

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

---

APPENDIX III

COST REIMBURSEMENT LIMITATIONS

---

TN No. 90-08

Approval Date 10-19-90

Effective Date 10-01-90

Supersedes

TN No. 86-11

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

---

12VAC30-90-290. Cost reimbursement limitations.

A. This appendix outlines operating, NATCEPs and plant cost limitations that are not referenced in previous sections of these regulations.

B. All of the operating cost limitations are further subject to the applicable operating ceilings.

§1.2. Fees

A. Directors' fees.

1. Although Medicaid does not require a board of directors (Medicare requires only an annual stockholders' meeting), the Program will recognize reasonable costs for directors' meetings related to patient care.
2. It is not the intent of DMAS to reimburse a facility for the conduct of business related to owner's investments, nor is it the intent of the Program to recognize such costs in a closely held corporation where one person owns all stock, maintains all control, and approves all decisions.
3. To receive reimbursement for directors' meetings, the written minutes must reflect the name of the facility for which the meeting is called, the content and purpose of the meeting, members in attendance, the time the meeting began and ended, and the date. If multiple facilities are discussed during a meeting, total allowable director fees, as limited herein, shall be pro-rated between such facilities.
4. Bona fide directors may be paid an hourly rate of \$125 up to a maximum of four hours per month. These fees include reimbursement for time, travel, and services performed.

---

TN No. 90-08  
Supersedes  
TN No. 86-11

Approval Date 10-19-90

Effective Date 10-01-90

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

---

5. Compensation to owner/administrators who also serve as directors shall include any director's fees paid, subject to the above referenced limit set forth in these regulations.

C. Membership fees.

1. These allowable costs will be restricted to membership in health care organizations and appropriate professional societies which promote objectives in the provider's field of health care activities.
2. Membership fees in health care organizations and appropriate professional societies will be allowed for the administrator, owner, and home office personnel.
3. Comparisons will be made with other providers to determine reasonableness of the number of organizations to which the provider will be reimbursed for such membership and the claimed costs, if deemed necessary.

D. Management fees.

1. External management services shall only be reimbursed if they are necessary, cost effective, and non-duplicative of existing nursing facility internal management services.
2. Costs to the provider, based upon a percentage of net and/or gross revenues or other variations thereof, shall not be an acceptable basis for reimbursement. If allowed, management fees must be reasonable and based upon rates related to services provided.
3. Management fees paid to a related party may be recognized by the Program as the owner's compensation subject to administrator compensation guidelines.
4. A management fees service agreement exists when the contractor provides non-duplicative personnel, equipment, services, and supervision.

---

TN No. 90-08

Approval Date 10-19-90

Effective Date 10-01-90

Supersedes

TN No. 86-11

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

- 
5. A consulting service agreement exists when the contractor provides non-duplicative supervisory or management services only.
  6. Limits will be based upon comparisons with other similar size facilities and/or other DMAS guidelines and information.

Effective for all providers' cost reporting periods ending on or after October 1, 1990, a per patient day ceiling for all full service management service costs shall be established. The ceiling limitation for cost reporting periods ending on or after October 1, 1990, through December 31, 1990, shall be the median per patient day cost as determined from information contained in the most recent cost reports for all providers with fiscal years ending through December 31, 1989. These limits will be adjusted annually by a Consumer Price Index effective January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually. Effective July 1, 2006, these limits apply only to related parties.

E. Pharmacy consultants' fees. Costs will be allowed to the extent they are reasonable and necessary.

F. Physical therapy fees (for outside services). Limits are based upon current PRM-15 guidelines.

G. Inhalation therapy fees (for outside services). Limits are based upon current PRM-15 guidelines.

H. Medical directors' fees. Costs will be allowed up to the established limit per year to the extent that such fees are determined to be reasonable and proper. This limit will be escalated annually by the CPI-U January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually. Effective July 1, 2006, these limits apply only to related parties. The following limitations apply to the time periods as indicated:

Jan. 1, 1988 - Dec. 31, 1988 \$6,204

Jan. 1, 1989 - Dec. 31, 1989 \$6,625

I. 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 nursing facility or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the nursing facility to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

J. Personal automobile.

1. Use of personal automobiles when related to patient care will be reimbursed at the maximum of the allowable IRS mileage rate when travel is documented.
2. Flat rates for use of personal automobiles will not be reimbursed.

---

|                     |                               |                                |
|---------------------|-------------------------------|--------------------------------|
| TN No. <u>06-09</u> | Approval Date <u>03-21-07</u> | Effective Date <u>07-01-06</u> |
| Supersedes          |                               |                                |
| TN No. <u>90-26</u> |                               |                                |

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

---

K. Seminar expenses.

These expenses will be treated as allowable costs, if the following criteria are met:

1. Seminar must be related to patient care activities, rather than promoting the interest of the owner or organization.
2. Expenses must be supported by:
  - a. Seminar brochure,
  - b. Receipts for room, board, travel, registration, and educational material.
3. Only the cost of two persons per facility will be accepted as an allowable cost for seminars which involve room, board, and travel.

L. Legal retainer fees.

DMAS will recognize legal retainer fees if such fees do not exceed the following:

| BED SIZE  | LIMITATIONS     |
|-----------|-----------------|
| 0 - 50    | \$100 per month |
| 51 - 100  | \$150 per month |
| 101 - 200 | \$200 per month |
| 201 - 300 | \$300 per month |
| 301 - 400 | \$400 per month |

The expense to be allowed by DMAS shall be supported by an invoice and evidence of payment.

M. Architect fees.

Architect fees will be limited to the amounts and standards as published by the Virginia Department of General Services.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

---

N. Administrator/owner compensation.

DMAS ADMINISTRATOR/OWNER COMPENSATION SCHEDULE

JANUARY 1, 1989 - DECEMBER 31, 1989

| BED SIZE   | NORMAL ALLOWABLE<br>FOR ONE<br>ADMINISTRATOR | MAXIMUM FOR 2 OR<br>MORE ADMINISTRATORS |
|------------|----------------------------------------------|-----------------------------------------|
| 1 - 75     | 32,708                                       | 49,063                                  |
| 76 - 100   | 35,470                                       | 53,201                                  |
| 101 - 125  | 40,788                                       | 61,181                                  |
| 126 - 150  | 46,107                                       | 69,160                                  |
| 151 - 175  | 51,623                                       | 77,436                                  |
| 176 - 200  | 56,946                                       | 85,415                                  |
| 201 - 225  | 60,936                                       | 91,399                                  |
| 226 - 250  | 64,924                                       | 97,388                                  |
| 251 - 275  | 68,915                                       | 103,370                                 |
| 276 - 300  | 72,906                                       | 108,375                                 |
| 301 - 325  | 76,894                                       | 115,344                                 |
| 326 - 350  | 80,885                                       | 121,330                                 |
| 351 - 375  | 84,929                                       | 127,394                                 |
| 376 & over | 89,175                                       | 133,763                                 |

These limits will be escalated annually by the CPI-U effective January 1 of each calendar year to be effective for all provider's cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually. Effective July 1, 2006, these limits apply only to related parties.

---

TN No. 06-09  
Supersedes  
TN No. 90-08

Approval Date 03-21-07

Effective Date 07-01-06

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**State of VIRGINIA

---

## §1.8. Kinetic Therapy.

For specialized care reimbursement effective December 2, 1996, a limitation per patient day on kinetic therapy shall be established based on historical data\*. This limit shall be reviewed annually by January 1 of each calendar year, and compared to actual cost data, then revised if appropriate, to be effective for all providers' cost reporting periods ending on or after that date. The limit will be published and distributed to providers annually. It shall be:

December 1, 1996 – December 31, 1997      \$102.00 per day

\*NOTE: DMAS will gather data over time from provider cost reports, supplemented from other industry sources, on prices of kinetic therapy equipment. From this data, DMAS will develop a trend factor to be applied to the base amount.

---

TN No. 97-21Approval Date 11-09-98Effective Date 12-01-97

Supersedes

TN No. 96-15

