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MEMORANDUM

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

FROM: **ABRAR AZAMUDDIN**
Assistant Attorney General

DATE: **March 8, 2018**

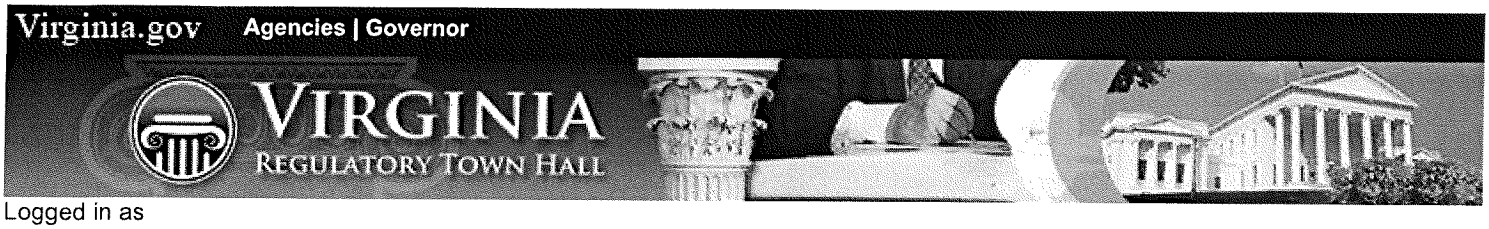
SUBJECT: **Proposed regulations regarding Durable Medical Equipment and Supplies Suitable for the Home (12VAC30-50-165)**

I have reviewed the proposed regulations that would amend 12VAC30-50-165. Based on my review, DMAS has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Virginia Code §§ 32.1-324 and 32.1-325 grant to the Board of Medical Assistance Services the authority to administer and amend the plan for Medical Assistance and authorizes the Director of DMAS to administer and amend the plan for Medical Assistance according to the Board's requirements. The authority for these proposed regulations derives from Virginia Code § 32.1-351(J).

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

cc: Kim F. Piner
Senior Assistant Attorney General



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Proposed Text

Action: Clarifications for Durable Medical Equipment and Supplies

Stage: Proposed 2/13/18 10:39 PM [latest] ▾

12VAC30-50-165. Durable medical equipment (DME) and supplies suitable for use in the home.

A. Definitions. The following words and terms when used in these regulations shall have the following meanings unless the context clearly indicates otherwise:

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

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

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

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

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

"Enteral nutrition" refers to any method of feeding that uses the gastrointestinal (GI) tract to deliver part or all of an individual's caloric requirements. Enteral nutrition may include a routine oral diet, the use of liquid supplements, or delivery of part or all of the daily requirements by use of a tube (tube feeding).

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

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

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

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

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

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

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

B. General requirements and conditions.

1. a. All medically necessary supplies and equipment shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.

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

2. DME providers shall adhere to all applicable federal and state laws and regulations and DMAS policies for DME and supplies. DME providers shall comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations that are required by such licensing agency or agencies shall result in denial of coverage for DME or supplies.

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

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

5. DME shall be furnished exactly as ordered by the licensed practitioner who signed the CMN. The CMN and any supporting verifiable documentation shall be fully completed, signed, and dated by the licensed practitioner, and in the DME provider's possession within 60 days from the time the ordered DME and supplies are initially furnished by the DME provider. Each component of the DME items shall be specifically ordered on the CMN by the licensed practitioner.

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

7. DMAS or its designated agent shall have the authority to determine a different (from those specified above) length of time a CMN may be valid based on medical documentation submitted on the CMN. The CMN may be completed by the DME provider or other appropriate health care professionals, but it shall be signed and dated by the licensed practitioner, as specified in subdivision 5 of this subsection. Supporting documentation may be attached to the CMN but the licensed practitioner's entire order for DME and supplies shall be on the CMN.

8. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for DMAS' post payment audit review purposes. DME providers shall not create or revise CMNs or supporting documentation for this service after the initiation of the post payment review audit process. Licensed practitioners shall not complete, sign, or date CMNs once the post payment audit review has begun.

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

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

11. Supporting documentation, added to a completed CMN, shall be allowed to further justify the medical need for DME. 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, and the supporting documentation shall be fully signed and dated by the licensed practitioner.

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

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

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

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

3. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other

bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales);

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

5. Prosthesis, except for artificial arms, legs, and their supportive devices, which shall be prior authorized by the DMAS ~~central office~~ or designated agent;

6. Items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (e.g., dentifrices; toilet articles; shampoos that do not require a licensed practitioner's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions that do not require a licensed practitioner's prescription; sugar and salt substitutes; and support stockings);

7. Orthotics, including braces, diabetic shoe inserts, splints, and supports;

8. Home or vehicle modifications;

9. Items not suitable for or not used primarily in the home setting (e.g., car seats, equipment to be used while at school, etc.);

10. Equipment for which the primary function is vocationally or educationally related (e.g., computers, environmental control devices, speech devices, etc.);

11. Diapers for routine use by children younger than three years of age who have not yet been toilet trained;

12. Equipment or items that are not suitable for use in the home; and

13. Equipment or items that the Medicaid individual or caregiver is unwilling or unable to use in the home.

E. For coverage of blood glucose meters for pregnant women, refer to 12VAC30-50-510.

F. Coverage of home infusion therapy.

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

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

3. The following limitations shall apply to this service:

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

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

(1) Reside in either a private home or a domiciliary care facility, such as an assisted living facility. Because the reimbursement for DME is already provided under institutional reimbursement, individuals in hospitals, nursing facilities, rehabilitation centers, and other institutional settings shall not be covered for this service;

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

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

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

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

H. Medicaid shall not provide reimbursement to the DME and supply vendor 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. If reimbursement is denied for one or all of these reasons, the DME and supply vendor shall not bill the Medicaid individual for the service that was provided.

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

1. Ordered by the licensed practitioner on the CMN;

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

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

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

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

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

J. Medical documentation shall provide DMAS or the designated agent with evidence of the individual's DME needs. Medical documentation may be recorded on the CMN or evidenced in the supporting documentation attached to the CMN. The following applies to the medical justification necessary for all DME services regardless of whether prior authorization is required. The documentation is necessary to identify:

1. The medical need for the requested DME;

2. The diagnosis related to the reason for the DME request;

3. The individual's functional limitation and its relationship to the requested DME;

4. How the DME service will treat the individual's medical condition;

5. For expendable supplies, the quantity needed and the medical reason the requested amount is needed;

6. The frequency of use to describe how often the DME is used by the individual;

7. The estimated duration of use of the equipment (rental and purchased);

8. Any other treatment being rendered to the individual relative to the use of DME or supplies;

9. How the needs were previously met identifying changes that have occurred that necessitate the DME;

10. Other alternatives tried or explored and a description of the success or failure of these alternatives;

11. How the DME service is required in the individual's home environment; and

12. The individual's or caregiver's ability, willingness, and motivation to use the DME.

K. DME provider responsibilities. To receive reimbursement, the DME provider shall, at a minimum, perform the following:

1. Verify the individual's current Medicaid eligibility;

2. Determine whether the ordered item or items are a covered service and require prior authorization;

3. Deliver all of the item or items ordered by the licensed practitioner;

4. Deliver only the quantities ordered by the licensed practitioner on the CMN and prior authorized by DMAS if required;

5. Deliver only the item or items for the periods of service covered by the licensed practitioner's order and prior authorized, if required, by DMAS;

6. Maintain a copy of the licensed practitioner's signed CMN and all verifiable supporting documentation for all DME and supplies ordered;

7. Document and justify the description of services (i.e., labor, repairs, maintenance of equipment);

8. Document and justify the medical necessity, frequency and duration for all items and supplies as set out in the Medicaid DME guidance documents;

9. Document all DME and supplies provided to an individual in accordance with the licensed practitioner's orders. The delivery ticket/proof of delivery shall document the requirements as stated in subsection L of this section.

10. Documentation requirements for the use of DME billing codes that have Individual Consideration (IC) indicated as the reimbursement fee shall include a complete description of the item or items, a copy of the supply invoice or supplies invoices or the manufacturer's cost information, and all discounts that were received by the DME provider. Additional information regarding requirements for the IC reimbursement process can be found in the relevant agency guidance document.

L. Proof of delivery.

1. The delivery ticket shall contain the following information:

a. The Medicaid individual's name and Medicaid number or date of birth or a unique identifier (e.g. an individual's medical record number);

b. A detailed description of the item or items being delivered, including the product name or names and brand or brands;

c. The serial number or numbers or the product numbers of the DME or supplies, if available, but not required;

d. The quantity delivered; and

e. The dated signature of either the individual or caregiver.

2. If a commercial shipping service is used, the DME provider's records shall reference, in addition to the information required in subdivision 1 of this subsection, the delivery service's package identification number or numbers with a copy of the delivery service's delivery ticket, which may be printed from the online record on the delivery service's website.

a. The delivery service's ticket identification number or numbers shall be recorded on the DME provider's delivery documentation.

b. The service delivery documentation may be substituted for the individual's signature as proof of delivery.

c. In the absence of a delivery service's ticket, the DME provider shall obtain the individual's or caregiver's dated signature on the DME provider's delivery ticket as proof of delivery.

3. Providers may use a postage-paid delivery invoice from the individual or caregiver as a form of proof of delivery. The descriptive information concerning the item or items delivered, as described in subdivisions 1 and 2 of this subsection, as well as the required signature and date from either the individual or caregiver shall be included on this invoice.

4. DME providers shall make affirmative contact with the individual or caregiver and document the interaction prior to dispensing repeat orders or refills to ensure that:

a. The item is still needed;

b. The quantity, frequency, and product are still appropriate; and

c. The individual ~~still~~ resides at the address in the provider's records.

5. The DME provider shall contact the individual prior to each delivery. This contact shall not occur any sooner than seven calendar days prior to the delivery or shipping date and shall be documented in the individual's record.

6. DME providers shall not deliver refill orders sooner than five days prior to the end of the usage period.

7. Providers shall not bill for dates of service prior to delivery. The provider shall confirm receipt of the DME or supplies via the shipping service record showing the item was delivered prior to billing. Claims for refill orders shall be the start of the new usage period and shall not overlap with the previous usage period.

8. The purchase prices listed in the Virginia Medicaid Durable Medical Equipment and Supplies Manual, Appendix B, represent the amount DMAS shall pay for newly purchased equipment. Unless otherwise approved by DMAS or its designated agent, documentation on the delivery ticket shall reflect that the purchased equipment is new upon the date of the service billed. Any warranties associated with new equipment shall be effective from the date of the service billed. Since Medicaid is the payer of last resort, the DME provider shall explore coverage available under the warranty prior to requesting coverage of repairs from DMAS.

9. DME and supplies for home use for an individual being discharged from a hospital or nursing facility may be delivered to the hospital or nursing facility one day prior to the discharge. However, the DME provider's claim date of service shall not begin prior to the date of the individual's discharge from the hospital or nursing facility.

M. Enteral nutrition products. Coverage of enteral nutrition (EN) that does not include a legend drug shall be limited to when the nutritional supplement ~~is the sole source form of nutrition,~~ is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. DMAS shall provide coverage for nutritional supplements for enteral feeding only if the nutritional supplements are not available over-the-counter. Additionally, DMAS shall cover medical foods that are: (i) specific to inherited diseases, metabolic disorders, PKU, etc.; (ii) not generally available in grocery stores, health food stores or the retail section of a pharmacy; and, (iii) not used as food by the general population. Coverage of EN shall not include the provision of routine infant formula or feedings as meal replacement only. Coverage of medical foods shall not extend to regular foods prepared to meet particular dietary restrictions, limitations or needs, such as meals designed to address the situation of individuals with diabetes or heart disease. A nutritional assessment shall be required for all ~~recipients~~ individuals for whom nutritional supplements are ordered.

1. General requirements and conditions.

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

b. DME providers shall adhere to all applicable DMAS policies, laws, and regulations. DME providers shall also comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of coverage for enteral nutrition that is regulated by such licensing agency or agencies.

2. Service units and service limitations.

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

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

supportive documentation submitted with the CMN.

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

d. The CMN shall contain a licensed practitioner's order for the enteral nutrition products that are medically necessary to treat the diagnosed condition and the individual's functional limitation. The justification for enteral nutrition products shall be demonstrated in the written documentation either on the CMN or on the attached supporting documentation. The CMN shall be valid for a maximum period of six months.

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

f. A face-to-face nutritional assessment completed by trained clinicians (e.g., physician, physician assistant, nurse practitioner, registered nurse, or a registered dietitian) shall be completed as required documentation of the need for enteral nutrition products.

~~g. The CMN shall not be changed, altered, or amended after the licensed practitioner has signed it. As indicated by the individual's condition, if changes are necessary in the ordered enteral nutrition products, the DME provider shall obtain a new CMN.~~

~~(1) New CMNs shall be signed and dated by the licensed practitioner within 60 days from the time the ordered enteral nutrition products are furnished by the DME provider.~~

~~(2) The order shall not be backdated to cover prior dispensing of enteral nutrition products. If the order is not signed within 60 days of the service initiation, then the date the order is signed becomes the effective date.~~

g.~~h.~~ Prior authorization of enteral nutrition products shall not be required. The DME provider shall assure that there is a valid CMN (i) completed every six months in accordance with subsection B of this section and (ii) on file for all Medicaid individuals for whom enteral nutrition products are provided.

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

(2) Upon post payment review, DMAS or its designated contractor may deny reimbursement for any enteral nutrition products that have not been provided and billed in accordance with these regulations and DMAS policies.

h.~~i.~~ DMAS shall have the authority to determine that the CMN is valid for less than six months based on medical documentation submitted.

3. Provider responsibilities.

a. The DME provider shall provide the enteral nutrition products as prescribed by the licensed practitioner on the CMN. Physician orders shall not be changed unless the DME provider obtains a new CMN prior to ordering or providing the enteral nutrition products to the individual.

b. The licensed practitioner's order (CMN) shall ~~state that the enteral nutrition products are the sole source of nutrition for the individual and~~ specify either a

brand name of the enteral nutrition product being ordered or the category of enteral nutrition products that must be provided. If a licensed practitioner orders a specific brand of enteral nutrition product, the DME provider shall supply the brand prescribed. The licensed practitioner order shall include the daily caloric intake and the route of administration for the enteral nutrition product. ~~Additional supporting~~ Supporting documentation may be attached to the CMN, but the entire licensed practitioner's order shall be on the CMN.

c. The CMN shall be signed and dated by the licensed practitioner within 60 days of the CMN begin service date. The order shall not be backdated to cover prior dispensing of enteral nutrition products. If the CMN is not signed and dated by the licensed practitioner within 60 days of the CMN begin service date, the CMN shall ~~not~~ become valid ~~until the~~ on the effective date of the licensed practitioner's signature.

d. The CMN shall include all of the following elements:

(1) Height of individual (or length for pediatric patients);

(2) Weight of individual. For initial assessments, indicate the individual's weight loss over time;

(3) Tolerance of enteral nutrition product (e.g., is the individual experiencing diarrhea, vomiting, constipation). This element is only required if the individual is already receiving enteral nutrition products;

~~(4) Indication of whether or not the enteral nutrition product is the primary or sole source of nutrition;~~

(4) ~~(5)~~ Route of administration; and

(5) ~~(6)~~ The daily caloric order and the number of calories per package or can.~~; and~~

~~(7) Extent to which the quantity of the enteral nutrition product is available through WIC, the Special Supplemental Nutrition Program for Women, Infants and Children.~~

~~e. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for DMAS' post payment review purposes. DME providers shall not create or revise CMNs or supporting documentation for this service after the initiation of the post payment review process. Licensed practitioners shall not complete or sign and date CMNs once the post payment review has begun.~~

e~~f~~. Medicaid reimbursement shall be recovered when the enteral nutrition products have not been ordered on the CMN. Supporting documentation is allowed to justify the medical need for enteral nutrition products. 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, and the supporting documentation shall be fully signed and dated by the licensed practitioner.

~~g. To receive reimbursement, the DME provider shall:~~

~~(1) Deliver only the item or items and quantity or quantities ordered by the licensed practitioner and approved by DMAS or the designated prior or service authorization contractor;~~

~~(2) Deliver only the item or items for the periods of service covered by the licensed practitioner's order and approved by DMAS or the designated prior or service authorization contractor;~~

~~(3) Maintain a copy of the licensed practitioner's order and all verifiable supporting documentation for all DME ordered; and~~

~~(4) Document all supplies provided to an individual in accordance with the licensed practitioner's orders. The delivery ticket must document the individual's name and Medicaid number, the date of delivery, the item or items that were delivered, and the quantity delivered.~~

N.~~h~~. Reimbursement Denials.

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

~~(1)~~a. Absence of a current, fully completed CMN appropriately signed and dated by the licensed practitioner;

~~(2)~~b. Documentation does not verify that the item was provided to the individual;

~~(3)~~c. Lack of medical documentation, signed by the licensed practitioner to justify the ~~enteral nutrition~~ products DME and supplies; or

~~(4)~~d. Item is noncovered or does not meet DMAS criteria for reimbursement.

~~i.~~2. If reimbursement is denied by Medicaid, the DME provider shall not bill the Medicaid individual for the service that was provided.

O. Replacement DME following a natural disaster.

1. Medicaid individuals who live in areas that have been declared by the Governor of the Commonwealth of Virginia as a disaster or emergency in accordance with § 44-146.16 of the Code of Virginia, who need to replace DME and supplies previously approved by Medicaid, that were damaged as a result of the disaster or emergency, may contact a DME provider (either enrolled in Fee-for-Service Medicaid or a Medicaid Health Plan) of their choice to obtain a replacement.

2. For Medicaid enrolled providers, the provider shall make a request to the Service Authorization contractor; however, a new CMN and medical documentation is not required unless the DME and supplies are beyond the service limit (e.g. the individual has a wheelchair that is older than five years). The provider shall keep documentation in the individual's chart that includes the individual's current place of residence and states that the original DME or supplies were lost due to the natural disaster.

3. Individuals who are approved to receive DME and supplies from a DME provider in an area that has been declared by the Governor of the Commonwealth of Virginia as a disaster or emergency and with DME or supplies that were damaged as a result of the disaster or emergency in accordance with § 44-146.16 of the Code of Virginia but are unable to obtain replacement DME and supplies because the provider is no longer in business or unable to provide the approved DME and supplies may obtain the approved items from a new DME provider of their choice who is enrolled in Medicaid or contracted with a Medicaid Health Plan. The original authorization will be cancelled or amended and a new authorization will be provided to the new DME provider. The DME provider shall submit a signed statement from the Medicaid individual requesting a change in DME provider due to the declaration by the Governor of the Commonwealth of Virginia as a state of emergency due to a natural disaster and giving his or her current place of residence.