12VAC30-10-630. [Repealed]

12VAC30-10-631. With respect to nursing facilities and intermediate care faciities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

CERTIFIED:

__10/31/2001_____ __/s/ Eric S. Bell_____

Date Eric S. Bell, Director

Dept. of Medical Assistance Services

12VAC30-30-10. Mandatory coverage: Categorically needy and other required special groups.

The Title IV-A agency determines eligibility for Title XIX services.

1. Recipients of AFDC.

a. The approved state AFDC plan includes:

(1) Families with an unemployed parent for the mandatory six-month period and an optional extension of 0 months.

(2) AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

b. The standards for AFDC payments are listed in 12VAC30-40-220.

2. Deemed recipients of AFDC.

a. Individuals denied a Title IV-A cash payment solely because the amount would be less than $10.

b. Effective October 1, 1990, participants in a work supplementation program under Title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with §482(e)(6) of the Act.

c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.

d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of §406(h) of the Act.

e. Individuals deemed to be receiving AFDC who meet the requirements of §473(b)(1) or (2) for whom an adoption of assistance agreement is in effect or foster care maintenance payments are being made under Title IV-E of the Act.

3. Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under §407 of the Act because the principal wage earner is unemployed.

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to 12 months of extended benefits in accordance with §1925 of the Act.

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

a. Families denied AFDC solely because of income and resources deemed to be available from:

(1) Stepparents who are not legally liable for support of stepchildren under a state law of general applicability;

(2) Grandparents;

(3) Legal guardians; and

(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);

b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

6. Individuals who would be eligible for AFDC except for the increases in OASDI benefits under P.L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972 and who were receiving cash assistance in August 1972.

a. Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in the state's August 1972 plan).

b. Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this state's August 1972 plan).

7. Qualified pregnant women and children.

a. A pregnant woman whose pregnancy has been medically verified who:

(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

(2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the state had an AFDC-unemployed parents program; or

(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the state's approved AFDC plan.

b. Children born after September 30, 1973 (specify optional earlier date), who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the state's approved AFDC plan.

12VAC30-40-280 and 12VAC30-40-290 describe the more liberal methods of treating income and resources under §1902(r)(2) of the Act.

8. Pregnant women and infants under one year of age with family incomes up to 133% of the federal poverty level who are described in §§1902(a) (10)(A)(i)(IV) and 1902(l)(A) and (B) of the Act. The income level for this group is specified in 12VAC30-40-220.

9. Children:

a. Who have attained one year of age but have not attained six years of age, with family incomes at or below 133% of the federal poverty levels.

b. Born after September 30, 1983, who have attained six years of age but have not attained 19 years of age, with family incomes at or below 100% of the federal poverty levels.

Income levels for these groups are specified in 12VAC30-40-220.

10. Individuals other than qualified pregnant women and children under subdivision 7 of this section who are members of a family that would be receiving AFDC under §407 of the Act if the state had not exercised the option under §407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.

11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved state plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

b. A pregnant women who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth

as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

13. Aged, blind and disabled individuals receiving cash assistance.

a. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under §1619(a) of the Act or who meet the eligibility requirements for SSI status under §1619(b)(1) of the Act and who met the state's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under §1619(a) or met the requirements under §1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the §1619(a) eligibility standard or the requirements of §1619(b) of the Act.)

b. These persons include the aged, the blind, and the disabled.

c. Protected SSI children (pursuant to § 1902 (a)(10)(A)(i)(II) of the Act) (P.L. 105-33 § 4913). Children who meet the pre-welfare reform definition of childhood disability who lost their SSI coverage solely as a result of the change in the definition of childhood disability, and who also meet the more restrictive requirements for Medicaid than the SSI requirements.

~~c.~~ d. The more restrictive categorical eligibility criteria are described below:

(1) See 12VAC30-30-40.

(2) Financial criteria are described in 12VAC30-40-10.

14. Qualified severely impaired blind and disabled individuals under age 65 who:

a. For the month preceding the first month of eligibility under the requirements of §1905(q)(2) of the Act, received SSI, a state supplemental payment under §1616 of the Act or under §212 of P.L. 93-66 or benefits under §1619(a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under §1619(b) of the Act and were eligible for Medicaid. These individuals must:

(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under §1611(b) of the Act;

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

The state applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under §1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under §1619(b)(1) of the Act and who met the state's more restrictive requirements in the month before the month they qualified for SSI under §1619(a) or met the requirements of §1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under §1619(a) of the Act or meet the SSI requirements under §1619(b)(1) of the Act.

15. Except in states that apply more restrictive requirements for Medicaid than under SSI, blind or disabled individuals who:

a. Are at least 18 years of age;

b. Lose SSI eligibility because they become entitled to OASDI child's benefits under §202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absence their OASDI eligibility.

c. The state does not apply more restrictive income eligibility requirements than those under SSI.

16. Except in states that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional state supplements (if the agency provides Medicaid under §435.230 of the Act), because of requirements that do not apply under Title XIX of the Act.

17. Individuals receiving mandatory state supplements.

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the state's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for have his or her needs included in computing the cash payment.

In December 1973, Medicaid coverage of the essential spouse was limited to: the aged; the blind; and the disabled.

19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of Title XIX medical institutions or residents of Title XIX intermediate care facilities, if, for each consecutive month after December 1973, they:

a. Continue to meet the December 1973 Medicaid State Plan eligibility requirements;

b. Remain institutionalized; and

c. Continue to need institutional care.

20. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and

b. Were eligible for Medicaid in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under P.L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

This includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this state's August 1972 plan), and persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this state's August 1972 plan).

22. Individuals who:

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under §215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

The state applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by §134 of P.L. 98-21 and who are deemed, for purposes of Title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under §1634(b) of the Act.

The state does not apply more restrictive income eligibility standards than those under SSI.

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least 10 years before the divorce became effective, who have attained the age of 50, who are receiving Title II payments, and who because of the receipt of Title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive Title II payments, who would be eligible for SSI or SSP if the amount of the Title II benefit were not counted as income, and who are not entitled to Medicare Part A.

The state applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

25. Qualified Medicare beneficiaries:

a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under §1818 of the Act);

b. Whose income does not exceed 100% of the federal level; and

c. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare cost sharing as defined in item 3.2 of this plan.)

26. Qualified disabled and working individuals:

a. Who are entitled to hospital insurance benefits under Medicare Part A under §1818A of the Act;

b. Whose income does not exceed 200% of the federal poverty level; and

c. Whose resources do not exceed twice the maximum standard under SSI.

d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

(Medical assistance for this group is limited to Medicare Part A premiums under §§1818 and 1818A of the Act.)

27. Specified low-income Medicare beneficiaries:

a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under §1818A of the Act);

b. Whose income for calendar years 1993 and 1994 exceeds the income level in subdivision 25 b of this section, but is less than 110% of the federal poverty level, and whose income for calendar years beginning 1995 is less than 120% of the federal poverty level; and

c. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare Part B premiums under §1839 of the Act.)

28. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of §1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

b. The state applies more restrictive eligibility standards than those under SSI.

Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of §1611(e)(3)(A) and who continue to meet the more restrictive requirements for Medicaid eligibility under the state plan, are eligible for Medicaid as categorically needy.

CERTIFIED:

10/31/2001
Date

/s/ Eric S. Bell
Eric S. Bell, Director
Dept. of Medical Assistance Services

Family Size	Need Standard	Payment Standard	Maximum Payment Amounts
	See Table 1	See Table 2	

STANDARDS OF ASSISTANCE (adjusted to reflect increases in the Medically Needy Income Limits at 12 VAC 30-40-220 E)

GROUP I

Size of Assistance Unit	Table 1 (100%)	Table 2 (90%)
1	$146	$131
2	229	207
3	295	265
4	358	322
5	422	380
6	473	427
7	535	482
8	602	541
9	657	591
10	718	647
Each person above 10	61	56

MAXIMUM REIMBURSABLE PAYMENT $403

GROUP II

Size of Assistance Unit	Table 1 (100%)	Table 2 (90%)
1	$174	$157
2	257	231
3	322	291
4	386	347
5	457	410
6	509	458
7	570	512
8	636	572
9	692	623
10	754	678
Each person above 10	61	56

MAXIMUM REIMBURSABLE PAYMENT $435

GROUP III

Size of Assistance Unit	Table 1 (100%)	Table 2 (90%)
1	$243	$220
2	327	294
3	393	354
4	457	410
5	542	488
6	593	534

7	655	590
8	721	650
9	779	701
10	838	755
Each person above 10	61	56

MAXIMUM REIMBURSABLE PAYMENT $518

2. Pregnant women and infants under 1902(a)(10)(i)(IV) of the Act:
Effective April 1, 1990, based on 133% of the official federal income poverty level.
3. Children under §1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133% of the federal poverty level (as revised annually in the Federal Register) for the size family involved.
4. For children under §1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983, and have attained age 6 but have not attained age 19), the income eligibility level is 100% of the federal poverty level (as revised annually in the Federal Register) for the size family involved.
B. Treatment of COLA for groups with income related to federal poverty level.
1. If an individual receives a Title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a Title II COLA is not counted as income during a "transition period" beginning with January, when the Title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual federal poverty level.
2. For individuals with Title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.
3. For individuals not receiving Title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.
C. Qualified Medicare beneficiaries with incomes related to federal poverty level.
The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of §1905(p)(2)(A) of the Act are as follows:
Section 1902(f) states which as of January 1, 1987, used income standards more restrictive than SSI. (VA did not apply a more restrictive income standard as of January 1, 1987.)
Based on the following percentage of the official federal income poverty level:
Effective Jan. 1, 1989: 85%
Effective Jan. 1, 1990: 90% (no more than 100)
Effective Jan. 1, 1991: 100% (no more than 100)
Effective Jan. 1, 1992: 100%

D. Aged and Disabled Individuals described in §1902(m)(1) of the Act: Levels for determining income eligibility for aged and disabled persons described in §1902(m)(1) of the Act is 80% of the official federal income poverty level (as revised annually in the Federal Register) for the size family involved.

E. Income levels - medically needy.

1. The following income levels (as adjusted annually by the increase in the CPI) are applicable to all groups, urban and rural.

2. The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

(1)	(2)	(3)

Family Size	Net income level protected for maintenance for 12 months			Amt by which Column 2 exceeds limits specified in 42 CFR 435.1007
	Group I	Group II	Group III	
1	2691.00	3105.00	4036.50	$0
2	3519.00	3824.00	4867.00	$0
3	4036.50	4450.50	5485.50	$0
4	4554.00	4968.00	6003.00	$0
5	5071.50	5485.50	6520.50	$0
6	5589.00	6003.00	7038.00	$0
7	6106.50	6520.50	7555.50	$0
8	6727.50	7141.50	8073.00	$0
9	7348.50	7762.50	8797.50	$0
10	8073.00	8487.00	9418.50	$0
For each add'tl person, add:	$695.52	$695.52	$695.52	$0

FN1 As authorized in § 4718 of OBRA '90.

Grouping of Localities

GROUP I

Counties

Accomack	King George
Alleghany	King and Queen
Amelia	King William
Amherst	Lancaster
Appomattox	Lee
Bath	Louisa
Bedford	Lunenburg
Bland	Madison
Botetourt	Matthews
Brunswick	Mecklenburg
Buchanan	Middlesex
Buckingham	Nelson
Campbell	New Kent

Caroline	Northampton
Carroll	Northumberland
Charles City	Nottoway
Charlotte	Orange
Clarke	Page
Craig	Patrick
Culpeper	Pittsylvania
Cumberland	Powhatan
Dickenson	Prince Edward
Dinwiddie	Prince George
Essex	Pulaski
Fauquier	Rappahannock
Floyd	Richmond
Fluvanna	Rockbridge
Franklin	Russell
Frederick	Scott
Giles	Shenandoah
Gloucester	Smyth
Goochland	Southampton
Grayson	Spotsylvania
Greene	Stafford
Greensville	Surry
Halifax	Sussex
Hanover	Tazewell
Henry	Washington
Highland	Westmoreland
Isle of Wight	Wise
James City	Wythe
	York

Cities

Bristol	Franklin
Buena Vista	Galax
Clifton Forge	Norton
Danville	Poquoson
Emporia	Suffolk

GROUP II

Counties

Albemarle	Loudoun
Augusta	Roanoke
Chesterfield	Rockingham
Henrico	Warren

Cities

Chesapeake	Portsmouth
Covington	Radford
Harrisonburg	Richmond
Hopewell	Roanoke
Lexington	Salem
Lynchburg	Staunton
Martinsville	Virginia Beach

Newport News
Norfolk
Petersburg
Williamsburg
Winchester

GROUP III

Counties
Arlington
Fairfax
Montgomery
Prince William

Cities
Alexandria
Charlottesville
Colonial Heights
Fairfax
Falls Church
Fredericksburg
Hampton
Manassas
Manassas Park
Waynesboro

CERTIFIED:

10/31/2001
Date

/s/ Eric S. Bell
Eric S. Bell, Director
Dept. of Medical Assistance Services

12 VAC 30-10-640.

12VAC30-10-640. Program for licensing administrators of nursing homes.

The State has a program that, except with respect to ~~Christian Science sanatoria~~ Religious Nonmedical Health Care Institutions, meets the requirements of 42 CFR 431, Subpart N, for the licensing of nursing home administrators.

CERTIFIED:

10/31/2001
Date

/s/ Eric S. Bell
Eric S. Bell, Director
Dept. of Medical Assistance Services

12VAC30-50-100. Inpatient hospital services provided at general acute care hospitals and freestanding psychiatric hospitals; enrolled providers.

A. Preauthorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals and freestanding psychiatric hospitals. Nonauthorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS). Preauthorization shall be based on criteria specified by DMAS. In conjunction with preauthorization, an appropriate length of stay will be assigned using the HCIA, Inc., Length of Stay by Diagnosis and Operation, Southern Region, 1996, as guidelines.

1. Admission review.

a. Planned/scheduled admissions. Review shall be done prior to admission to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned at the time of this review. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

b. Unplanned/urgent admissions. Review shall be performed within one working day to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned for those admissions which have been determined to be appropriate. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

2. Concurrent review shall end for nonpsychiatric claims with dates of admission and services on or after July 1, 1998, with the full implementation of the DRG reimbursement methodology. Concurrent review shall be done to determine that inpatient hospitalization continues to be medically necessary. Prior to the expiration of the previously assigned initial length of stay, the provider shall be responsible for obtaining authorization for continued inpatient hospitalization. If continued inpatient hospitalization is determined necessary, an additional length of stay shall be assigned. Concurrent review shall continue in the same manner until the discharge of the patient from acute inpatient hospital care. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

3. Retrospective review shall be performed when a provider is notified of a patient's retroactive eligibility for Medicaid coverage. It shall be the provider's responsibility to obtain authorization for covered days prior to billing DMAS for these services. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

4. Reconsideration process.

a. Providers requesting reconsideration must do so upon verbal notification of denial.

b. This process is available to providers when the nurse reviewers advise the providers by telephone that the medical information provided does not meet DMAS specified criteria. At this point, the provider must request by telephone a higher level of review if he disagrees with the nurse reviewer's findings. If higher level review is not requested, the case will be denied and a denial letter generated to both the provider and recipient identifying appeal rights.

c. If higher level review is requested, the authorization request will be held in suspense and referred to the Utilization Management Supervisor (UMS). The UMS shall have one working day to render a decision. If the UMS upholds the adverse decision, the provider may accept that decision and the case will be denied and a denial letter identifying appeal rights will be generated to both the provider and the recipient. If the provider continues to disagree with the UMS' adverse decision, he must request physician review by DMAS medical support. If higher level review is requested, the authorization request will be held in suspense and referred to DMAS medical support for the last step of reconsideration.

d. DMAS medical support will review all case specific medical information. Medical support shall have two working days to render a decision. If medical support upholds the adverse decision, the request for authorization will then be denied and a letter identifying appeal rights will be generated to both the provider and the recipient. The entire reconsideration process must be completed within three working days.

5. Appeals process.

a. Recipient appeals. Upon receipt of a denial letter, the recipient shall have the right to appeal the adverse decision. Under the Client Appeals regulations, Part I (12VAC30-110-10 et seq.) of 12VAC30-110, the recipient shall have 30 days from the date of the denial letter to file an appeal.

b. Provider appeals. If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the date of the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered. The appeal shall be held in accordance with the Administrative Process Act (§9-6.14:1 et seq. of the Code of Virginia).

B. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

C. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus were carried to term.

D. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be authorized for payment. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically indicated. Except as previously noted, regardless of authorization for the hospitalization, the claims will be processed in accordance with the limit for 21 days in a 60-day period. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days for nonpsychiatric admissions shall cease with dates of service on or after July 1, 1998.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric hospitals in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination. The admission and length of stay must be medically justified and preauthorized via the

admission and concurrent or retrospective review processes described in subsection A of this section. Medically unjustified days in such hospitalizations shall not be authorized for payment.

E. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

F. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section and 12VAC30-50-105.

G. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be

covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS medical support. Inpatient hospitalization related to kidney transplantation will require preauthorization at the time of admission and, concurrently, for length of stay. Cornea transplants do not require preauthorization of the procedure, but inpatient hospitalization related to such transplants will require preauthorization for admission and, concurrently, for length of stay. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. ~~Reimbursement for covered liver, heart, and bone marrow transplant/stem cell services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate.~~ Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-570.

H. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review. Hospitals must submit the required DMAS forms corresponding to the procedures. Regardless of authorization for the hospitalization during which these procedures were performed, the claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy

CERTIFIED:

10/31/2001
Date

/s/ Eric S. Bell
Eric S. Bell, Director
Dept. of Medical Assistance Services

12VAC30-50-105. Inpatient hospital services provided at general acute care hospitals and freestanding psychiatric hospitals; nonenrolled providers (nonparticipating/out of state).

A. The full DRG inpatient reimbursement methodology shall become effective July 1, 1998, for general acute care hospitals and freestanding psychiatric hospitals which are nonenrolled providers (nonparticipating/out of state) and the same reviews, criteria, and requirements shall apply as are applied to enrolled, in-state, participating hospitals in 12VAC30-50-100.

B. Inpatient hospital services rendered by nonenrolled providers shall not require preauthorization with the exception of transplants as described in subsection K of this section. However, these inpatient hospital services claims will be suspended from payment and manually reviewed for medical necessity as described in subsections C through K of this section using criteria specified by DMAS.

C. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under four days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed three days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection H of this section.)

D. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

E. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus was carried to term.

F. Hospital claims with an admission date prior to the first surgical date, regardless of the number of days prior to surgery, must be medically justified. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for all pre-operative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

G. Reimbursement will not be provided for weekend (Saturday/Sunday) admissions, unless medically justified. Hospital claims with admission dates on Saturday or Sunday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admission will be denied.

H. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be reimbursed. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically justified. The admission and length of stay must be medically justified and preauthorized via the admission and concurrent review processes described in subsection A of 12VAC30-50-100. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days shall cease with dates of service on

or after

July 1, 1998. Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age who are Medicaid eligible for medically necessary stays in general hospitals and freestanding psychiatric facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination.

I. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically necessary.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

J. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the DMAS outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions.

K. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. ~~Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover: procurement costs; all hospital costs from admission to discharge for the transplant procedure; total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are~~

~~lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate.~~ Standards for coverage of organ transplant services are in 12VAC30-50-540 through ~~12VAC30-50-570~~ 12VAC30-50-580.

L. In compliance with 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of the required DMAS forms corresponding to the procedures. The claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

CERTIFIED:

10/31/2001
Date

/s/ Eric S. Bell
Eric S. Bell, Director
Dept. of Medical Assistance Services

12VAC30-50-140. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are not covered except when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well-child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

D. Outpatient psychiatric services.

1. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension (subject to DMAS' approval) of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by DMAS. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. Consistent with §6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary psychiatric services shall be covered when prior authorized by DMAS for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening.

2. Psychiatric services can be provided by psychiatrists or by a licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric under the direct supervision of a psychiatrist.*

3. Psychological and psychiatric services shall be medically prescribed treatment which is directly and specifically related to an active written plan designed and signature-dated by either a psychiatrist or by a licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric under the direct supervision of a psychiatrist.*

4. Psychological or psychiatric services shall be considered appropriate when an individual meets the following criteria:

a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels which have been impaired;

b. Exhibits deficits in peer relations, dealing with authority; is hyperactive; has poor impulse control; is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, ability to learn, or ability to participate in employment, educational, or social activities;

c. Is at risk for developing or requires treatment for maladaptive coping strategies; and

d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

5. Psychological or psychiatric services may be provided in an office or a mental health clinic.

E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus was carried to term.

G. Physician visits to inpatient hospital patients over the age of 21 are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses or treatment plan and is further restricted to medically necessary authorized (for enrolled providers)/approved (for nonenrolled providers) inpatient hospital days as determined by the Program.
EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Payments for physician visits for inpatient days shall be limited to medically necessary inpatient hospital days.

H. (Reserved.)

I. Reimbursement shall not be provided for physician services provided to recipients in the inpatient setting whenever the facility is denied reimbursement.

J. (Reserved.)

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. ~~Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure specific flat fee determined by the agency or a prospectively determined, procedure specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement~~

~~for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate.~~ Standards for coverage of organ transplant services are in 12VAC30-50-540 through ~~12VAC30-50-570~~ 12VAC30-50-580.

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If prior authorized, breast reconstruction surgery and prostheses may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorized, for all medically necessary indications. Such procedures shall be considered noncosmetic.

2. Breast reconstruction or enhancements for cosmetic reasons shall not be covered. Cosmetic reasons shall be defined as those which are not medically indicated or are intended solely to preserve, restore, confer, or enhance the aesthetic appearance of the breast.

*Licensed clinical social workers, licensed professional counselors, and licensed clinical nurse specialists-psychiatric may also directly enroll or be supervised by psychologists as provided for in 12VAC30-50-150.

CERTIFIED:

10/31/2001
Date

/s/ Eric S. Bell
Eric S. Bell, Director
Dept. of Medical Assistance Services

CHAPTER 70.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES;
INPATIENT
HOSPITAL CARE.

PART V.

INPATIENT HOSPITAL PAYMENT SYSTEM.

Article 1.

Application of Payment Methodologies.

12 VAC 30-70-200. Repealed.

VAC 30-70-201. Application of payment methodologies.

A. The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12 VAC 30-70-221 et seq.) describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12 VAC 30-70-400 et seq.) describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, Inpatient hospital services that are provided in long stay hospitals and state-owned rehabilitation hospitals shall be subject to the provisions of Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130).

C. Transplant services shall not be subject to the provisions of this part. ~~These services shall continue to be subject to 12VAC30-50-100 through 12VAC30-50-310 and 12VAC30-50-540.~~ Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists,

patholologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges.

Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea tranplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12 VAC 30-50-540 through 12 VAC 30-50-580.

CERTIFIED:

10/31/2001
Date

/s/ Eric S. Bell
Eric S. Bell, Director
Dept. of Medical Assistance Services

12 VAC 30-50-229.1. School health services.

A. School health services shall require parental consent and shall be defined as those therapy, nursing services, psychiatric/psychological, and well child screenings rendered by employees of school divisions which are enrolled with DMAS to serve children who:

1. Qualify to receive special education services as described under and consistent with all of the requirements of Part B of the federal Individuals with Disabilities Education Act, as amended (20 USC § 1400 et seq.). Children qualifying for special education services pursuant to Part B of the federal Individuals with Disabilities Education Act, as amended, shall not be restricted in their choice of enrolled providers of medical care services as described in the State Plan for Medical Assistance or

2. Qualify to receive routine screening services under the State Plan. Diagnostic and treatment services, which are otherwise covered under Early and Periodic Screening, Diagnosis and Treatment services, shall not be covered for participating school divisions. Participating school divisions must receive parental consent before conducting screening services.

B. Physical therapy and related services.

1. The services covered under this subsection shall include physical therapy, occupational therapy, and speech/language pathology services. All of the requirements, with the exception of the 24 visit limit, of 12 VAC 30-50-200 and 42 CFR 440.110 applicable to these services shall continue to apply with regard to, but not necessarily limited to, necessary authorizations, documentation requirements, and provider qualifications. Consistent with the child's Individualized Education Program, 35 therapy visits will be covered per year per discipline without DMAS prior authorization.

~~2. Consultation by physical therapy, occupational therapy, or speech pathology providers in meetings for the development, evaluation, or reevaluation of the Individualized Education Program (IEP) for specific children shall be covered when the IEP with the physical therapy, occupational therapy, or speech pathology services is implemented (based on the date of services billed to DMAS) as soon as possible after the IEP meeting, not to exceed 60 days, except where there are extenuating circumstances. This consultation is to be billed to DMAS no earlier than the date such services are implemented. No more than two consultations may be billed for each child annually. This annual limitation includes consultations billed to DMAS attended by either registered nurses or licensed practical nurses. If an IEP eligibility meeting is billed to DMAS, then the subsequent IEP plan meeting must also be billed for any DMAS reimbursement to occur.~~

~~3. Extenuating circumstances are recognized regarding the coverage of the IEP consultation when the physical therapy, occupational therapy, or speech pathology services cannot be implemented as soon as possible following the effective date of the IEP. Such extenuating circumstances may include, but shall not be limited to, arrangements for transportation, hospitalization of the child, or summer or vacation periods. DMAS or its contractor must approve other extenuating circumstances.~~

~~4~~2. Consistent with the *COV* § 32.1-326.3, speech-language services must be rendered either by:

a. A speech-language pathologist who meets the qualifications under 42 CFR 440.110(c):

(i) Has a certificate of clinical competence from the American Speech and Hearing Association; or (ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or (iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate; OR

b. A speech-language pathologist with a current license in speech pathology issued by the Board of Audiology and Speech-Language Pathology; OR

c. A speech-language pathologist licensed by the Board of Education with an endorsement in speech-language disorders preK-12 and a master's degree in speech-language pathology. These persons also have a license without examination from the Board of Audiology and Speech-Language Pathology; OR

d. A speech-language pathologist who does not meet the criteria for (a), (b), or (c) above and is directly supervised by a speech-language pathologist who meets the criteria (a)(i), (a)(ii), (b), or (c) above. The speech-language pathologist must be licensed by the Board of Education with an endorsement in speech-language disorders preK-12 but does not hold a master's degree in speech-language pathology. Direct supervision must take place on-site at least every 30-calendar days for a minimum of two hours and must be documented accordingly. The speech-language pathologist who meets the criteria for (a)(I), (a)(ii), (b), or (c) above is readily available to offer needed supervision when speech-language services are provided.

C. Skilled nursing services.

1. These must be medically necessary skilled nursing services which are required by a child in order to benefit from an educational program, as described under Part B of the federal Individuals with Disabilities Education Act, as amended (20 USC § 1400 et seq.). These services shall be limited to a maximum of 26 units a day of medically necessary services. Services not deemed to be medically necessary, upon utilization review, shall not be covered.

A unit, for the purposes of this school-based health service, shall be defined as 15 minutes of skilled nursing care.

2. These services must be performed by a Virginia-licensed registered nurse (RN) or licensed practical nurse (LPN) under the supervision of a licensed RN. The service provider shall be either employed by the school division or under contract to the school division. The skilled nursing services shall be rendered in accordance with the licensing standards and criteria of the Virginia Board of Nursing. Supervision of LPNs shall be provided consistent with the regulatory standards of the Board of Nursing at 18 VAC 90-20-270.

~~3. Consultation by skilled nursing providers in meetings for the development, evaluation, or reevaluation of the IEP for specific children shall be covered when the IEP with the skilled nursing services is implemented (based on the dates of services billed to DMAS) as soon as possible after the IEP meeting, not to exceed 60 days, except where there are extenuating circumstances. This consultation is to be billed to DMAS no earlier than the date such services are implemented. No more than two consultations may be billed for each child annually. This annual limitation includes consultations billed to DMAS attended by physical therapists, occupational therapists, and speech therapists. If an IEP eligibility meeting is billed to DMAS, then the subsequent IEP plan meeting must also be billed for any DMAS reimbursement to occur.~~

~~4. Extenuating circumstances are recognized regarding the coverage of the IEP consultation when the skilled nursing services cannot be implemented as soon as possible following the effective date of the IEP. Such extenuating circumstances may include but shall not be limited to arrangements for transportation, hospitalization of the child, or summer or vacation periods. DMAS or its contractor must approve other extenuating circumstances.~~

~~5~~3. The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) which are consistent with skilled nursing services when performed by a Registered Nurse or a Licensed Practical Nurse. These skilled nursing services shall include, but not necessarily be limited to, dressing changes, maintaining patent airways, medication administration/ monitoring and urinary catheterizations. Skilled nursing services shall be consistent with the medical necessity criteria in the school services manual.

~~6~~4. Skilled nursing services shall be directly and specifically related to an active, written plan of care, which is based on a physician's or nurse practitioner's written order for skilled nursing services. The Registered Nurse is to establish, sign, and date the plan of care. The plan of care is to be periodically reviewed by a physician or nurse practitioner, after any needed consultation with skilled nursing staff. The services shall be specific and provide effective treatment for the child's condition in accordance with accepted standards of skilled nursing practice. The plan of care is further described in subdivision ~~7~~ 5 of this subsection. Skilled nursing services rendered which exceed the physician or nurse practitioner written order for skilled nursing services shall not be reimbursed by DMAS. A copy of the POC shall be given to the child's Medicaid primary care provider.

~~7~~5. Documentation of school-based skilled nursing services. Documentation of services shall include a written POC which identifies the medical condition or conditions to be addressed by skilled nursing services, goals for skilled nursing services, time tables for accomplishing such stated goals, actual skilled nursing services to be delivered and whether the services will be delivered by an RN or LPN. Services which have been delivered and for which reimbursement from Medicaid is to be claimed must be supported with like documentation. Documentation shall include the dates and times of services entered by the responsible

licensed nurse; the actual nursing services rendered; the identification of the child on each page of the medical record; the current diagnosis and elements of the history and exam which form the basis of the diagnosis; any prescribed drugs which are part of the treatment including the quantities and dosage; and notes to indicate progress made by the child, changes to the diagnosis or treatment and response to treatment. The Plan of Care is to be part of the child's medical record. Actions related to the skilled nursing services such as notifying parents, calling the physician, or notifying emergency medical services shall also be documented. All documentation shall be signed and dated by the person performing the service. Lengthier skilled nursing services shall have more extensive documentation. The documentation shall be written immediately, or as soon thereafter as possible, after the procedure or treatment was implemented with the date and time specified, unless otherwise instructed in writing by Medicaid. Documentation is further described in the Medicaid school services manual. Skilled nursing services documentation shall otherwise be in accordance with the Virginia Board of Nursing, Department of Health, and Department of Education statutes, regulations, and standards relating to school health. Documentation shall also be in accordance with school division standards.

~~8~~6. Service limitations. The following general conditions shall apply to reimbursable skilled nursing services in school divisions:

a. Patient must be under the care of a physician or nurse practitioner who is legally authorized to practice and who is acting within the scope of his license.

b. A recertification by a physician or nurse practitioner of the skilled nursing services shall be conducted at least once each school year. The recertification statement must be signed and dated by the physician or nurse practitioner who reviews the plan of care, and may be

obtained when the plan of care is reviewed. The physician or nurse practitioner recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

c. Physician or nurse practitioner orders for skilled nursing services shall be required.

d. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the child's school medical record as having been rendered shall be deemed not to have been rendered and no payment shall be provided.

e. Skilled nursing services are to be terminated when further progress toward the treatment goals are unlikely or when they are not benefiting the child or when the services can be provided by someone other than the skilled nursing professional.

D. Psychiatric and psychological services. Evaluations and therapy services shall be covered, when rendered by individuals who are licensed by the Board of Medicine and practice as psychiatrists or by psychologists licensed by the Board of Psychology as clinical psychologists or by school psychologists-limited licensed by the Board of Psychology. Services by these practitioners shall be subject to coverage at 12 VAC 30-50-140 D.

~~1. Consultation by psychiatric/psychologist providers in meetings for the development, evaluation, or reevaluation of the IEP for specific children shall be covered when the IEP with the psychiatric/psychological services is implemented (based on the dates of services billed to DMAS) as soon as possible after the IEP meeting, not to exceed 60 days, except where there are extenuating circumstances. This consultation is to be billed to DMAS no earlier than the date such services are implemented. No more than two consultations (across~~

~~all three therapies, nursing, and psychiatric/psychological disciplines) may be billed for each child annually. This annual limitation includes consultations billed to DMAS attended by physical therapists, occupational therapists, and speech therapists, and nurses. If an IEP eligibility meeting is billed to DMAS, then the subsequent IEP plan meeting must also be billed for any DMAS reimbursement to occur.~~

~~2. Extenuating circumstances are recognized regarding the coverage of the IEP consultation when the psychological services cannot be implemented as soon as possible following the effective date of the IEP. Such extenuating circumstances may include but shall not be limited to arrangements for transportation, hospitalization of the child, or summer or vacation periods. DMAS or its contractor must approve other extenuating circumstances.~~

E. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Routine screening services shall be covered for school divisions when rendered by either physicians or nurse practitioners. Diagnostic and treatment services also covered under EPSDT shall not be covered for school divisions. Schools divisions shall be required to refer children who are identified through health assessment screenings as having potential abnormalities to their primary care physician for further diagnostic and treatment procedures.

F. Specific exclusions from school health services. All services encompassing and related to family planning, pregnancy, and abortion services shall be specifically excluded from Medicaid reimbursement if rendered in the school district setting.

CERTIFIED:

10/31/2001
Date

/s/ Eric S. Bell
Eric S. Bell, Director
Dept. of Medical Assistance Services

12 VAC 30-60-170. Utilization review of treatment foster care case management services (TFC). Service description and provider qualifications.

TFC case management is a community based program where treatment services are designed to address the special needs of children. TFC case management focuses on a continuity of services, is goal directed~~,~~ and results oriented~~, and emphasizes permanency planning for the child in care~~. Services shall not include room and board. Child-placing agencies licensed or certified by the Virginia Department of Social Services and which meet the provider qualifications for treatment foster care set forth in these regulations shall provide these services.

A. Utilization control.

1. Assessment. Each child referred for TFC case management must be assessed by a Family Assessment and Planning Team (FAPT) under the Comprehensive Services Act or by an interdisciplinary team approved by the State Executive Council. ~~The~~ For purposes of high quality case management services, the team must: (i) assess the child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; (ii) assess the potential for reunification of the child's family; (iii) set treatment objectives; and (iv) prescribe therapeutic modalities to achieve the plan's objectives.

2. Qualified Assessors: A Family Assessment and Planning Team as authorized by the *Code of Virginia* § §2.1-753, 754, and 755.

3. Preauthorization. Preauthorization shall be required for Medicaid payment of TFC case management services for each admission to this service and will be conducted by DMAS or its utilization management contractor. When service is authorized, an initial length of stay will be assigned. The provider must request authorization for continued stay. Failure to obtain authorization of Medicaid reimbursement for this service within 10 days of admission will result in denial of payments or recovery of expenditures.

4. Medical Necessity Criteria. Children whose conditions meet this medical necessity criteria will be eligible for Medicaid payment for TFC case management. TFC case management will serve children under age 21 in treatment foster care who are seriously emotionally disturbed (SED) or children with behavioral disorders who in the absence of such programs, would be at risk for placement into more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs or group homes. The child must have a documented moderate to severe impairment and moderate to severe risk factors as recorded on a state-designated uniform assessment instrument. The child's condition must meet one of the three levels described below.

a. Level I: Moderate impairment with one or more of the following moderate risk factors as documented on the state designated uniform assessment instrument:

(1) Needs intensive supervision to prevent harmful consequences;

(2) Moderate/frequent disruptive or noncompliant behaviors in home setting that increase the risk to self or others;

(3) Needs assistance of trained professionals as caregivers.

b. Level II: The child must display a significant impairment with problems with authority, impulsivity and caregiver issues as documented on the state designated uniform assessment instrument. For example, the child must:

(1) Be unable to handle the emotional demands of family living;

(2) Need 24-hour immediate response to crisis behaviors; or

(3) Have severe disruptive peer and authority interactions that increase risk and impede growth.

c. Level III: Child must display a significant impairment with severe risk factors as documented on the state designated uniform assessment instrument. Child must demonstrate risk behaviors that create significant risk of harm to self or others.

5. TFC case management admission documentation required. Before Medicaid preauthorization will be granted, the referring entity must submit the following documentation. The documentation will be evaluated by DMAS or its designee to determine whether the child's condition meets the Department's medical necessity criteria.

a. A completed state designated uniform assessment instrument;

b. Diagnosis, (Diagnostic Statistical Manual, Fourth Revision (DSM IV), including Axis I (Clinical Disorders); Axis II (Personality Disorders/Mental Retardation); Axis III (General Medical Conditions); Axis IV (Psychosocial and Environmental Problems); and Axis V (Global Assessment of Functioning);

c. A description of the child's immediate behavior prior to admission;

d. A description of alternative placements tried or explored;

e. The child's functional level;

f. Clinical stability;

g. The level of family support available;

h. Initial plan of care, AND

i. One of the following:

(i) Written documentation that the Community Planning and Management Team (CPMT) has approved the admission to treatment foster care OR

(ii) Certification by the FAPT that TFC case management is medically necessary.

6. Penalty for failure to obtain preauthorization or to prepare and maintain the previously described documentation. The failure to obtain authorization for this service within 10 days of admission or to develop and maintain the documentation enumerated above will result in denial of payments or recovery of expenditures.

B. Non-covered services. Permanency planning and other activities performed by foster care workers shall not be considered covered services and shall not be reimbursed.

CERTIFIED:

10/31/2001
Date

/s/ Eric S. Bell
Eric S. Bell, Director
Dept. of Medical Assistance Services

12VAC30-50-260. Nurse-midwife services.

Covered services for nurse midwives are defined as those services allowed under the licensure requirements of the state statute and as specified in the ~~Social Security Act~~ Code of Federal Regulations at 42 CFR § 440.165.

CERTIFIED:

___10/31/2001_____ __/s/ Eric S. Bell_____
Date Eric S. Bell, Director
Dept. of Medical Assistance Services

Article 3.

Other Provisions for Payment of Inpatient Hospital Services.

12 VAC 30-70-400. Determination of per diem rates.

This section shall be applicable to only those claims for discharges prior to July 1, 1999. Each hospital's revised per diem rate or rates to be used during the transition period (SFY 1997 and SFY 1998) shall be based on the hospital's previous peer group ceiling or ceilings that were established under the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, with the following adjustments:

1. All operating ceilings will be increased by the same proportion to effect an aggregate increase in reimbursement of $40 million in SFY 1997. This adjustment incorporates in per diem rates the system wide aggregate value of payment that otherwise would be made through the payment adjustment fund. This adjustment will be calculated using estimated 1997 rates and 1994 days.

2. Starting July 1, 1996, operating ceilings will be increased for inflation to the midpoint of the state fiscal year, not the hospital fiscal year. Inflation shall be based on the DRI-Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS, increased by two percentage points per year. The most current table available prior to the effective date of the new rates shall be used. For services to be paid at SFY 1998 rates, per diem rates shall be adjusted consistent with the methodology for updating rates under the DRG methodology 12 VAC 30-70-351.

3. There will be no disproportionate share hospital (DSH) per diem.

4. To pay capital cost through claims, a hospital specific adjustment to the per diem rate will be made. At settlement of each hospital fiscal year, this per diem adjustment will be eliminated and capital shall be paid as a pass through.

5. This methodology shall be used after the transition period to reimburse days of hospital stays with admission dates before July 1, 1996.

6.

7. This methodology shall be used after the transition period to make interim payments until such time as the DRG payment methodology is operational.

8.

12 VAC 30-70-410. State university teaching hospitals.

For hospitals that were state owned teaching hospitals on January 1, 1996, all the calculations which support the determination of hospital specific rate per case and rate per day amounts under the prospective payment methodology shall be carried out separately from the other hospitals, using cost data taken only from state university

12 VAC 30-70-420. Reimbursement of noncost-reporting general acute care hospital providers.

Effective ~~January 1, 2000~~ July 1, 2000, noncost-reporting (general acute care hospitals that are not required to file cost reports) shall be paid based on DRG rates unadjusted for geographic variation increased by the average capital percentage among hospitals filing cost reports in a recent year. General acute care hospitals shall not file cost reports if they have less than 1,000 days per year (in the most recent provider fiscal year) of inpatient utilization by Virginia Medicaid recipients, inclusive of patients in managed care capitation programs.

Prior approval must be received from DMAS when a referral has been made for treatment to be received from a non-participating acute care facility (in-state or out-of-state). Prior approval will be granted for inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the state of Virginia under any one the following conditions. It shall be the responsibility of the non-participating hospital, when requesting prior authorization for the admission of the Virginia resident, to demonstrate that one of the following conditions exists in order to obtain authorization. Services

provided out of state for circumstances other than these specified reasons shall not be covered.

A. The medical services must be needed because of a medical emergency;

B. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

C. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

D. It is general practice for recipients in a particular locality to use medical resources in another state.

12 VAC 30-70-435. Lump sum payment.

A. ~~Effective July 1, 2000 , the Department of Medical Assistance Services (DMAS)~~ In addition to the DRG payment, DMAS shall make a one-time, lump sum payment of $12,243,204 to eligible Virginia hospitals participating in the Medicaid program ~~to mitigate the estimated impact of the rebased Diagnosis Related Groupings rates, effective July 1, 1998, on each individual hospital for services provided between July 1, 1998, through December 31, 1999~~. ~~The~~ This payment shall be made in two equal, semi-annual amounts during fiscal year 2001. For purposes of distribution, each hospital's share of the total amount shall be determined as follows:

1. DMAS shall determine the total operating payments due each hospital for inpatient hospital services provided from January 1, 2000, through June 30, 2000, using hospital claims data from discharges in that period.

2. DMAS shall determine the total operating payments that would have been due each hospital for the same services, had the inpatient hospital rates and weights applicable in fiscal year 1998 been continued with inflation for fiscal years 1999 and 2000.

3. The difference between the two values calculated in (i) and (ii) above, summed across all hospitals, is the "statewide difference." Each hospital-specific difference divided by the statewide difference is the hospital-specific percent share of the statewide difference.

4. The hospital-specific percent share of the statewide difference, times the total funds provided by this appropriation, is the hospital-specific lump sum payment to be paid in two equal

semi-annual payments during fiscal year 2001. This payment shall be made as an increase to reimbursement for services provided to Medicaid recipients during state fiscal year 2001. For each hospital, the hospital-specific lump sum payment amount shall be divided by the number of DRG cases in the hospital discharged from July 1, 2000, through December 31, 2000, on or before April 30, 2001. This per case amount shall be paid to each hospital for each of the cases discharged by the hospital during this specified time period, as determined by the DMAS.

B. The Department of Medical Assistance Services shall provide the data used, specific calculation, and mechanics of the payment adjustment to the Virginia Medicaid Hospital Policy Advisory Council.

CERTIFIED:

10/31/2001
Date

/s/ Eric S. Bell
Eric S. Bell, Director
Dept. of Medical Assistance Services