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 (12VAC30-80-160 has obstetric/pediatric fees). Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public), except that reimbursement rates for designated physician services when performed in hospital outpatient settings shall be 50% of the reimbursement rate established for those services when performed in a physician's office. 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 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 objectives, the accuracy and effectiveness of the ICD-9-CM code designations and the impact on recipients and providers.

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, licensed clinical nurse specialists-psychiatric or licensed marriage and family therapists shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME).

a. The rate paid for all items of durable medical equipment except nutritional supplements shall be the lower of the state agency fee schedule that existed prior to July 1, 1996, less 4.5%, or the actual charge.

b. The rate paid for nutritional supplements shall be the lower of the state agency fee schedule or the actual charge.

c. 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~~, including services paid to local school districts~~.

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 are 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.

17. 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 17 d and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 17 b (1) for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision (2) of this subdivision 17 b 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 17 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) 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.

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.

CERTIFIED: I hereby certify that these regulations are full, true and correctly dated.

_____ _____

Date Patrick W. Finnerty, Director

Dept of Medical Assistance Services

12 VAC 30-80-75 Local Education Agency (LEA) providers.

Definitions.

The following words are terms, when used in the regulation, shall have the following meaning unless the context clearly indicates otherwise:

"CMS" means Centers for Medicare and Medicaid Services.

"DMAS" means Department of Medical Assistance Services.

"FAMIS" means Family Access to Medical Insurance Security Plan.

"FFP" means Federal Financial Participation.

"IDEA" means Individuals with Disabilities Education Act.

" IEP" means Individual Education Plan.

"LEA" means Local Education Agency.

"MMIS" means Medicaid Management Information System .

A. Medical services provided by LEA providers for special education students. The following methodology will determine the reimbursement for (LEA) providers.

1. For each of the IDEA-related school-based medical services covered under the State Plan other than specialized transportation services, the LEA provider's actual cost of providing the services shall be certified and the FFP shall be paid to LEA providers based on the methodology described in the steps below. All costs to be certified and used subsequently to determine reconciliation and final settlement amounts as well as interim rates are identified on the CMS approved Medical Services Cost Report. Final payment

for each school year is based on actual costs as determined by desk review or audit for each LEA provider.

2. Step 1: Develop the personnel cost base for medical services.

Total annual salaries and benefits paid as well as contracted (vendor) payments shall be obtained initially from each LEA's payroll/benefits and financial system. This data shall be reported on the DMAS Medical Services Cost Report form for all direct service personnel (i.e. all personnel providing medical services covered under the State Plan). Personnel costs are reduced by any reimbursement that is not from state or local funding sources. The personnel cost base does not include any amounts for staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. The application of Step 1 results in total adjusted salary cost.

3. Step 2: Determine medical services personnel cost using a time study.

A time study which incorporates the CMS-approved time study methodology shall be used to determine the percentage of time medical service personnel spend on medical services and general and administrative (G&A) time. This time study shall assure that there shall be no duplicate claiming relative to claiming for administrative costs. G&A time shall be allocated to medical services based on the percentage of time spent on medical services. To reallocate G&A time to medical services, the percentage of time spent on medical services shall be divided by 100 percent minus the percentage of time spent on G&A. This shall result in a percentage that represents the medical services with appropriate allocation of G&A. This percentage shall be multiplied by the personnel cost

base as determined in Step 1 to allocate personnel cost to medical services. The product represents medical services personnel cost. A sufficient number of medical service personnel shall be sampled to ensure time study results that will have a confidence level of at least 95 percent with a precision of plus or minus five percent overall.

4. Step 3: Develop medical services non-personnel costs.

Costs for materials and supplies, employee travel, and capital used in the delivery of medical services shall be obtained from each LEA's financial system. Capital costs must exceed $5,000 and have a useful life greater than two years. The straight line method of depreciation is used for capital costs. Non-personnel costs shall be reduced by any reimbursement that is not from state or local funding sources.

5. Step 4: Determine indirect costs.

Indirect costs shall be determined by multiplying each LEA's indirect rate assigned by the cognizant agency (the Department of Education) by total direct costs as determined under Steps 2 and 3. No additional indirect costs shall be recognized outside of the indirect costs determined by Step 4.

6. Step 5: Total medical services costs.

Total medical services costs shall be determined by adding costs from steps 2, 3 and 4.

7. Step 6: Allocate total medical services costs to Medicaid, Medicaid Expansion and FAMIS.

To determine the Medicaid, Medicaid expansion, and FAMIS medical services costs to be certified, total medical services costs shall be multiplied by the ratios of Medicaid, Medicaid expansion and FAMIS recipients with an IEP to all students with an IEP.

B. Special transportation services provided by LEA providers for special education students.

1. The participating LEA's actual cost of providing special transportation services shall be claimed for Medicaid FFP based on the methodology described in the steps below. Special transportation refers to transportation on buses modified and dedicated for special education. All costs to be certified and used subsequently to determine the reconciliation and final settlement amounts as well as interim rates shall be identified on the CMS approved Special Transportation Cost Report. Final payment for each school year shall be based on actual costs as determined by desk review or audit for each LEA provider.

2. Step 1: Develop special transportation non-personnel costs.

The costs for special transportation fuel, repairs and maintenance, rentals, contract vehicle use costs, insurance and capital shall be obtained from the LEA's accounts payable system and reported on the Special Transportation Cost Report form. Non-personnel costs shall be reduced by any reimbursement that is not from state or local funding sources.

3. Step 2: Develop special transportation personnel costs.

Total annual salaries and benefits paid as well as contract costs (vendor payments) for special transportation services shall be obtained from each LEA's payroll/benefits and

financial systems. This data shall be reported on the Special Transportation Cost Report form for all direct service personnel.

4. Step 3: Determine indirect costs.

Indirect cost shall be determined by multiplying each LEA's unrestricted indirect rate assigned by the cognizant agency (the Department of Education) by total special transportation costs as determined under Steps 1 and 2. No additional indirect costs shall be recognized outside of the indirect costs determined by Step 3.

5. Step 4: Total special transportation costs.

Total special transportation services costs shall be determined by adding costs from steps 1, 2 and 3.

6. Step 5: Allocate total special transportation services cost to Medicaid, Medicaid Expansion, and FAMIS.

Special transportation drivers or other school personnel shall maintain logs of all students transported on each one-way trip. These logs shall be used to calculate reimbursable percentages for Medicaid, Medicaid Expansion and FAMIS. The denominator shall be the total annual one-way trips on special buses. The numerator shall be Medicaid, Medicaid Expansion or FAMIS special transportation one way trips. To qualify as a special transportation trip, the student must be eligible for Medicaid, Medicaid Expansion or FAMIS; transportation must be included in the IEP; and the student must have received a covered medical service on the day of the special transportation. To allocate special transportation costs to Medicaid, Medicaid Expansion and FAMIS, total special

transportation cost as determined under step 4 shall be multiplied by the reimbursable percentages described above.

C. Reconciliation of the federal share of LEA certified costs and MMIS paid claims.

1. Each LEA provider will complete the Medical Services and Special Transportation Cost Reports and submit the cost reports no later than five months after the end of the LEA's fiscal year. All cost reports shall be reviewed and the total certified expenditures shall be initially settled within 180 days of the receipt of a completed cost report based on a desk review by the agency's audit contractor. DMAS may conduct additional desk or field audits up to two years after the fiscal year-end based on risk assessment developed by DMAS. LEA providers may appeal audit findings in accordance with DMAS appeal procedures.

2. The agency's audit contractor shall reconcile the FFP from the Medical Services and Special Transportation Cost Reports against the MMIS paid claims data and DMAS shall issue a notice of reconciliation that denotes the amount due to or from the LEA provider. This reconciliation shall be inclusive of both medical services and special transportation services provided by the LEA provider.

a. If the interim payments exceed the FFP of the certified costs of an LEA's Medicaid, Medicaid Expansion or FAMIS services, DMAS shall recoup the overpayment in one of the following methods:

1) Offset all future claim payments from the affected LEA until the amount of the overpayment is recovered;

2) Recoup an agreed upon percentage from future claims payments to the LEA to ensure recovery of the overpayment within one year; or

3) Recoup an agreed upon dollar amount from future claims payments to the LEA to ensure recovery of the overpayment within one year.

b. If the FFP of the certified costs exceed interim payments, DMAS shall pay the difference to the LEA provider.

D. Interim Rates.

At the end of each settlement, interim rates for each LEA provider shall be determined by dividing total medical services cost and special transportation services cost by an estimate of the number of units of service. For the initial interim rates or for new providers, interim rates shall be based on pro forma cost data. Interim rates shall be provisional in nature pending completion of the cost report.

E. Billing.

Each LEA provider shall submit claims in accordance with the school division manual and shall be paid an interim rate for approved claims.

F. State Monitoring.

If DMAS becomes aware of potential instances of fraud, misuse or abuse of services and funds, it shall perform timely audits and investigations to identify and take the necessary actions to remedy and resolve the problems.

G. Other Services.

Other covered services provided to Medicaid, Medicaid expansion, and FAMIS recipients shall be reimbursed according to the agency fee schedule for all providers. These costs shall not be included on the cost report.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date

Patrick W. Finnerty, Director

Department of Medical Assistance Services