COMMONWEALTH of VIRGINIA
Office of the Attorney General

Mark R. Herring
Attorney General

202 North 9th Street
Richmond, Virginia 23219
804-786-2071
FAX 804-786-1991
Virginia Relay Services
800-828-1120
7-1-1

MEMORANDUM

TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **JENNIFER L. GOBBLE**
Assistant Attorney General

DATE: **July 2, 2021**

SUBJECT: **Exempt/Final Regulations: Update of DMAS-225 Form (5481 / 8893)**

I have reviewed the attached exempt final regulatory action that would amend existing regulations by making technical corrections concerning use of the DMAS-225 Long-Term Care Communication Form.

The amendments reflected in this regulatory action are technical in nature and are necessary to replace references to the DMAS-122 Form that is no longer in use with references to the DMAS-225 Form. Based on my review, it is this Office's view that the Director of the Department of Medical Assistance Services, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Virginia Administrative Process Act (VAPA), and has not exceeded that authority. Based on the foregoing, it is my view that this regulatory action is exempt from the procedures of Article 2 of the VAPA under Virginia Code § 2.2-4006(A)(3).

If you have any questions or need any additional information, please feel free to contact me at 786-2071.

cc: Kim F. Piner
Senior Assistant Attorney General/Section Chief

Action: Update of the DMAS-225 Form
Stage: Final

Part IX
~~DMAS-122~~ DMAS-225 Adjustment Process

12VAC30-130-600. Definitions.

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

"DMAS" or "the department" means the Virginia Department of Medical Assistance Services.

"~~DMAS-122~~ DMAS-225" means the Medicaid Communication form used for the provider and the DSS eligibility worker to report changes including ~~to determine patient pay amounts and to request~~ requests for adjustments to the patient pay.

"DSS" means the local Virginia Department of Social Services.

"Facility" means a nursing facility, intermediate care facility for the mentally retarded, or a long-stay acute care hospital enrolled in the Medicaid program.

"Medical necessity" means an item or service provided for the diagnosis or treatment of a patient's condition consistent with community standards of medical practice and in accordance with Medicaid policy.

"Preauthorization" means obtaining the approval necessary for receipt of a specified service from a specified provider for a specified recipient before the requested service is performed.

12VAC30-130-620. Limitations.

A. A ~~DMAS-122~~ DMAS-225 adjustment request shall always be used as the last source of payment. If a recipient has other sources of possible payment (i.e., Medicare, major medical insurance, prescription insurance, dental insurance, etc.), payment must be sought first from those other sources.

B. The maximum amount for noncovered medically necessary items or services that can be allowed as adjustments to the patient pay amount for nursing facility residents shall be the amount specified in 12VAC30-40-235.

C. Only the cost of medically necessary, resident-specific, customized, noncovered items or services may be deducted from patient pay. This shall include, but not necessarily be limited to, electric, motorized, or customized wheelchairs and other equipment not regularly supplied to residents by the facility as part of the cost of care. Supplies, equipment, or services used in the direct care and treatment of residents are covered services and must be provided by the facility. Covered items and services include, but are not necessarily limited to, standard wheelchairs, recliners, geriatric chairs, special mattresses, humidifiers, cots, and routine podiatry care (e.g., trimming nails for onychauxis, cleaning and soaking the feet, and other services performed in the absence of localized illness, injury, or symptoms involving the foot). Expenses incurred by the facility for covered items and services are considered "allowable expenses" and are covered by Medicaid as part of reimbursement to the facility for the resident's care; these costs cannot be deducted from patient pay.

D. Extenuating circumstances shall be considered for the provision of podiatry care when corrective trimming is performed to prevent further complications in a patient who has a systemic condition that has resulted in severe circulation deficits or areas of desensitization in the legs or feet. Trimming of nails for a systemic condition is limited to once every 60 days and must be medically necessary. In such cases, the facility is not responsible for routine podiatry care.

E. ~~DMAS-122~~ DMAS-225 adjustments shall be allowed for the cost of medically or remedially necessary services provided prior to Medicaid eligibility or prior to admission. Any decision made by DMAS or DSS to deny a service may be appealed to DMAS. Appeals must be made in writing by the resident or his legally appointed representative, as provided for in DMAS Client Appeals Regulations (12VAC30-110).

F. The facility shall monitor the proper care of the resident's medical supplies and equipment. Requests for adjustment made because an item is lost or broken by facility staff must include

documentation on the resident's interdisciplinary plan of care regarding proper care and treatment of the item. When loss or breakage is incurred as a result of facility staff following improper practices, the facility must replace the item.

G. All requests for ~~DMAS-122~~ DMAS-225 adjustments submitted by providers to either DMAS or DSS shall include:

1. The recipient's correct Medicaid identification number;

2. The current physician's orders for the noncovered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair to hearing aids or eyeglasses);

3. Medical justification for the service being requested (see subsection H of this section);

4. The service description;

5. Actual cost information;

6. Documentation that the recipient continues to need the equipment for which a repair, replacement, or battery is requested;

7. A statement of proof of denial or noncoverage by other insurance; and

8. A copy of the most current, fully completed Minimum Data Set (MDS) and quarterly review.

H. Medical justification documentation as specified in subdivision G 3 of this section shall include the following:

1. Physician prescription;

2. Identification of the diagnosis related to the reason for the request;

3. Identification of the resident's functional limitation;

4. Identification of the quantity needed, frequency of use, estimated length of use; and

5. Identification of how the item or service will be used in the resident's environment.

I. Adjustments of a recipient's patient pay amount may only be authorized by DMAS or DSS.