Table of Contents

State Name: Virginia

State Plan Amendment (SPA) #: 12-07

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

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

SWIFT #082020124068

Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Jones:

The Centers for Medicare & Medicaid Services (CMS) has reviewed Virginia's State Plan Amendment (SPA) 12-07, Durable Medical Equipment and Supplies Services Update. The purpose of this State Plan Amendment is to better define and establish the requirements of the Durable Medical Equipment program in order to reduce waste and inappropriately rendered services.

This SPA is acceptable. Therefore, we are approving SPA 12-07 with an effective date of July 1, 2012. Enclosed is the approved SPA pages and signed CMS-179 form.

If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

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: 12-07

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, 2012

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 440

7. FEDERAL BUDGET IMPACT
a. FFY 2011 $ (3,988,334)
b. FFY 2012 $ (3,339,755)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: See Attached Page - updated attachment CH 1/26/16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): See Attached Page

10. SUBJECT OF AMENDMENT: Durable Medical Equipment and Supplies Services Updates

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/ [redacted]

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: 7/18/12

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: August 20, 2012

18. DATE APPROVED: 03/23/2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2012

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Francis McCullough

22. TITLE: Associate Regional Administrator

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

Save

STATE PLAN AMENDMENT 12-07

Durable Medical Equipment and Supplies Services Update

Page Number of Plan Section or Attachment	Replaces Page	New Page
3.1 A&B Supplement 1 pages: 12, 13	Same page number	
		3.1 A&B Supplement 1 pages: 13.1, 13.2, 13.3, 13.4, 13.5
3.1 A&B Supplement 1 pages: 14, 15, 15.1, 15.2, 15.3	Same page number	
		3.1 A&B Supplement 1 pages: 16.0.1
Attachment 3.1 C, page 17	Same page number	
		Attachment 3.1 C, page 17.1, 17.2, 17.3
Attachment 3.1 C, page 18	Same page number	

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
and MEDICALLY 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.

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
and MEDICALLY NEEDY

§ 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 meanings unless the context clearly indicates otherwise:

"Affirmative contact" means speaking, either face-to-face or by phone, with either the individual or caregiver in order to ascertain that the DME and supplies are still needed and appropriate. Such contacts shall be documented in the individual's medical record.

"Certificate of Medical Necessity" or "CMN" means the DMAS-352 form required to be completed and submitted in order for DMAS to provide coverage.

"Designated agent" means an entity with whom DMAS has contracted to perform contracted functions such as provider audits and prior authorizations of services.

"DME provider" means those entities enrolled with DMAS to render DME services.

"Durable medical equipment" or "DME" means medical equipment, supplies, and appliances suitable for use in the home consistent with 42 CFR 440.70(b)(3) that treat a diagnosed condition or assist the individual with functional limitations.

"Expendable supply" means an item that is used and then disposed of.

"Frequency of use" means the rate of use by the individual as documented by the number of times per day/week/month, as appropriate, a supply is used by the individual. Frequency of use must be recorded on the face of the CMN in such a way that reflects whether a supply is used by the individual on a daily, weekly, or monthly basis. Frequency of use may be documented on the CMN as a range of the rate of use. By way of example and not limitation, the frequency of use of a supply may be expressed as a range, such as four to six adult diapers per day. However, large ranges shall not be acceptable documentation of frequency of use (for example, the range of one to six adult diapers per day shall not be acceptable.) The frequency of use provides the justification for the total quantity of supplies ordered on the CMN.

"Functional limitation" means the inability to perform a normal activity.

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

"Prior authorization" or "PA" (also "service authorization") means the process of approving either by DMAS or its prior authorization (or service authorization) contractor for the purposes of DMAS reimbursement for the service for the individual before it is rendered or reimbursed.

"Quantity" means the total number of supplies ordered on a monthly basis as reflected on the CMN. The monthly quantity of supplies ordered for the individual shall be dependent upon the individual's frequency of use.

"Sole source of nutrition" means that the individual is unable to tolerate (swallow or absorb) any other form of oral nutrition in instances when more than 75% of the individual's daily caloric intake is received from nutritional supplements.

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
and MEDICALLY NEEDY

B. General requirements and conditions (pursuant to 42 CFR § 440.70) Medical supplies, equipment, and appliances shall be provided to Medicaid individuals in accordance with the Septemer 4, 1998 State Medicaid Director letter.

1. a. All medically necessary 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.

b. No provider shall have a claim of ownership on DME reimbursed by Virginia Medicaid once it has been delivered to the Medicaid individual. Providers shall only be permitted to recover DME, for example, when DMAS determines that it does not fulfill the required medically necessary purpose as set out in the Certificate of Medical Necessity, when there is an error in the ordering practitioner's CMN, or when the equipment was rented.

2. DME providers shall adhere to all applicable federal and state laws and regulations and DMAS policies for DME and supplies. DME providers shall comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations that are required by such licensing agency or agencies shall result in denial of coverage for DME or supplies which are regulated by such licensing agency or agencies. Upon post payment review, DMAS or its designated contractor may deny coverage for any DME products or supplies that have not been provided and billed in accordance with these regulations and DMAS policies.

3. DME products or supplies must be furnished pursuant to a properly completed Certificate of Medical Necessity (CMN) (DMAS-352). In order to obtain Medicaid coverage, specific fields of the DMAS-352 form shall be completed as specified in Attachment 3.1-C, p. 17.1 (12VAC30-60-75).

4. DME and supplies shall be ordered by the physician and shall be related to medical treatment of the Medicaid individual. The complete DME order shall be recorded on the CMN for Medicaid individuals to receive such services. In the absence of a different effective period determined by DMAS or its designated agent, the CMN shall be valid for a maximum period of six months for Medicaid individuals younger than 21 years of age. In the absence of a different effective period determined by DMAS or its designated agent, the maximum valid time period for CMNs for Medicaid individuals 21 years of age and older shall be 12 months. The validity of the CMN shall terminate when the individual's medical need for the prescribed DME or supplies no longer exists as determined by the physician.

5. DME shall be furnished exactly as ordered by the physician who signed the CMN. The CMN and any supporting verifiable documentation shall be fully completed, signed, and dated by the physician, and in the DME 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 items shall be specifically ordered on the CMN by the physician. The order shall not be backdated to cover prior dispensing of all DME products and supplies. If the order is not signed within 60 days of the service initiation, then the date the order is signed becomes the effective date.

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
and MEDICALLY NEEDY

6. The CMN shall not be changed, altered, or amended after the physician has signed it. If the individual's condition indicates that changes in the ordered DME or supplies are necessary, the DME provider shall obtain a new CMN. All new CMNs shall be signed and dated by the physician within 60 days from the time the ordered supplies are furnished by the DME provider.

7. DMAS or its designated agent 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 appropriate health care professionals, but it shall be signed and dated by the physician, as specified in subdivision 5 of this subsection. Supporting documentation may be attached to the CMN but the physician's entire order for DME and supplies shall 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. Physicians shall not complete, sign, or date CMNs once the post payment audit review has begun.

9. The DME provider shall be responsible for knowledge of items requiring prior authorization and the limitation on the provision of certain items as described in the Virginia Medicaid Durable Medical Equipment and Supplies Manual, Appendix B. (This limitation may be exceeded based upon medical necessity.) The Appendix B shall be the official listing of all items covered through the Virginia Medicaid DME program and lists the service limits, items that require prior authorization, billing units, and reimbursement rates.

10. The DME provider shall be required to make affirmative contact with the individual or caregiver and document the interaction prior to the next month's delivery and prior to the recertification CMN to assure that the appropriate quantity, frequency, and product are provided to the individual.

11. Supporting documentation, added to a completed CMN, shall be allowed to further justify the medical need for DME but shall not replace the requirement for a properly completed CMN.

12. DMAS shall deny payment to the DME provider if any of the following occur:

a. Absence of a current, fully completed CMN appropriately signed and dated by the practitioner;

b. Documentation does not verify that the item was provided to the individual;

c. Lack of medical documentation, signed by the practitioner to justify the DME products or supplies; or

d. Item is noncovered or does not meet DMAS criteria for coverage.

13. If coverage is denied by Medicaid, the DME provider shall not bill the Medicaid individual for the service that was provided.

C. Effective July 1, 2010, incontinence supplies (such as diapers, pull-ups, and panty liners) shall be by each product. For example, if the incontinence supply being provided is diapers, DMAS will cover them by each individual diaper, rather than a case of diapers. Prior authorization shall be required for incontinence supplies provided in quantities greater than the allowable service limit per month. This service shall be provided by a sole source contract.

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

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

2. DME and supplies for any hospital resident, except ventilators and associated supplies or specialty beds for the treatment of wounds consistent with DME criteria that have been prior approved by the DMAS central office or designated agent;

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

5. Prostheses. Refer to section 12 for the coverage requirements of prosthetics services, Attachment 3.1A&B, Supplement 1, page 20 (12 VAC 30-50-210).

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
and MEDICALLY NEEDY

6. Items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (e.g., dentifrices; toilet articles; shampoos that do not require a practitioner's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions that do not require a practitioner's prescription; sugar and salt substitutes; and support stockings);
7. Orthotics, including braces, diabetic shoe inserts, splints, and supports;
8. Home or vehicle modifications;
9. Items not suitable for or not used primarily in the home setting (e.g., car seats, equipment to be used while at school, etc.);
10. Equipment for which the primary function is vocationally or educationally related (e.g., computers, environmental control devices, speech devices, etc.);
11. Diapers for routine use by children younger than three years of age who have not yet been toilet trained;
12. Equipment or items that are not suitable for use in the home; and
13. Equipment or items that the Medicaid individual or caregiver is unwilling or unable to use in the home.
14. All medically necessary supplies and equipment shall be covered; unusual types shall be preauthorized based on a medical necessity determination. Individuals shall be notified of their right to appeal any denial determination.

E. For coverage of blood glucose meters for pregnant women, refer to Supplement 3 to Attachment 3.1 A&B.

F. Coverage of home infusion therapy.

1. Home infusion therapy shall be defined as the intravenous (I.V.) administration of fluids, drugs, chemical agents, or nutritional substances to recipients in the home setting. DMAS shall cover these services, supplies, and drugs on a service day rate methodology established in Attachment 4.19-B, page 4.8 (12VAC30-80-30). The therapies to be covered under this policy shall be: hydration therapy, chemotherapy, pain management therapy, drug therapy, and total parenteral nutrition (TPN). All the therapies that meet criteria shall be covered and do not require prior authorization. The established service day rate shall cover all services delivered in a single day. There shall be no additional reimbursement for special or extraordinary services. In the event of incompatible drug administration, a separate HCPCS code shall be used to allow for rental of a second infusion pump and purchase of an extra administration tubing. When applicable, this code may be billed in addition to the other service day rate codes. There shall be documentation to support the use of this code on the I.V. Implementation Form. Proper documentation shall include the need for pump administration of the medications ordered, frequency of administration to support that they are ordered simultaneously, and indication of incompatibility.

2. The service day rate payment methodology shall be mandatory for reimbursement of all I.V. therapy services except for the individual who is enrolled in the Technology Assisted Waiver.

3. The following limitations shall apply to this service:

a. This service must be medically necessary to treat an individual's medical condition. The service must be ordered and provided in accordance with accepted medical practice. The service must not be desired solely for the convenience of the individual or the individual's caregiver.

b. In order for Medicaid to cover this service, the individual shall:

(1) Reside in either a private home or a domiciliary care facility;

(2) Be under the care of a physician who prescribes the home infusion therapy and monitors the progress of the therapy;

(3) Have body sites available for peripheral intravenous catheter or needle placement or have a central venous access; and

(4) Be capable of either self-administering such therapy or have a caregiver who can be adequately trained, is capable of administering the therapy, and is willing to safely and efficiently administer and monitor the home infusion therapy. The caregiver must be willing to and be capable of following appropriate teaching and adequate monitoring. In cases where the individual is incapable of administering or monitoring the prescribed therapy and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

G. The DME and supply vendor shall provide the equipment and supplies as prescribed by the physician on the CMN. Orders shall not be changed unless the vendor obtains a new CMN, which includes the physician's signature, prior to ordering the equipment or supplies or providing the equipment or supplies to the individual.

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
and MEDICALLY NEEDY

H. Medicaid shall not provide coverage to the DME and supply vendor for services that are provided either: (i) prior to the date prescribed by the physician; (ii) prior to the date of the delivery; or (iii) when services are not provided in accordance with DMAS' published regulations and guidance documents. If coverage is denied for one or all of these reasons, the DME and supply vendor shall not bill the Medicaid individual for the service that was provided.

I. Criteria for the coverage of equipment, appliances, and supplies. The following criteria shall be satisfied through the submission of adequate and verifiable documentation on the CMN satisfactory to DMAS. Medically necessary DME and supplies shall be:

1. Ordered by the physician on the CMN;

2. A reasonable and necessary part of the individual's treatment plan;

3. Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;

4. Not furnished solely for the convenience, safety, or restraint of the individual, the family or caregiver, the physician, or other physician or supplier;

5. Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and

6. Furnished at a safe, effective, and cost-effective level suitable for use in the individual's home environment.

J. Medical documentation shall provide DMAS or the designated agent with evidence of the individual's DME needs. Complete and accurate medical documentation must be submitted to DMAS and may be recorded on the CMN or evidenced in the supporting documentation attached to the CMN.

K. DME provider responsibilities. Providers must follow all required state processes, including authorization processes, in order to receive appropriate reimbursement.

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
and MEDICALLY NEEDY

L. Enteral nutrition products. Individuals receive covered enteral nutrition based on medical need. Coverage of enteral nutrition (EN) that does not include a legend drug shall be limited to when the nutritional supplement is the sole source form of nutrition, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of EN shall not include the provision of routine infant formula. A nutritional assessment shall be required for all recipients for whom nutritional supplements are ordered.

1. General requirements and conditions.

a. Enteral nutrition products shall only be provided by enrolled DME providers.

b. DME providers shall adhere to all applicable DMAS policies, laws, and regulations. 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 enteral nutrition that is regulated by such licensing agency or agencies.

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
and MEDICALLY NEEDY

2. Service units and service limitations.

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

b. The DME provider shall include documentation related to the nutritional evaluation findings on the CMN and may include supplemental information on any supportive documentation submitted with the CMN.

c. DMAS shall cover medically necessary formulae and medical foods when used under a physician's direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods.

d. The CMN shall contain a physician's order for the enteral nutrition products that are medically necessary to treat the diagnosed condition and the individual's functional limitation. The CMN shall be valid for a maximum period of six months.

e. Regardless of the amount of time that may be left on a six-month approval period, the validity of the CMN shall terminate when the individual's medical need for the prescribed enteral nutrition products either ends, as determined by the physician, or when the enteral nutrition products are no longer the primary source of nutrition.

f. Prior authorization of enteral nutrition products shall not be required.

g. The DME provider is further responsible for assuring that enteral nutrition products are provided in accordance with DMAS reimbursement criteria in Attachment 4.19-B §6(A)(6), (12VAC30-80-30 A 6).

h. DMAS shall deny payment to the DME provider if any of the following occur:
(1) Absence of a current, fully completed CMN appropriately signed and dated by the physician;
(2) Documentation does not verify that the item was provided to the individual;
(3) Lack of medical documentation, signed by the physician to justify the enteral nutrition products; or
(4) Item is noncovered or does not meet DMAS criteria for coverage.

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
and MEDICALLY NEEDY

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§8 Private duty nursing services. (12 VAC 30-50-170)

A. Not provided.

§9 Clinic services. (12 VAC 30-50-180)

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to the life of the mother if the fetus were carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;

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
and MEDICALLY NEEDY

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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
and MEDICALLY NEEDY

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§ 9.5 Clinic services: substance abuse treatment services (12 VAC 30-50-180) and 42 CFR 440.90)

D. Coverage of community mental health clinics for substance abuse treatment services is provided only when performed by a qualified therapist. For purposes of providing this service a qualified therapist shall be:

1. Medical doctors and doctors of osteopathy who have completed three years of post-graduate residency training in psychiatry or by a physician or doctor of osteopathy who is certified in addiction medicine.

2. A licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, or a licensed substance abuse treatment practitioner. The provider must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities.

3. An individual who holds a master's or doctorate degree, who has completed all coursework necessary for licensure by the respective board, and who has applied for a license but has not yet received such license, and who is currently supervised in furtherance of the application for such license, in accordance with requirements or regulations promulgated by DMAS, by one of the licensed practitioners listed in subdivisions 1 and 2 of this subsection.

A. Substance abuse treatment services provided in clinics shall be prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by one of the professionals listed in (D)(1) or (2).

2) Occupational therapy services shall be directly and specifically related to an active written plan of care designed by a physician after any needed consultation with an occupational therapist registered and licensed by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and licensed by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine, or an occupational therapy assistant who is certified by the National Board for Certification in Occupational Therapy under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant, such services shall be provided under the supervision of a qualified occupational therapist, as defined above, who makes an onsite supervisory visit at least once every 30 days. This supervisory visit shall not be reimbursable.

(3) Speech-language pathology services shall be directly and specifically related to an active written plan of care designed and personally signed and dated by a physician after any needed consultation with a speech-language pathologist licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech Pathology. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech Pathology.

(d) A visit shall be defined as the duration of time that a nurse, home health aide, or rehabilitation therapist is with a client to provide services prescribed by a physician and that are covered home health services. Visits shall not be defined in measurements or increments of time.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

Durable Medical Equipment (DME) and Supplies. (12 VAC 30-60-75)

A. No provider shall have a claim of ownership on DME covered by Virginia Medicaid once it has been delivered to the Medicaid individual. Providers shall only be permitted to recover DME, for example, when DMAS determines that it does not fulfill the required medically necessary purpose as set out in the Certificate of Medical Necessity (CMN), when there is an error in the ordering physician's CMN, or when the equipment was rented. DMAS shall not cover the DME and supply provider for services that are provided either: (i) prior to the date prescribed by the physician; (ii) prior to the date of the delivery; or (iii) when services are not provided in accordance with DMAS' published regulations and guidance documents. In instances when the DME or supply is shipped directly to the Medicaid individual, the DME provider shall confirm that the DME or supplies have been received by the individual before submitting the claim for payment to DMAS.

B. DME providers, as defined in Attachment 3.1A&B, Supplement 1, page 13 (12VAC30-50-165), shall retain copies on file of the fully completed CMN and all applicable supporting documentation for post payment audit reviews. Coverage that has been made by Medicaid shall be retracted if the DME and supplies have not been ordered on the CMN. Additional supporting documentation is allowed to justify the medical need for durable medical equipment and supplies. Supporting documentation shall not replace the requirement for a properly completed CMN. The dates of the supporting documentation shall coincide with the dates of service on the CMN. The physician providing the supporting documentation shall be identified by name and title. DME providers shall not create or revise CMNs or supporting documentation for durable medical equipment and supplies that have been provided once the post payment audit review has been initiated.

C. Individuals requiring only DME or supplies may obtain such services directly from the DME provider without having to consult or obtain services from a home health service or home health provider. Supplies used for treatment during a home health visit shall be included in the visit rate of the home health provider. Treatment supplies left in the home to maintain treatment after the visits shall be charged separately.

D. CMN requirements. The CMN shall have two required components: (i) the physician's order and (ii) the clinical diagnosis. Failure to have a complete CMN may result in nonpayment of services rendered or retraction of payments made subsequent to post payment audits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

1. Physician's order.

a. The physician's complete order shall appear on the face of the CMN. A complete order on the CMN shall consist of the item's complete description, the quantity ordered, the frequency of use, and the physician's signature and complete date of signing as defined in Attachment 3.1A&B, Supplement 1, page 13 (12VAC30-50-165). If the DME provider determines that the prescribing physician's signature and complete date of signing are missing, he shall consider the CMN to be invalid and he shall request a new CMN.

b. The following CMN fields (as indicated by an asterisk on the CMN) shall be required for coverage:

(1) The ordered item's description. If the item is an E1399 (miscellaneous), the description of the item shall not be "miscellaneous DME," but the provider shall specify the DME item or supply.
(2) The quantity ordered as found in the physician's order. For expendable supplies the provider shall designate supplies needed for one month. If an item is not needed every month, the provider may designate an alternate time frame.
(3) The frequency of use of the DME item or supply.
(4) The physician's signature and full date. If either the signature or full date, or both, are missing, then the entire CMN shall be deemed to be invalid and a new CMN shall be obtained. The physician's signature certifies that the ordered DME and supplies are a part of the treatment plan and are medically necessary for the Medicaid individual.

c. The begin service date on the CMN is optional.

(1) If the provider enters a begin service date, the CMN must be signed and dated by the physician within 60 days of the begin service date in order for the CMN to start from the begin date.
(2) If no begin service date is documented on the CMN, the date of the physician's signature shall be the start date of the CMN.

2. The clinical diagnosis.

a. The narrative description of the clinical diagnosis shall be recorded on the face of the CMN.
b. The recording on the face of the CMN of the relevant ICD-~~9~~ diagnosis code shall be optional.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

3. Supporting documentation.

a. Supporting documentation may be included in the additional information attached to the CMN.

b. The attachment of supporting documentation shall not replace the requirement for a properly completed CMN.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

K. Optometrists services are limit to examinations (refractions) after preauthorization by the State Agency except for eyeglasses as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).