COMMONWEALTH of VIRGINIA
Office of the Governor

Marvin B. Figueroa
Secretary of Health and Human Resources

October 23, 2026

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Dear Mr. McMillion:

Attached for your review and approval is amendment 26-034, entitled "Update to Durable Medical Equipment (DME) & Supplies" to the Plan for Medical Assistance for the Commonwealth. I request that your office approve this change as quickly as possible.

Sincerely,

Marvin B. Figueroa

Attachment

cc: Steve Ford, Director, Department of Medical Assistance Services
CMS, Region III

Transmittal Summary

SPA 26-034

I. IDENTIFICATION INFORMATION

Title of Amendment: Update to Durable Medical Equipment (DME) & Supplies

II. SYNOPSIS

Basis and Authority: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements.

Purpose: This is a clean-up SPA that will align the state plan with federal regulations (42 CFR 440.70(b)(3)) and DMAS current practice that allow both physicians and other licensed providers to order durable medical equipment (DME) and sign certificates of medical need (CMNs). Currently, the state plan only references physicians, so it needs to be updated accordingly.

Substance and Analysis: The sections of the State Plan that are affected by this amendment are "Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy and Medically Needy" and "Standards Established and Methods Used to Assure High Quality of Care."

Impact: None.

Tribal Notice: Please see attached.

Prior Public Notice: N/A

Public Comments and Agency Analysis: N/A

Outlook

Tribal Notification

From Williams, Jimeequa (DMAS) <Jimeequa.Williams@dmas.virginia.gov>

Date Wed 10/7/2026 9:19 AM

To TribalOffice@MonacanNation.com <tribaloffice@monacannation.com>; Ann Richardson <chiefannerich@aol.com>; Pam Thompson <pamelathompson4@yahoo.com>; Rappahannock Tribe <rappahannocktrib@aol.com>; Reginald Stewart <regstew007@gmail.com>; richard.matens@pamunkey.org <richard.matens@pamunkey.org>; chief <chief@monacannation.gov>; Stephen Adkins <chiefstephenadkins@gmail.com>; bradbybrown@gmail.com <bradbybrown@gmail.com>; administrator@nansemond.gov <administrator@nansemond.gov>; info@afwellness.com <info@afwellness.com>; info@fishingpointhc.com <info@fishingpointhc.com>; Nansemond Indian Nation <contact@nansemond.gov>; brandon.custalow@mattaponination.com <brandon.custalow@mattaponination.com>; admin@umitribe.org <admin@umitribe.org>; Reels-Pearson, Lorraine (IHS/NAS/AO) <lorraine.reels-pearson@ihs.gov>; Holmes, Remedios (IHS/NAS/RIC) <remedios.holmes@ihs.gov>; lindsey.taylor@ihs.gov <lindsey.taylor@ihs.gov>; joni.lyon@ihs.gov <joni.lyon@ihs.gov>; Howard, Joanne <Joanne.howard@cit-ed.org>; chief <Chief@Nansemond.gov>; AssistantChief@Nansemond.gov <AssistantChief@Nansemond.gov>; steven.tupponce@umithealth.com <steven.tupponce@umithealth.com>; owen.adams@umitribe.gov <owen.adams@umitribe.gov>; Jennifer.Floor@ihs.gov <jennifer.floor@ihs.gov>; Brown, Alexandria (DMAS) <Alexandria.Brown@dmas.virginia.gov>

1 attachment (57 KB)

Tribal Notice Letter (10.5.26) - signed.docx;

Good morning.

Dear Tribal Leaders and Indian Health Programs:

Attached is a Tribal Notice letter from Virginia Medicaid's Director, Steve Ford, indicating that the Dept. of Medical Assistance Services (DMAS) plans to submit a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services (CMS) regarding the Update to Durable Medical Equipment (DME) & Supplies.

If you would like a copy of the SPA documents or proposed text changes, or if you have any questions, please let us know.

Thank you.
-J. Williams

Jimeequa Williams
Regulatory Coordinator
Policy Division
Department of Medical Assistance Services
Hours: 7:30 a.m. - 5:00 p.m. (Monday-Thursday); 7:30 a.m. - 11:30 a.m. (Friday)
jimeequa.williams@dmas.virginia.gov

(804) 225-3508
www.dmas.virginia.gov



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

STEVE FORD
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

October 5, 2026

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to the Update to Durable Medical Equipment (DME) & Supplies.

Dear Tribal Leader and Indian Health Programs:

This letter is to notify you that the Department of Medical Assistance Services (DMAS) is planning to amend the Virginia State Plan for Medical Assistance with the Centers for Medicare and Medicaid Services (CMS). Specifically, DMAS is providing you notice about a State Plan Amendment (SPA) that the Agency will file with CMS to align the state plan with federal regulations (42 CFR 440.70(b)(3)) and DMAS current practice that allow both physicians and other licensed providers to order durable medical equipment (DME) and sign certificates of medical need (CMNs). Currently, the state plan only references physicians, so it needs to be updated accordingly.

We realize that the changes in this SPA may impact Medicaid members and providers, including tribal members and providers. Therefore, we encourage you to let us know if you have any comments or questions. The tribal comment period for this SPA is open through November 7, 2026. You may submit your comments directly to Jimeequa Williams, DMAS Policy Division, by phone (804) 225-3508, or via email: Jimeequa.Williams@dmas.virginia.gov. Finally, if you prefer regular mail you may send your comments or questions to:

Virginia Department of Medical Assistance Services
Attn: Jimeequa Williams
600 East Broad Street
Richmond, VA 23219

Please forward this information to any interested party.

Sincerely,

Steve Ford
Director
Department of Medical Assistance Services

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

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY
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§ 7.5. Durable medical equipment (DME) and supplies suitable for use. (12 VAC 30-50-165)

A. Definitions. The following words and terms when used in this section shall have the following meaning 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 that operates as a plan of care, and that must be completed and submitted in order for DMAS to provide coverage.
"Designated agent" means an entity with whom DMAS has contracted to perform functions such as provider audits and prior authorizations of services.
"DMAS" means the Department of Medical Assistance Services.
"DME provider" means those entities enrolled with DMAS to render DME services.
"Durable medical equipment" or "DME" means medical supplies, equipment, and appliance suitable for use 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 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, which is called a 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, or 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, at the frequency of use of a supply may be expressed as a range, such 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" ~~"Physician"~~ means a provider of physician services as defined in 42 CFR 440.50 or a provider of "other licensed practitioner" services as defined in 42 CFR 440.60.~~50.~~
"Prior authorization" or "PA" means the process of approving either by DMAS or its prior 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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B. General requirements and conditions.

1. a. All medically necessary medical 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 DME provider shall have a claim of ownership on DME reimbursed by Virginia Medicaid once it has been delivered to the Medicaid individual. DME providers ~~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 is rented.

2. DME providers shall adhere to all applicable federal laws and regulations, including the face-to-face requirements in 42 CFR 410.38. DME providers shall also adhere to all applicable 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 which are regulated by a licensing agency. Upon post payment review, DMAS or its designated contractor may deny coverage for any DME products or supplies that have not been provided and billed in accordance with these regulations and DMAS policies.

3. DME and supplies must be furnished pursuant to a properly completed Certificate of Medical Necessity (CMN) (DMAS-352). In order to obtain Medicaid coverage, specific fields of the DMAS-352 form shall be completed as specified in Attachment 3.1-C, p. 17.1 (12 VAC 30-60-75).

4. DME and supplies shall be ordered by the practitioner ~~physician~~ 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 practitioner ~~physician~~.

5. DME shall be furnished exactly as ordered by the practitioner ~~physician~~ who signed the CMN. The CMN and any supporting verifiable documentation shall be fully completed, signed and dated by the practitioner ~~physician~~, 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 shall be specifically ordered on the CMN by the practitioner ~~physician~~. The order shall not be backdated to cover prior dispensing of all DME products and supplies. If the order is not signed within 60 days of the service initiation, then the date the order is signed becomes the effective date.

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6. The CMN shall not be changed, altered, or amended after the attending practitioner ~~physician~~ has signed it. If individual's condition indicates that changes in the ordered DME or supplies are necessary, the DME provider shall obtain a new CMN. All CMNs shall be signed and dated by the practitioner ~~physician~~ 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 length of time from those specified in subdivisions 4, 5, and 6 of this subsection that 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 practitioner ~~physician~~, as specified in subdivision 5 of this subsection. Supporting documentation may be attached to the CMN but the attending practitioner's entire order shall be on the CMN.

8. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for purposes of the DMAS post payment audit review. DME providers shall not create or revise CMNs or supporting documentation for this service after the initiation of the post payment review audit process. Practitioners ~~Physicians~~ shall not complete, nor sign and 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. (This limitation may be exceeded based upon medical necessity.) 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 his 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 but shall not replace the requirement for a properly completed CMN.

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4. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, dentifrices; toilet articles; shampoos which do not require a practitioner's ~~physician's~~ prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a practitioner's prescription; sugar and salt substitutes; and support stockings);
5. Home or vehicle modifications;
6. Equipment for which the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.);
7. Diapers for routine use by children younger than three years of age who have not yet been toilet trained.

E. For coverage of blood glucose meters for pregnant women, refer to Supplement 3 to Attachment 3.1 A & B.

F.

1. Coverage of home infusion therapy. Home infusion therapy shall be defined as the administration of fluids, drugs, chemical agents, or nutritional substances to individuals through intravenous (I.V.) therapy or an implantable pump in the home setting. 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 which meet criteria shall be covered and do not require prior authorization.

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2. 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 recipient or the recipient's caregiver.

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

      (a) Reside in either a private home or a domiciliary care facility;

      (b) Be under the care of a practitioner ~~physician~~ who prescribes the home infusion therapy and monitors the progress of the therapy.

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

      (d) 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 those 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 vendor shall provide the equipment and supplies as prescribed by the practitioner ~~physician~~ on the CMN. Orders shall not be changed unless the vendor obtains a new CMN, which includes the practitioner's ~~physician's~~ signature, prior to ordering the equipment or supplies or providing the equipment or supplies to the individual.

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H. Medicaid shall not provide coverage to the DME and supply vendor for services that are provided (i) prior to the date prescribed by the practitioner ~~physician~~; (ii) prior to the date of the delivery; (iii) or when services are not provided in accordance with DMAS published regulations and guidance documents. If coverage is denied for one of these reasons, the medical equipment 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 physician or 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, ~~attending~~ physician, or other licensed practitioner, DME provider, 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 the individual's use.

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STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

Durable Medical Equipment (DME) and Supplies. (12 VAC 30-60-75)

A. No DME provider shall have a claim of ownership on DME covered by Virginia Medicaid once it has been delivered to the Medicaid individual. DME 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 (CMN), when there is an error in the ordering practitioner's ~~physician's~~ CMN, or when the equipment was rented. DMAS shall not cover the DME and supply provider for services that are provided either: (i) prior to the date prescribed by the practitioner ~~physician~~; (ii) prior to the date of the delivery; or (iii) when services are not provided in accordance with DMAS' published regulations and guidance documents. In instances when the DME or supply is shipped directly to the Medicaid individual, the DME provider shall confirm that the DME or supplies have been received by the individual before submitting the claim for payment to DMAS.

B. DME providers, as defined in Attachment 3.1A&B, supplement 1, page 13 (12 VAC 30-50-165), shall retain copies on file of the fully completed CMN and all applicable supporting documentation for post payment audit reviews. Coverage that has been made by Medicaid shall be retracted if the DME and supplies have not been ordered on the CMN. Additional supporting documentation is allowed to justify the medical need for durable medical equipment and supplies. 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. DME providers shall not create or revise CMNs or supporting documentation for durable medical equipment and supplies that have been provided once the post payment audit review has been initiated.

C. Individuals requiring only DME or supplies may obtain such services directly from the DME provider without having to consult or obtain services from a home health service or home health provider. Supplies used for treatment during a home health visit shall be included in the visit rate of the home health provider. Treatment supplies left in the home to maintain treatment after the visits shall be charged separately.

D. CMN requirements. The CMN shall have two required components: (i) the practitioner's ~~physician's~~ order and (ii) the clinical diagnosis. Failure to have a complete CMN may result in nonpayment of services rendered or retraction of payments made subsequent to post payment audits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

1. Practitioner's ~~Physician's~~ order.

   a. "Practitioner" in this section means a provider of physician services as defined in 42 CFR 440.50 or a provider of "other licensed practitioner" services as defined in 42 CFR 440.60.

   b. ~~a.~~The practitioner's ~~physician's~~ complete order shall appear on the face of the CMN. A complete order on the CMN shall consist of the item's complete description, the quantity ordered, the frequency of use, and the practitioner's ~~physician's~~ signature and complete date of signing as defined in Attachment 3.1 A&B, Supplement 1, page 13 (12 VAC 30-50-165). If the DME provider determines that the prescribing practitioner's ~~physician's~~ signature and compete date of signing are missing, he shall consider the CMN to be invalid and he shall request a new CMN.

   c. ~~b.~~ The following CMN fields (as indicated by an asterisk on the CMN) shall be required for coverage:

   (1) The ordered item's description. If the item is an E1399 (miscellaneous), the description of the item shall not be "miscellaneous DME", but the provider shall specify the DME item or supply.

   (2) The quantity ordered as found in the practitioner's ~~physician's~~ order. For expendable supplies the provider shall designate supplies needed for one month. If an item is not needed every month, the provider may designate an alternate time frame.

   (3) The frequency of use of the DME item or supply.

   (4) The practitioner's ~~physician's~~ signature and full date. If either the signature or full date, or both, are missing, then the entire CMN shall be deemed to be invalid and a new CMN shall be obtained. The practitioner's ~~physician's~~ signature certifies that the ordered DME and supplies are a part of the treatment plan and are medically necessary for the Medicaid individual.

   d. ~~c.~~ The begin service date on the CMN is optional.

   (1) If the provider enters a begin service date, the CMN must be signed and dated by the practitioner ~~physician~~ within 60 days of the begin service date in order for the CMN to start from the begin date.

   (2) If no begin service date is documented on the CMN, the date of the practitioner's ~~physician's~~ signature shall be the start date of the CMN.

2. The clinical diagnosis.

   a. The narrative description of the clinical diagnosis shall be recorded on the face of the CMN.

   b. The recording on the face of the CMN of the relevant ICD-9 diagnosis code shall be optional.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26 — 0034

2. STATE: VA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/1/2026

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 440.70

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2027 $ 0
b. FFY 2028 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A&B, Supplement 1, revised pages 13, 13.1, 13.2, 14, 14.1, 14.2

Attachment 3.1-C, revised pages 17.1, 17.2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same as box #7.

9. SUBJECT OF AMENDMENT
Update to Durable Medical Equipment (DME) & Supplies

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
Secretary of Health and Human Resources

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Steve Ford

13. TITLE
Director

14. DATE SUBMITTED
10/05/2026

15. RETURN TO
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

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

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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B. General requirements and conditions.

1. a. All medically necessary medical 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 DME provider shall have a claim of ownership on DME reimbursed by Virginia Medicaid once it has been delivered to the Medicaid individual. DME 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 is rented.

2. DME providers shall adhere to all applicable federal laws and regulations, including the face-to-face requirements in 42 CFR 410.38. DME providers shall also adhere to all applicable 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 which are regulated by a licensing agency. Upon post payment review, DMAS or its designated contractor may deny coverage for any DME products or supplies that have not been provided and billed in accordance with these regulations and DMAS policies.

3. DME and supplies must be furnished pursuant to a properly completed Certificate of Medical Necessity (CMN) (DMAS-352). In order to obtain Medicaid coverage, specific fields of the DMAS-352 form shall be completed as specified in Attachment 3.1-C, p. 17.1 (12 VAC 30-60-75).

4. DME and supplies shall be ordered by the practitioner physician 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 practitioner.

5. DME shall be furnished exactly as ordered by the practitioner who signed the CMN. The CMN and any supporting verifiable documentation shall be fully completed, signed and dated by the 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 shall be specifically ordered on the CMN by the practitioner. The order shall not be backdated to cover prior dispensing of all DME products and supplies. If the order is not signed within 60 days of the service initiation, then the date the order is signed becomes the effective date.

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6. The CMN shall not be changed, altered, or amended after the attending practitioner has signed it. If individual's condition indicates that changes in the ordered DME or supplies are necessary, the DME provider shall obtain a new CMN. All CMNs shall be signed and dated by the 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 length of time from those specified in subdivisions 4, 5, and 6 of this subsection that 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 practitioner, as specified in subdivision 5 of this subsection. Supporting documentation may be attached to the CMN but the attending practitioner's entire order shall be on the CMN.

8. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for purposes of the DMAS post payment audit review. DME providers shall not create or revise CMNs or supporting documentation for this service after the initiation of the post payment review audit process. Practitioners shall not complete, nor sign and 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. (This limitation may be exceeded based upon medical necessity.) 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 his 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 but shall not replace the requirement for a properly completed CMN.

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4. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, dentifrices; toilet articles; shampoos which do not require a practitioner's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a practitioner's prescription; sugar and salt substitutes; and support stockings;
5. Home or vehicle modifications;
6. Equipment for which the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.);
7. Diapers for routine use by children younger than three years of age who have not yet been toilet trained.

E. For coverage of blood glucose meters for pregnant women, refer to Supplement 3 to Attachment 3.1 A & B.

F.

1. Coverage of home infusion therapy. Home infusion therapy shall be defined as the administration of fluids, drugs, chemical agents, or nutritional substances to individuals through intravenous (I.V.) therapy or an implantable pump in the home setting. 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 which meet criteria shall be covered and do not require prior authorization.

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2. 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 recipient or the recipient's caregiver.

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

      (a) Reside in either a private home or a domiciliary care facility;

      (b) Be under the care of a practitioner who prescribes the home infusion therapy and monitors the progress of the therapy.

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

      (d) 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 those 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 vendor shall provide the equipment and supplies as prescribed by the practitioner on the CMN. Orders shall not be changed unless the vendor obtains a new CMN, which includes the practitioner's signature, prior to ordering the equipment or supplies or providing the equipment or supplies to the individual.

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H. Medicaid shall not provide coverage to the DME and supply vendor for services that are provided (i) prior to the date prescribed by the practitioner; (ii) prior to the date of the delivery; (iii) or when services are not provided in accordance with DMAS published regulations and guidance documents. If coverage is denied for one of these reasons, the medical equipment 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 physician or 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, physician, or other licensed practitioner, DME provider, 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 the individual's use.

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STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

Durable Medical Equipment (DME) and Supplies. (12 VAC 30-60-75)

A. No provider shall have a claim of ownership on DME covered 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 (CMN), when there is an error in the ordering practitioner's CMN, or when the equipment was rented. DMAS shall not cover the DME and supply provider for services that are provided either: (i) prior to the date prescribed by the 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. In instances when the DME or supply is shipped directly to the Medicaid individual, the DME provider shall confirm that the DME or supplies have been received by the individual before submitting the claim for payment to DMAS.

B. DME providers, as defined in Attachment 3.1A&B, supplement 1, page 13 (12 VAC 30-50-165), shall retain copies on file of the fully completed CMN and all applicable supporting documentation for post payment audit reviews. Coverage that has been made by Medicaid shall be retracted if the DME and supplies have not been ordered on the CMN. Additional supporting documentation is allowed to justify the medical need for durable medical equipment and supplies. 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. DME providers shall not create or revise CMNs or supporting documentation for durable medical equipment and supplies that have been provided once the post payment audit review has been initiated.

C. Individuals requiring only DME or supplies may obtain such services directly from the DME provider without having to consult or obtain services from a home health service or home health provider. Supplies used for treatment during a home health visit shall be included in the visit rate of the home health provider. Treatment supplies left in the home to maintain treatment after the visits shall be charged separately.

D. CMN requirements. The CMN shall have two required components: (i) the practitioners' order and (ii) the clinical diagnosis. Failure to have a complete CMN may result in nonpayment of services rendered or retraction of payments made subsequent to post payment audits.

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1. Practitioner's order.

   a. "Practitioner" in this section means a provider of physician services as defined in 42 CFR 440.50 or a provider of "other licensed practitioner" services as defined in 42 CFR 440.60.

   b. The practitioner's complete order shall appear on the face of the CMN. A complete order on the CMN shall consist of the item's complete description, the quantity ordered, the frequency of use, and the practitioner's signature and complete date of signing as defined in Attachment 3.1 A&B, Supplement 1, page 13 (12 VAC 30-50-165). If the DME provider determines that the prescribing practitioner's signature and compete date of signing are missing, he shall consider the CMN to be invalid and he shall request a new CMN.

   c. The following CMN fields (as indicated by an asterisk on the CMN) shall be required for coverage:

   (1) The ordered item's description. If the item is an E1399 (miscellaneous), the description of the item shall not be "miscellaneous DME", but the provider shall specify the DME item or supply.

   (2) The quantity ordered as found in the practitioner's order. For expendable supplies the provider shall designate supplies needed for one month. If an item is not needed every month, the provider may designate an alternate time frame.

   (3) The frequency of use of the DME item or supply.

   (4) The practitioner's signature and full date. If either the signature or full date, or both, are missing, then the entire CMN shall be deemed to be invalid and a new CMN shall be obtained. The practitioner's signature certifies that the ordered DME and supplies are a part of the treatment plan and are medically necessary for the Medicaid individual.

   d. ~~c.~~ The begin service date on the CMN is optional.

   (1) If the provider enters a begin service date, the CMN must be signed and dated by the practitioner within 60 days of the begin service date in order for the CMN to start from the begin date.

   (2) If no begin service date is documented on the CMN, the date of the practitioner's signature shall be the start date of the CMN.

2. The clinical diagnosis.

   a. The narrative description of the clinical diagnosis shall be recorded on the face of the CMN.

   b. The recording on the face of the CMN of the relevant ICD-9 diagnosis code shall be optional.