12VAC30-80-20. Services which 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. 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 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 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 which 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. Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals

2. Outpatient hospital services 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 which 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 which 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 which may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 2 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 2b (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 diagnosis codes and necessary supporting documentation.

(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 code designations, and the impact on recipients and providers.

c. Limitation to 80% of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at 80% of allowable cost, with cost to be determined as provided in A, B, and C above. For hospitals with fiscal years that do not begin on July 1, 2003, 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. Operating costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Capital costs apportioned before that date shall be settled according to the principles in effect before that date,

and those after at 80% of allowable cost. Operating and capital costs of Type One hospitals shall continue to be reimbursed at 94.2% and 90% of cost respectively.

d. RESERVED FOR NEW FINAL REGULATION Outpatient reimbursement methodology prior to July 1, 2003.

e. RESERVED FOR NEW FINAL REGULATION Payment for direct medical education costs……

3. Rehabilitation agencies operated by Community Services Boards. For the reimbursement methodology applicable to other rehabilitation agencies, see 12 VAC 30-80-200. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

4. Comprehensive outpatient rehabilitation facilities.

5. Rehabilitation hospital outpatient services.

12 VAC 30-80-200. Prospective reimbursement for rehabilitation agencies.

A. Effective for dates of service on and after July 1, 2003, rehabilitation agencies, excluding those operated by Community Services Boards, shall be reimbursed a prospective rate equal to the lesser of the agency's cost per visit for each type of rehabilitation service (physical therapy, occupational therapy, and speech therapy) or a statewide ceiling established for each type of service. The prospective ceiling for each type of service shall be equal to 112% of the median cost per visit, for such services, of rehabilitation agencies. The median shall be calculated using a base year to be determined by the Department. Effective July 1, 2003, the median calculated and the resulting ceiling shall be applicable to all services beginning on and after July 1, 2003, and all services in provider fiscal years beginning in SFY2004.

B. In each provider fiscal year, each provider's prospective rate shall be determined based on the cost report from the previous year and the ceiling, calculated by DMAS, that is applicable to the state fiscal year in which the provider fiscal year begins.

C. For providers with fiscal years that do not begin on July 1, 2003, services 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 before and after that date. Costs apportioned before that date shall be settled based on allowable costs, and those after shall be settled based on the prospective methodology.

D. Beginning with state fiscal years beginning on and after July 1, 2004, the ceiling and the provider specific cost per visit shall be adjusted for inflation, from the previous year to the prospective year, using the nursing facility inflation factor published for Virginia by DRI, applicable to the calendar year in progress at the start of the state fiscal year.