Table of Contents

State Name: Virginia

State Plan Amendment (SPA) #: 10-12

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

JUN 29 2011

Gregg A. Pane, MD, MPA
Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Dr. Pane:

We have reviewed State Plan Amendment (SPA) 10-12, in which the Commonwealth is implementing changes to its payment methodology for durable medical equipment (DME) and supplies. Specifically, the Commonwealth proposed rate reductions to the DME Regional Carrier (DMERC) rate; category specific rate reductions to the July 1, 1996 rates; development of rates for procedure codes that were once not priced; and changes to the billing unit for incontinence supplies from a "case amount" to an "each" amount or single item.

This SPA is acceptable. Therefore, we are approving SPA 10-12 with an effective date of July 1, 2010. Enclosed are the approved SPA pages and signed CMS-179 form.

If you have further questions about this SPA, please contact William G. Cahill at (215) 861-4173.

Sincerely,

/S/

Ted Gallagher
Associate Regional Administrator

Enclosures

cc: Alexandra Smilow – CMCS
De Earhart - DMCHO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 10 – 12

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 447

7. FEDERAL BUDGET IMPACT
a. FFY 2011 $ [2,141,471.00]
b. FFY 2012 $ [3,983,428]

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 3.1 A&B, Supp. 1, Pages 12-14 of 41, and Attach. 4.19-B, Pages 6.1 and 6.2 of 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: 2010 Durable Medical Equipment Updates

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2011
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/

13. TYPED NAME: Gregg A. Pane, M.D. MPA

14. TITLE: Director 9/14/10

15. DATE SUBMITTED:

16. RETURN TO

Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUN 29 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Ted Gallagher

22. TITLE: Associate Regional Administrator, DMCHO

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

3. For home health aide services, patients may receive up to 32 visits annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. The state assures that this limit is sufficient to meet the service needs of recipients.

D. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility in accordance with 42 CFR 440.110.

1. Service covered only as part of a physician's plan of care.

2. Patients may receive up to five visits for each rehabilitative therapy service ordered annually without authorization. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

E. The following services are not covered under the home health services program:

1. Medical social services;
2. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private-duty nursing services, or items of comfort which have no medical necessity, such as television;
3. Community food service delivery arrangements;
4. Domestic or housekeeping services which are unrelated to patient care and which materially increase the time spent on a visit;
5. Custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care; and
6. Services related to cosmetic surgery.

§ 7.5. Durable medical equipment (DME) and supplies suitable for use in the home. (12 VAC 30-50-165)

A. Definitions. The following words and terms when used in these regulations shall have the following meaning unless the context clearly indicates otherwise:

"Durable medical equipment" or "DME" means medical supplies, equipment, and appliance suitable for use in the home consistent with 42 CFR 440.70(b)(3).

"Practitioner" means a provider of physician services as defined in 42 CFR 440.50.

B. General requirements and conditions.

1. All medically necessary medical supplies and equipment shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

2. DME providers shall adhere to all applicable DMAS' policies, laws, and regulations for durable medical equipment and supplies. DME providers shall also comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of coverage for durable medical equipment or supplies which are regulated by such licensing agency or agencies.

3. DME and supplies must be furnished pursuant to a Certificate of Medical Necessity (CMN) (DMAS-352).

4. A CMN shall contain a physician's diagnosis of a recipient's medical condition and an order for the durable medical equipment and supplies that are medically necessary to treat the diagnosed condition and the recipient functional limitation. The order for DME or supplies must be justified in the written documentation either on the CMN or attached thereto. The CMN shall be valid for a maximum period of six months for Medicaid recipients 21 years of age and younger. The maximum valid time period for Medicaid recipients older than 21 years of age is 12 months. The validity of the CMN shall terminate when the recipient's medical need for the prescribed DME or supplies ends.

5. DME must be furnished exactly as ordered by the attending physician on the CMN. The CMN and any supporting verifiable documentation must be complete (signed and dated by the physician) and in the provider's possession within 60 days from the time the ordered DME and supplies are initially furnished by the DME provider. Each component of the DME must be specifically ordered on the CMN by the physician. For example, the order must specify IV pole, pump, and tubing. A general order for IV supplies shall not be acceptable.

6. The CMN shall not be changed, altered, or amended after the attending physician has signed it. If changes are necessary, as indicated by the recipient's condition, in the ordered DME or supplies, the DME provider must obtain a new CMN. New CMNs must be signed and dated by the attending physician within 30 days from the time the ordered supplies are furnished by the DME provider.

7. DMAS shall have the authority to determine a different (from those specified above) length of time a CMN may be valid based on medical documentation submitted on the CMN. The CMN may be completed by the DME provider or other health care professionals, but it must be signed and dated by the attending physician. Supporting documentation may be attached to the CMN but the attending physician's entire order must be on the CMN.

8. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for DMAS' post payment audit review purposes. DME providers shall not create or revise CMNs or supporting documentation for this service after the initiation of the post payment review audit process. Attending physicians shall not complete, nor sign and date CMNs once the post payment audit review has begun.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

C. Effective July 1, 2010, the billing unit for incontinence supplies (such as diapers, pull-ups, and panty liners) shall be by each item. For example, an item can be one diaper. Prior authorization shall be required for incontinence supplies requested in quantities greater than the allowable limit as contained in the agency's guidance documents that apply to DME providers.

D. Supplies, equipment, or appliances that are not covered include, but are not limited to, the following:

1. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners

2. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office

3. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales)

4. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface;) mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience (i.e., electric wheelchair plus a manual chair); cleansing wipes.

5. Prosthesis, except for artificial arms, legs, and their supportive devices which must be preauthorized by the DMAS central office (Effective July 1, 1989)

6. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; and support stockings;

7. Orthotics, including braces, splints, and supports

8. Home or vehicle modifications

9. Items not suitable for or not used primarily in the home setting (i.e., car seats, equipment to be used while at school, etc.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

§ 6 A Fee for service providers.

4. Podiatry
5. Nurse-midwife services
6. Durable medical equipment (DME).

Definitions. The following words and terms, when used in this part, shall have :the following meanings unless the context clearly indicates otherwise:

"DMERC" means the Durable Medical Equipment Regional Carrier rate as published by Medicare at www.cms.gov/DMEPOSFeeSched/LSMDEPOSFEE/list.asp.

"HCPCS" means the Healthcare Common Procedure Coding System as published by Ingenix (copyright 2006), as may be periodically updated.

a. Reimbursement method.

(1) Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of durable medical equipment. The agency's fee schedule rate was set as of July 1, 2010, and is effective for services provided on or after that date.
(2) If the DME item has a DMERC rate, the reimbursement rate shall be the DMERC rate minus 10%.
(3) For DME items with no DMERC rate, the agency shall use the fee schedule amount. The reimbursement rates for durable medical equipment and supplies shall be listed in the appropriate agency guidance document. The fee schedule is available on the agency website at www.dmas.virginia.gov.
(4) If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the net manufacturer's charge to the provider, less shipping and handling, plus 30%.

b. Subject to CMS' approval, DMAS shall have the authority to amend the DME fee schedule as it deems appropriate and with notice to providers. DMAS shall determine alternate pricing, based on agency research, for any code which does not have a DMERC rate.

c. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be under specified procedure codes and reimbursed as determined by the agency. Certain services/durable medical equipment such as service maintenance agreements shall be under specified procedure codes and reimbursed as determined by the agency.

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12 VAC 30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

§ 6 A Fee for service providers. Durable Medical Equipment (continued)

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, non-continuous ventilators, and suction machines. Ventilators, non-continuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services
8. Laboratory services (Other than inpatient hospital)
9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)
10. X-Ray services.
11. Optometry services
12. Medical supplies and equipment
13. Home health services: Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by Supplement 3. (12 VAC30-80-180)
14. Physical therapy, occupational therapy, and speech, hearing, language disorders services when rendered to non-institutionalized recipients. Physical therapy, occupational therapy, and speech-language therapy services furnished by state rehabilitation agencies are paid on a cost basis (see sec. 2 D, page 4.1). All other services under this section furnished by state rehabilitation agencies are paid according to the state fee schedule (see sec. 6 A, page 4.8).
15. Clinic services, as defined under 42 CFR 440.90.
16. Supplemental payments to state government-owned or operated clinics. *(Repealed effective July 1, 2005)*