does not replace the requirement for a properly completed CMN/DMAS-352. (12 VAC 30-60-75)

Following a post payment review, a report will be written detailing the findings of the utilization review. Based on the review report and recommendations, DMAS or its contractor may request a corrective action plan. (12 VAC 30-60-75) Actions taken and the level of management involved will be based on the severity of the cited deficiencies which adversely affect the health and safety of the individuals, the quality of life of the individuals, or utilization control regulations.

If DMAS or its contractor requests a corrective action plan, the DME provider must submit the corrective action plan within 30 days of the receipt of the utilization review findings report, to DMAS or its contractor.

Subsequent contact may be made to the provider for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

DMAS or its contractor will deny or retract payment from the DME provider if any of the following occur, but are not limited to (12 VAC 30-60-75):

- No current, fully completed CMN/DMAS-352 (physician's order), appropriately signed and fully dated by the physician;
- Documentation does not verify that the DME item was provided to and received by the individual;
- Lack of medical documentation, signed and dated by the physician, to justify the DME and supplies; or
- Item is non-covered or does not meet DMAS criteria for reimbursement.

Contact Information for Provider Questions

Upon review of this manual, if DME providers continue to have clinical or documentation

related questions, providers have the following options:

- The "Ask Questions" link on the DMAS website, listed under the Long-Term Care and Waiver Services section. The link access is; http://www.dmas.virginia.gov/Content_pgs/ltc-faq_form.aspx

- Questions may be directed to the DMAS DME e-mail address at:

- Virginia Medicaid Web Portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal

- Billing or Policy Questions, call the DMAS Provider Helpline at:
  1-804-786-6273 Richmond area and out-of-state long distance
  1-800-552-8627 All other areas (in-state, toll-free long distance

The helpline is for provider use only. Providers must have their Medicaid National Provider Identification Number (NPI) available when calling.