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MEMORANDUM

TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **MICHELLE A. L'HOMMEDIEU**
Assistant Attorney General

DATE: **April 10, 2014**

SUBJECT: **Exempt Final Regulation to Update References to ICD 9 (4135/6882)**

I have reviewed the attached exempt final regulation regarding the update of references in DMAS' regulations from the International Classification of Diseases (ICD), 9th edition to the 10th edition in compliance with federal requirements (FR 77:172, 9/5/2012, pp. 54664 *et seq.*). You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to amend the regulations and if the regulations comport with state and federal law.

The Centers for Medicare & Medicaid Services, of the U.S. Department of Health & Human Services (CMS) published a final rule in the *Federal Register* (FR 77:172) on September 5, 2012 (pp. 54664 *et seq.*) requiring the implementation of the tenth editions of the International Classification of Diseases, Clinical Modification, and the International Classification of Diseases, Procedure Coding System by October 1, 2014. DMAS is complying with the final rule by updating its regulations' references to International Classification of Diseases from "ICD-9" to "ICD" and creating a general definitions regulation. The sections of the State Plan that are being updated by this action are: Standards Established and Methods Used to Assure High Quality of Care (12 VAC 30-60-75 durable medical equipment services); Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services (12 VAC 30-70-221); Methods and

Standards for Establishing Payment Rates-Other Types of Providers (12 VAC 30-80-20 (cost based providers) and 80-30 (fee-for-service providers)); and Amount, Duration, and Scope of Selected Services (12 VAC 30-130 client medical management). The Virginia specific regulation created by this action is: Standards Established and Methods Used for Fee-for-Service Reimbursement, General Definitions (12 VAC 30-95-5). Based on my review, it is my view that the Director of DMAS, acting on behalf of the Board of Medical Assistance Services, pursuant to Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA") and has not exceeded that authority.

Based on the foregoing, it is my view that the amendments and addition to these regulations are exempt from the procedures of Article 2 of the APA pursuant to Va. Code § 2.2-4006(A)(4)(c). Because some of these regulations will amend the State Plan, approval by CMS regarding those regulations will also be required. If you have any questions, please contact me at 786-6005.

cc: Kim F. Piner, Esquire

Attachment

Project 3959 - Final

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Update References to ICD 9

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-60-75. Durable medical equipment (DME) and supplies.

A. 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 (CMN), when there is an error in the ordering practitioner's CMN, or when the equipment was rented. DMAS shall not reimburse the DME and supply provider for services that are provided either: (i) prior to the date prescribed by the licensed practitioner; (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 his claim for payment to DMAS.

B. DME providers, as defined in 12VAC30-50-165, shall retain copies on file of the fully completed CMN and all applicable supporting documentation for post payment audit reviews. Reimbursement 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 licensed practitioner 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 licensed practitioner'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.

1. Licensed practitioner's order.

a. The licensed practitioners' 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 licensed practitioner's signature and complete date of signing as defined in 12VAC30-50-165. If the DME provider determines that the prescribing licensed practitioner'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 reimbursement:

(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 licensed practitioner'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 licensed practitioner's signature and full date. If either the licensed practitioner's 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 licensed practitioner'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 licensed practitioner 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 practitioner'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~~ ICD diagnosis code shall be optional. As used here, the term "ICD" is defined in 12 VAC 30-95-5.

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.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

Article 2

Prospective (DRG-Based) Payment Methodology

12VAC30-70-221. General.

A. Effective July 1, 2000, the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

1. As stipulated in 12VAC30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times relative weight of the DRG to which the case is assigned.

2. As stipulated in 12VAC30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities

licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12VAC30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12VAC30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12VAC30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12VAC30-70-281, payments for direct medical education costs of nursing schools and paramedical programs shall be made on an allowable cost basis. Payment for direct graduate medical education (GME) costs for interns and residents shall be made quarterly on a prospective basis, subject to cost settlement based on the number of full time equivalent (FTE) interns and residents as reported on the cost report.

7. As stipulated in 12VAC30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12VAC30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the

DRG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" reflects the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" reflects the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases."

"Cost" means allowable cost as defined in Supplement 3 (12VAC30-70-10 through 12VAC30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid utilization rate in excess of 14%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subdivision 2 of this definition does not apply to a hospital:

a. At which the inpatients are predominantly individuals under 18 years of age; or

b. Which does not offer nonemergency obstetric services as of December 21, 1987.

"DRG cases" means medical/surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

"Medicaid utilization percentage" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This definition includes all paid Medicaid days (from DMAS MR reports for fee-for-service days and managed care organization or hospital reports for HMO days) and nonpaid/denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits (with appropriate documentation). The definition of Medicaid days does not include any general assistance, Family Access to Medical Insurance Security (FAMIS), State and Local Hospitalization (SLH), charity care, low-income, indigent care, uncompensated care, bad debt, or Medicare dually eligible days. It does not include days for newborns not enrolled in Medicaid during the fiscal year even though the mother was Medicaid eligible during the birth.

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric DPU, divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The operating cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and include (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ~~ICD-9-CM~~ ICD as defined in 12 VAC 30-95-5. Not all mental disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A & B (12VAC30-50-95 through 12VAC30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" occur when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ~~ICD-9-CM~~ ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12 VAC 30-95-5.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ~~ICD-9-CM~~ ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12 VAC 30-95-5.

"Type One" hospitals means those hospitals that were state-owned teaching hospitals on January 1, 1996. "Type Two" hospitals means all other hospitals.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. Until notification of a change is given, Version 14.0 of this grouper shall be used. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology	
Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file

Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports
Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims history file
Outlier adjustment factor	Federal Register

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-70)

All Patient Diagnosis Related Groups (AP-DRG) Grouper, DRG and MDC Code Listings, Version 12, January 1995.

Health Care Cost Review, Third Quarter 2009, IHS Global Insight.

International Classification of Diseases (ICD-9-CM) (effective for claims with dates of service through September 30, 2014), Physician, Volumes 1 and 2, American Medical Association, 2007.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-80-20. Services that are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision D 1 d. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules that reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. Outpatient hospital services including rehabilitation hospital outpatient services and excluding laboratory.

a. Definitions. The following words and terms when used in this regulation shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services, including those obstetric and pediatric procedures contained in 12VAC30-80-160, rendered in emergency departments that DMAS determines were nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ~~ICD-9-CM~~ ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12 VAC 30-95-5.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ~~ICD-9-CM~~ ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12 VAC 30-95-5.

c. Limitation of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at various percentages as noted in subdivisions 1 c (1) and (2) of this subsection of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date,

based on the number of calendar months in the cost reporting period, falling before and after that date.

(1) Type One hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating reimbursement shall be at 91.2% of allowable cost and capital reimbursement shall be at 87% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating reimbursement shall be at 90.2% of allowable cost and capital reimbursement shall be at 86% of allowable cost.

(2) Type Two hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating and capital reimbursement shall be 77% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating and capital reimbursement shall be 76% of allowable cost.

d. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12VAC30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

2. Rehabilitation agencies or comprehensive outpatient rehabilitation.

a. Effective July 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities that are operated by community services boards or state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

b. Effective October 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities operated by state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-80-30. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12VAC30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services. Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public). The following limitations shall apply to emergency physician services.

a. Definitions. The following words and terms, when used in this subdivision 1 shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services, including those obstetric and pediatric procedures contained in

12VAC30-80-160, rendered in emergency departments that DMAS determines are nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services determined by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology in subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology in subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ~~ICD-9-CM~~ ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12 VAC 30-95-5.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ~~ICD-9-CM~~ ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12 VAC 30-95-5.

2. Dentists' services.

3. Mental health services including: (i) community mental health services; (ii) services of a licensed clinical psychologist; or (iii) mental health services provided by a physician.

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME) and supplies.

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 the Centers for Medicare and Medicaid Services at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

"HCPCS" means the Healthcare Common Procedure Coding System, Medicare's National Level II Codes, HCPCS 2006 (Eighteenth edition), as published by Ingenix, as may be periodically updated.

a. Obtaining prior authorization shall not guarantee Medicaid reimbursement for DME.

b. The following shall be the reimbursement method used for DME services:

(1) If the DME item has a DMERC rate, the reimbursement rate shall be the DMERC rate minus 10%.

(2) For DME items with no DMERC rate, the agency shall use the agency fee schedule amount.The reimbursement rates for DME and supplies shall be listed in the DMAS Medicaid Durable Medical Equipment (DME) and Supplies Listing and updated periodically. The agency fee schedule shall be available on the agency website at www.dmas.virginia.gov.

(3) If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the manufacturer's net charge to the provider, less shipping and handling, plus 30%. The manufacturer's net charge to the provider shall be the cost to the provider minus all available discounts to the provider. Additional information specific to how DME providers, including manufacturers who are enrolled as providers, establish and document their cost or costs for DME codes that do not have established rates can be found in the relevant agency guidance document.

c. DMAS shall have the authority to amend the agency fee schedule as it deems appropriate and with notice to providers. DMAS shall have the authority to determine alternate pricing, based on agency research, for any code that does not have a rate.

d. The reimbursement for incontinence supplies shall be by selective contract. Pursuant to § 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d), the Commonwealth assures that adequate services/devices shall be available under such arrangements.

e. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be bundled under specified procedure codes and reimbursed as determined by the agency. Certain services/durable medical equipment such as service maintenance agreements shall be bundled 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 bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12VAC30-80-40, 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 bundled 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.

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components bundled 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, noncontinuous ventilators, and suction machines. Ventilators, noncontinuous 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 bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled 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 12VAC30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90.

16. Supplemental payments for services provided by Type I physicians.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Type I physicians for furnished services provided on or after July 2, 2002. A Type I physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 2, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for Type I physician services and Medicare rates. Effective August 13, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 143% of Medicare rates. This percentage was determined by dividing the total commercial allowed amounts for Type I physicians for at least the top five commercial insurers in CY 2004 by what Medicare would have allowed. The average commercial allowed amount was determined by multiplying the relative value units times the conversion factor for RBRVS procedures and by multiplying the unit cost times anesthesia units

for anesthesia procedures for each insurer and practice group with Type I physicians and summing for all insurers and practice groups. The Medicare equivalent amount was determined by multiplying the total commercial relative value units for Type I physicians times the Medicare conversion factor for RBRVS procedures and by multiplying the Medicare unit cost times total commercial anesthesia units for anesthesia procedures for all Type I physicians and summing.

c. Supplemental payments shall be made quarterly.

d. Payment will not be made to the extent that this would duplicate payments based on physician costs covered by the supplemental payments.

17. Supplemental payments for services provided by physicians at Virginia freestanding children's hospitals.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Virginia freestanding children's hospital physicians providing services at freestanding children's hospitals with greater than 50% Medicaid inpatient utilization in state fiscal year 2009 for furnished services provided on or after July 1, 2011. A freestanding children's hospital physician is a member of a practice group (i) organized by or under control of a qualifying Virginia freestanding children's hospital, or (ii) who has entered into contractual agreements for provision of physician services at the qualifying Virginia freestanding children's hospital and that is designated in writing by the Virginia freestanding children's hospital as a practice plan for the quarter for which the supplemental payment is made subject to DMAS approval. The freestanding children's hospital physicians also must have entered into contractual agreements with the practice plan for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 1, 2011, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 143% of Medicare rates as defined in the supplemental payment calculation for Type I physician services subject to the following reduction. Final payments shall be reduced on a pro-rated basis so that total payments for freestanding children's hospital physician services are $400,000 less annually than would be calculated based on the formula in the previous sentence. Payments shall be made on the same schedule as Type I physicians.

18. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. Effective July 1, 2005, a qualifying clinic is a clinic operated by a community services board. The state share for supplemental clinic payments will be funded by general fund appropriations.

b. The amount of the supplemental payment made to each qualifying nonstate government-owned or operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 18 d and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 18 b (1) for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision 18 b (2) by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments for furnished services made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

d. To determine the aggregate upper payment limit referred to in subdivision 18 b (3), Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12VAC30-80-190 B 2) in regard to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

19. Personal Assistance Services (PAS) for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200. These services are reimbursed in accordance with the state agency fee schedule described in 12VAC30-80-190. The state agency fee schedule is published on the Single State Agency Website.

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, and take into account the room and board furnished by the facility, equal to at least 95% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be

paid according to the location of the service delivery and not the location of the agency's home office.

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-80)

Approved Drug Products with Therapeutic Equivalence Evaluations, 25th Edition, 2005, U.S. Department of Health and Human Services.

International Classification of Diseases, ICD-9-CM 2007 (effective for claims with dates of service through September 30, 2014), Physician, Volumes 1 and 2, 9th Revision-Clinical Modification, American Medical Association.

Durable Medical Equipment, Prosthetics/Orthotics & Supplies Fee Schedules, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html, Jan. 2012, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services.

Virginia Medicaid Durable Medical Equipment and Supplies Provider Manual, Appendix B (rev. 1/11), Department of Medical Assistance Services.

CHAPTER 95

STANDARDS ESTABLISHED AND METHODS USED FOR FEE-FOR-SERVICE REIMBURSEMENT

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-95-5. General definitions.

The following words and terms when used in these regulations for Title 12, Agency 30 shall have the following meanings unless the context clearly indicates otherwise:

"ASAM" means (McKesson InterQual ® Criteria)

"CPT" means the Current Procedural Terminology, Revised 2014, American Medical Association.

"DSM" means (i) for diagnoses made up through September 30, 2014, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-TR-IV), copyright 2012; (ii) for diagnoses made beginning October 1, 2014, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), copyright 2013, American Psychiatric Association.

"HCPCS" means the Health Care Procedure Coding System, Level II, Revised 2013, OptumInsight, Inc.

"ICD" means (i) for claims with dates of service on or prior to September 30, 2014, the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Volumes 1, 2, and 3, OptumInsight, Inc., and (ii) for claims with dates of service on or after October 1, 2014, the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and Procedure Coding System (ICD-10-PCS) pursuant to 45 CFR 162.1002, OptumInsight, Inc.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

Part XIII

Client Medical Management Program

12VAC30-130-800. Definitions.

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

"APA" means the Administrative Process Act established by Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 of the Code of Virginia.

"Abuse by recipients" means practices by recipients which are inconsistent with sound fiscal or medical practices and result in unnecessary costs to the Virginia Medicaid Program.

"Abuse by providers" means practices which are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Virginia Medicaid Program or in reimbursement for a level of utilization or pattern of services that is not medically necessary.

"Card-sharing" means the intentional sharing of a recipient eligibility card for use by someone other than the recipient for whom it was issued, or a pattern of repeated unauthorized use of a recipient eligibility card by one or more persons other than the recipient for whom it was issued due to the failure of the recipient to safeguard the card.

"Client Medical Management Program (CMM) for recipients" means the recipients' utilization control program designed to prevent abuse and promote improved and cost efficient medical management of essential health care for noninstitutionalized recipients through restriction to one primary care provider, one pharmacy, and one transportation provider, or any combination of these three designated providers. Referrals may not be made to providers restricted through the Client Medical Management Program, nor may restricted providers serve as covering providers.

"Client Medical Management Program (CMM) for providers" means the providers' utilization control program designed to complement the recipient abuse and utilization control program in promoting improved and cost efficient medical management of essential health care. Restricted providers may not serve as designated providers for restricted recipients. Restricted providers may not serve as referral or covering providers for restricted recipients.

"Contraindicated medical care" means treatment which is medically improper or undesirable and which results in duplicative or excessive utilization of services.

"Contraindicated use of drugs" means the concomitant use of two or more drugs whose combined pharmacologic action produces an undesirable therapeutic effect or induces an adverse effect by the extended use of a drug with a known potential to produce this effect.

"Covering provider" means a provider designated by the primary provider to render health care services in the temporary absence of the primary provider.

"DMAS" means the Department of Medical Assistance Services.

"Designated provider" means the provider who agrees to be the designated primary physician, designated pharmacy, or designated transportation provider from whom the restricted recipient must first attempt to seek health care services. Other providers may be established as designated providers with the approval of DMAS.

"Diagnostic category" means the broad classification of diseases and injuries found in the ~~International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)~~ ICD as defined in 12 VAC 30-95-5 which is commonly used by providers in billing for medical services.

"Drug" means a substance or medication intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease as defined by the Virginia Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).

"Duplicative medical care" means two or more practitioners concurrently treat the same or similar medical problems or conditions falling into the same diagnostic category, excluding confirmation for diagnosis, evaluation, or assessment.

"Duplicative medications" means more than one prescription of the same drug or more than one drug in the same therapeutic class.

"Emergency hospital services" means those hospital services that are necessary to treat a medical emergency. Hospital treatment of a medical emergency necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"EPSDT" means the Early and Periodic Screening, Diagnosis, and Treatment Program which is federally mandated for eligible individuals under the age of 21.

"Excessive medical care" means obtaining greater than necessary services such that health risks to the recipient or unnecessary costs to the Virginia Medicaid Program may ensue from the accumulation of services or obtaining duplicative services.

"Excessive medications" means obtaining medication in greater than generally acceptable maximum therapeutic dosage regimens or obtaining duplicative medication from more than one practitioner.

"Excessive transportation services" means obtaining or rendering greater than necessary transportation services such that unnecessary costs to the Virginia Medicaid Program may ensue from the accumulation of services.

"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 laws.

"Health care" means any covered services, including equipment, supplies, or transportation services, provided by any individual, organization, or entity that participates in the Virginia Medical Assistance Program.

"Medical emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in (i) placing the client's health in serious jeopardy, (ii) serious impairment of bodily functions, or (iii) serious dysfunction of any bodily organ or part.

"Medical management of essential health care" means a case management approach to health care in which the designated primary physician has responsibility for assessing the needs

of the patient and making referrals to other physicians and clinics as needed. The designated pharmacy has responsibility for monitoring the drug regimen of the patient.

"Noncompliance" means failing to follow Client Medical Management Program procedures, or a pattern of utilization which is inconsistent with sound fiscal or medical practices. Noncompliance includes, but is not limited to, failure to follow a recommended treatment plan or drug regimen; failure to disclose to a provider any treatment or services provided by another provider; requests for medical services or medications which are not medically necessary; or excessive use of transportation services.

"Not medically necessary" means an item or service which is not consistent with the diagnosis or treatment of the patient's condition or an item or service which is duplicative, contraindicated, or excessive.

"Pattern" means duplication or frequent occurrence.

"Practitioner" means a health care provider licensed, registered, or otherwise permitted by law to distribute, dispense, prescribe, and administer drugs or otherwise treat medical conditions.

"Primary care provider" or "PCP" means the designated primary physician responsible for medical management of essential health care for the restricted recipient.

"Provider" means the individual, facility or other entity registered, licensed, or certified, as appropriate, and enrolled by DMAS to render services to Medicaid recipients eligible for services.

"Psychotropic drugs" means drugs which alter the mental state. Such drugs include, but are not limited to, morphine, barbiturates, hypnotics, antianxiety agents, antidepressants, and antipsychotics.

"Recipient" means the individual who is eligible, under Title XIX of the Social Security Act, to receive Medicaid covered services.

"Recipient eligibility card" means the document issued to each Medicaid enrollee; an individual document issued to each Medicaid recipient listing the name and Medicaid number (either the identification or billing number) of the eligible individual. This document may be in the form of a plastic card magnetically encoded, allowing electronic access to inquiries for eligibility status.

"Restriction" means an administrative action imposed on a recipient which limits access to specific types of health care services through a designated primary provider or an administrative action imposed on a provider to prohibit participation as a designated primary provider, referral, or covering provider for restricted recipients.

"Social Security Act" means the Act, enacted by the 74th Congress on August 14, 1935, which provides for the general welfare by establishing a system of federal old age benefits, and by enabling the states to make more adequate provisions for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws.

"State Plan for Medical Assistance" or "the Plan" means the document listing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Surveillance and Utilization Review Subsystem (SURS)" or "Automated Exception Analysis (AEA)" means a computer subsystem of the Medicaid Management Information System (MMIS) which collects claims data and computes statistical profiles of recipient and provider activity and compares them with that of their particular peer group.

"Therapeutic class" means a group of drugs with similar pharmacologic actions and uses.

"Utilization control" means the control of covered health care services to assure the use of cost efficient, medically necessary or appropriate services.