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STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

Institutional care.

Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX**.**

Utilization Control: General Acute Care Hospitals (enrolled providers).

A. Prior authorization required. The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) shall not reimburse for services which are not authorized as follows:

1. DMAS shall monitor, consistent with State law, the utilization of all inpatient hospital services. All inpatient hospital stays shall be service authorized prior to admission. Services rendered without such service authorization shall not be covered, except as stated in subdivision 2 of this subsection.

2. If a provider has rendered inpatient services to an individual who later is determined to be Medicaid eligible, it shall be the provider's responsibility to obtain the required authorization prior to billing the DMAS for these services.

3. Regardless of service authorization, DMAS shall review all claims which are suspended for sterilization, hysterectomy, or abortion procedures for the presence of the required federal and state forms prior to reimbursement. If the forms are not attached to the bill and not properly completed, reimbursement for the services rendered will be denied or reduced, according to DMAS policy.

B. To determine that the DMAS enrolled hospital providers are in compliance with the regulations governing hospital utilization control found in 42 CFR 456.50 through 456.145, an annual audit will be conducted of each enrolled hospital. This audit can be performed either on-site or as a desk audit. The hospital shall make all requested records available and shall provide an

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Appropriate place for the auditors to conduct such review if done on-site. The audits shall consist of review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in 42 CFR 456.100 through 456.145.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in 42 CFR 456.105 through456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and list of attendees to determine that the committee is meeting according to their Utilization Management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR 456.141 through 42CFR 456.145.

5. Topic of one on-going Medical Care Evaluation Study to determine the hospital is incompliance with 42 CFR 456.145.

6. From a list of randomly selected paid claims, the hospital must provide a copy of the physician admission certification and written plan of care for each selected stay to determine the hospital's compliance with the 42 CFR 456.60 and 456.80. If any of the required documentation does not meet the requirements found in 42 CFR 456.60 through 456.80, reimbursement may be retracted.

7. The hospital may appeal in accordance with the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) any adverse decision resulting from such audits which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.

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12 VAC 30-60-21. Utilization control of non-participating out-of-state inpatient hospitals. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the state of Virginia shall only be reimbursed under any one of the following conditions. It shall be the responsibility of the hospital, when requesting prior authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain service authorization. It shall be the responsibility of the admitting physician to adhere to these restrictions. Services provided out of state for circumstances other than these specified exceptions shall not be covered. When, during post payment utilization review, inappropriate or inaccurate payments are determined to have been made for reasons other than those specified herein, DMAS shall recover the inappropriately expended funds.

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 30-60-25. Freestanding psychiatric hospitals.

A. Psychiatric services in freestanding psychiatric hospitals shall only be covered for eligible persons younger than 21 years of age and older than 64 years of age.

B. Prior authorization required. DMAS shall monitor, consistent with state law, the utilization of all inpatient free-standing psychiatric hospitals. All inpatient

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hospital stays shall be preauthorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

C. All Medicaid services are subject to utilization review/audit. Absence of any of the required documentation may result in denial or retraction of any reimbursement. In each case for which payment for freestanding psychiatric hospital services is made under the State Plan:

1. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a freestanding psychiatric hospital consistent with 42 CFR.456.160.

2. The physician, physician assistant, or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician, mustrecertify at least every 60 days that the individual continues to require inpatient services in a psychiatric hospital.

3. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must petform a medical evaluation of the individual and appropriate professional personnel must make a psychiatric and social evaluation as cited in 42 CFR 456.170.

4. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each recipient patient as cited in 42 CFR 441.155 and 456.180. The plan shall also include· a list of services provided under written contractual airangement with the freestanding psychiatric hospital (see Attachment 3.1 A&B, Supplement 1, Item 4b pages 6.4 and 6.5 of 45 (12 VAC 30-50-130)) that will be furnished to the patient through the freestanding psychiatric hospital's referral to an employed or contracted provider, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought.

D. If the eligible individual is 21 years of age or older, then, in order to qualify for Medicaid payment for this service, he must be at least 65 years of age.

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C. If younger than 21 years of age, it shall be documented that the individual requiring admission to a free-standing psychiatric hospital is under 21 years of age, that treatment is medically necessary and that the necessity was identified as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening. Required patient documentation shall include, but not be limited to, the following:

1. An EPSDT physician's screening report showing the identification of the need for further psychiatric evaluation and possible treatment.

2. A diagnostic evaluation documenting a current (active) psychiatric disorder included in the DSM-III-R that supports treatment recommended. The diagnostic evaluation must be completed prior to admission.

3. For admission to free-standing psychiatric hospital for psychiatric services resulting from an EPSDT screening, a certification of the need for services as defined at 42 CFR §441.152 by an interdisciplinary team meeting the requirements of 42 CFR §441.153 or §441.156 and The Psychiatric Treatment of Minors Act (§16.1-335 et seq. *Code of Virginia).*

4. If a Medicaid eligible individual is admitted in an emergency to a freestanding psychiatric hospital on a Saturday, Sunday, holiday, or after normal working hours, it shall be the provider's responsibility obtain the required authorization on the next work day following such an admission.

5. The absence of any of the above required documentation shall result in DMAS 's denial of the requested preauthorization and coverage of subsequent hospitalization.

D. To determine that the DMAS enrolled mental hospital providers are in compliance with the· regulations governing mental hospital utilization control found in 42 CFR §456.150, an annual audit will be conducted of each enrolled hospital. This audit can be performed either on-site or as a desk audit.The hospital shall make all requested records available. and shall provide an appropriate place for the auditors to conduct such a review if done on-site. The audits shall consist of review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in the 42 CFR §§456.200 through 456.245.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in the 42 CFR §§
456.205 through 456.206.

3. Verification of Utilization Management Committee meetings, since including dates and lists of attendees to determine that the committee is meeting according to their Utilization Management meeting requirements.

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4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CPR §§456.241 through 456.245.

5. Topic of one on-going Medical Care Evaluation Study to determine the hospital is in compliance with 42 CPR §§456.245.

6. From a list of randomly selected paid claims, the free-standing psychiatric hospital must provide a copy of the certification for services, a copy of the physician admission certification, a copy of the required medical, psychiatric, and social evaluation, and a written plan of care for each selected stay to determine the hospital's compliance with the *Code of Virginia* §§16.1-335 through 16.1-348 and 42 CPR §§441.152, 456.160, 456.170, and §§456.180 through 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may beretracted.

7. The freestanding psychiatric hospital shall not receive a per diem reimbursement for any day that:

a. The comprehensive plan of care fails to include, within three business days of the initiation of the service provided under arrangement, all services that the individual needs while at the freestanding psychiatric hospital and that will be furnished to the individual through the freestanding psychiatric hospital's referral to an employed or contracted provider of services under arrangement;

b. The comprehensive plan of care fails to include within three business days of the initiation of the service the prescribed frequency of such service or includes a frequency that was exceeded;

c. The comprehensive plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;

d. The referral to the service provided under written contractual arrangement was not present in the patient's freestanding psychiatric hospital record or the record of the provider of services under arrangement;

e. The medical records from the provider of services under arrangement (i.e., any admission and discharge documents, treatment plans, progress notes, treatment summaries and documentation of medical results and findings) were not present in the patient's freestanding psychiatric hospital record, or had not been requested in writing by the freestanding psychiatric hospital within seven business days of completion of the service or services provided under arrangement; or

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f. The freestanding psychiatric hospital did not have a fully executed contract or an employee relationship with the provider of services under arrangement in advance of the provision of such services. For emergency services, the freestanding psychiatric hospital shall have a fully executed contract with the emergency services provider prior to submission of the emergency services provider's claim for payment.

8. The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service billed prior to receiving a referral from the freestanding psychiatric hospital or in excess of the amounts in the referral.

9. The hospital may appeal in accordance with the Code of Virginia § 2.2-4000 et seq. any adverse decisions resulting from such audits which results in retraction of payment. The appeal must be requested pursuant to the requirements of 12 VAC 30- 20-500 et seq.

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C. Utilization control: Nursing facilities. 12 VAC 30-60-40.

1. Long-term care of residents in nursing facilities will be provided in accordance with Federal law using practices and procedures that are based on the resident's medical and social needs and requirements. All nursing facility services, including specialized care, shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.

2. Nursing facilities must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than fourteen days after the date of admission and promptly after a significant change in the resident's physical or mental condition. Each resident must be reviewed at least quarterly, and a complete assessment conducted at least annually.

3. The Department of Medical Assistance Services shall periodically conduct a validation survey of the assessments completed by nursing facilities to determine that services provided to the residents are medically necessary and that needed services are provided. The survey will be composed of a sample of Medicaid residents and will include review of both current and closed medical records.

4. Nursing faciltieis must submit to the Department of Medical Assistance Services resident assessment information at least every six months for utilization review. If an assessment completed by the nursing facility does not reflect accurately a resident's capability to perform activities of daily living and significant impairments in functional capacity, then reimbursement to nursing facilities may be adjusted during the next quarter's reimbursement review. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties.

5. In order for reimbursement to be made to the nursing facility for a recipient's care, the recipient must meet nursing facility criteria as described in 12 VAC 30-60-300 (Nursing Facililty Criteria). In order for the additional $10 per day reimbursement to be made to the nursing facility for a recipient requiring a specialized treatment bed, the recipient must meet criteria as described in 12 VAC 30-60-350. Nursing facilities must obtain prior authorization for reimbursement. DMAS shall provide the additional $10 per day reimbursement for recipients meeting criteria for no more than 246 days annually. Nursing facilities may receive reimbursement for up to 82 days per new occurrence of a Stage IV ulcer. There must be at least 30 days between each reimbursement period. Limits are per recipient, regardless of the number of providers rendering services. Nursing facilities are not eligible to receive this reimbursement for recipients enrolled in the specialized care program.

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In order for the additional $10 per day reimbursement to be made to the nursing facility for a recipient requiring a specialized treatment bed, the recipient must meet criteria as descrived in 12 VAC 30-60-350. Nursing facilities must obtain prior authorization for the reimbursement. DMAS shall provide the additional $10 per day reimbursement for recipients meeting criteria for no more than 246 days annually. Nursing facilities may receive the reimbursement for up to 82 days per new occurrence of a Stage IV ulcer. There must be at least 30 days between each reimbursement period. Limits are per recipient, regardless of the number of providers rendering services. Nursing facilities are not eligible to receive this reimbursement for recipients enrolled in the specialized care program.

In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in 12 VAC 30-60-320 (Adult Ventilation/Tracheostomy Specialized Care Criteria) or 12 VAC 30-60-340 (Pediatric/Adolescent Specialized Care Criteria). In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis. Further specialized care servies requirements are set forth below.

In each case for which payment for nursing facility or specialized care services is made under the State Plan, a physician must recommend at the time of admission or, if later, the time at which the individual applies for medical assistance under the State Plan, that the individual requires nursing facility care.

F. For nursing facilities, a physician must approve a recommendation that an individual be admitted to a facility. The resident must be seen by a physician at least once ecvery 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

G. When the resident no longer meets nursing facility criteria or requires services that the nursing facility is unable to provide, then the resident must be discharged.

H. Specialized care services.

1. Providers must be nursing facilities certified by the Division of Licensure and Certification, State Department of Health, and must have a current signed participation agreement with DMAS to provide nursing facility care. Providdders must agree to provide care to at least four residnets who meet the specialized care criteria for children/adolescents or adults.

2. Providers must be able to provide the following specialized services to Medicaid specialized care recipients:

    a. Physician visits at least once weekly (after initial physician visit, subsequent visits may alternate between physician and physician assistant or nurse practitioner);

    b. Skilled nursing services by a registered nurse available 24 hours a day;

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c. Coordinated multidisciplinary team approach to mee the needs of the resident;

d. Infection control

e. For residents under age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of 90 minutes each day, five days per week.

f. Ancillary services related to a plan of care;

g. Respiratory therapy services by a board-certified therapist (for ventilator pateitns, these services must be available 24 hours per day);

h. Psychology services by a licensed clinical psychologist, a licensed clinical social worker, licensed professional counselor or licensed clinical nurse specialist-psychiatric related to a plan of care;

i. Necessary durable medical equipment and supplies as required by the plan of care;

j. Nutritional elements as required by the plan of care;

k. A plan to assure that specialized care residents have the same opportunity to participate in integrated nursing facility activieis as other residents;

l. Nonemergency transportation;

m. Discharge planning; and

n. Family or caregiver training.

3. Providers must coordinate with appropriate state and local agencies for educational and habilitative needs for Medcaid specialized care recipients who are under the age of 31.

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2. Family or caregiver training.

3. Providers must coordinate with appropriate state and local agencies for educational and habilitative needs for Medicaid specialized care recipients who are eligible for such services.

I. Contract Termination. The specialized care provider contract shall be terminated upon the demonstration of one or more of the following conditions:

1. The provider is no longer certified to participate in the Medicare or Medicaid programs.

2. The provider violates provisions of the written contract for specialized care.

3. The provider gives written notice to DMAS at least 30 days in advance that it wishes to terminate the contract.

D. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Institutions for Mental Disease (IMD)

1. With respect to each Medicaid-eligible resident in an ICF/MR or IMD in Virginia, a written plan of care must be developed prior to admission to or authorization of benefits in such facility, and a regular program of independent professional review (including a medical evaluation) shall be completed periodically for such services. The purpose of the review is to determine: the adequacy of the services available to meet his current health needs and promote his maximum physical well being; the necessity and desirability of his continued placement in the facility; and the feasibility of meeting his health care needs through alternative institutional or noninstitutional services. Long-term care of residents in such facilities will be provided in accordance with Federal law that is based on the resident's medical and social needs and requirements.

2. With respect to each ICF/MR or IMO, periodic on-site inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), shall be conducted. The review shall include, with respect to each recipient, a determination of the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, the necessity and desirability of continued placement in the facility, and the feasibility of meeting his health care needs through alternative institutional or noninstitutional services. Full reports shall be made to the State agency by the review team of the findings of each inspection, together with any recommendations.

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3. In order for reimbursement to be made to a facility for the mentally retarded, the resident must meet criteria for placement in such facility as described in Supplement 1, Part 4, to Attachment 3.1-C and the facility must provide active treatment for mental retardation.

4. In each case for which payment for nursing facility services for the mentally retarded or institution for mental disease services is made under the State Plan:

   a. a physician must certify for each applicant or recipient that inpatient care is needed in a facility for the mentally retarded or an institution for mental disease. The certification must be made at the time of admission or, if an individual applies for assistance while in the facility, before the Medicaid agency authorizes payment; and

   b. a physician, or physician assistant or nurse practitioner acting within the scope of the practice as defined by State law and under the supervision of a physician, must recertify for each applicant at least every 365 days that services are needed in a facility for the mentally retarded or institution for mental disease.

5. When a resident no longer meets criteria for facilities for the mentally retarded or an institution for mental disease or no longer requires active treatment in a facility for the mentally retarded, then the resident must be discharged.

6. All services provided in an IMD and in an ICF/MR shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.

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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 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 physician; (ii) prior to the date of the delivery; or (iii) when services are not provided in accordance with DMAS' published regulations and guidance doucments. 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 submittig 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 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.

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1. Physician's order.

   a. The physician's compelte order shall appear on theface of the CMN. A compelte order on the CMN shall consist of the item's complete description, the quantity ordered, the frequency of use, and the physician's signature and compelt 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 physician's signature and compete date of signing are missing, he shall consider the CMNto be invalid and he shall requiest a new CMN.

   b. The following CMN fileds (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 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 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 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.

   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 physician within 60 days of the begin service date in order fo rth eCMN to srart from the begin date.

   (2) If no begin service date is documented on the CMN, the date of the 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.

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3. Supporting documentation.

   a. Supporting documetnation may be included in the additional informaton attached to the CMN.

   b. The attachment of supporting documentation shall not replace the requirement for a properly completed CMN.

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K. Optometrists services are limit to examinations (refractions) after preauthorization by the State Agency except for eyeglasses as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

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K. Utilization control. Special Services. Repealed.

L. Standards in other specialized high quality programs such as the program of Crippled Children's Services will be incorporated as appropriate.

M. Provisions will be made for obtaining recommended medical care and services regardless of geographic boundaries.

N. Intensive Physical Rehabilitative Services.

1.1 A patient qualifies for intensive inpatient or outpatient physical rehabilitation if:

A. Adequate treatment of his medical condition requires an intensive rehabilitation program consisting of a multi-disciplinary coordinated team approach to improve his ability to function as independently as possible; and

B. It has been established that the rehabilitation program cannot be safely and adequately carried out in a less intense setting.

1.2 In addition to the disability requirement, participates must meet the following criteria:

A. Require at least two of the listed therapies in addition to rehabilitative nursing

1. Occupational Therapy
2. Physical Therapy
3. Cognitive Rehabilitation
4. Speech-Language Therapy

B. Medical condition stable and compatible with an active rehabilitation program.

2.1 Within 72 hours of a patient's admission to an intensive rehabilitation program, or within 72 hours of notification to the facility of the patient's Medicaid eligibility, the facility shall notify the Department of Medical Assistance Services in writing of the patient's admission. This notification shall include a description of the admitting diagnoses, plan of treatment, expected progress and a physician's certification that the patient meets the admission criteria. The Department of Medical Assistance Services will make a determination as to the appropriateness of the admission for Medicaid payment and notify the facility of its decision. If payment is approved, the Department will establish and notify the facility of an approved length of stay. Additional lengths of stay shall be requested in writing and approved by the Department. Admissions or lengths of stay not authorized by the Department of Medical Assistance Services will not be approved for payment.

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3.1 Documentation of rehabilitation services must, at a minimum:

A. Describe the clinical signs and symptoms of the patient necessitating admission to the rehabilitation program;
B. Describe any prior treatment and attempts to rehabilitate the patient;
C. Document an accurate and complete chronological picture of the patient's clinical course and progress in treatment;
D. Document that a multi-disciplinary co-ordinated treatment plan specifically designated for the patient has been developed:
E. Document in detail of all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response to treatment, and identify who provided such treatment;
F. Document each change in each of the patient's conditions;
G. Describe responses to and the outcome of treatment; and
H. Describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

3.2 Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no reimbursement will be provided. All intensive rehabilitative services shall be provided in accordance with guidelines found in the Virginia Medicaid Rehabilitation Manual.

4.1 For a patient with potential for physical rehabilitation for which an outpatient assessment cannot be adequately performed, an intensive evaluation of no more than seven (7) calendar days will be allowed. A comprehensive assessment will be made of the patient's medical condition, functional limitations, prognosis, possible need for corrective surgery, attitude toward rehabilitation, and the existence of any social problems affecting rehabilitation. After these assessments have been made, the physician, in consultation with the rehabilitation team, shall determine and justify the level of care required to achieve the stated goals.

4.2 If during a previous hospital stay an individual completed a rehabilitation program for essentially the same condition for which inpatient hospital care is not being considered, reimbursement for the evaluation will not be covered unless there is a justifiable intervening circumstance which necessitates a re-evaluation.

4.3 Admissions for evaluation and/or training for solely vocational or education purposes or for developmental or behavioral assessments are not covered services.

5.1 Team conferences shall be held as often as needed but at least every two weeks to assess and document the patient's progress or problems impeding progress. The team shall periodically assess the validity of the rehabilitation goals established at the time of the initial evaluation, and make appropriate adjustments in the rehabilitation goals and the prescribed treatment program. A review by the various team members of each others' notes does not constitute a team conference. A summary of the conferences, noting the team members present, shall be recorded in the clinical record and reflect the reassessments of the various contributors.

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5.2 Rehabilitation care is to be terminated, regardless of the approved length of stay, when further progress toward the established rehabilitation goal in unlikely or further rehabilitation can be achieved in less intensive setting.

5.3 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 patient's medical record as having been rendered shall be deemed not to have been rendered and no reimbursement shall be provided.

6.1 Properly documented medical reasons for furlough may be included as part of an overall rehabilitation program. Unoccupied beds (or days) resulting from an overnight therapeutic furlough will not be reimbursed by the Department of Medical Assistance Services.

7.1 Discharge planning must be an integral part of the overall treatment plan which is developed at the time of admission to the program. The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination. The patient, unless unable to do so, or the responsible party shall participate in the discharge planning. Notations concerning changes in the discharge plan shall be entered into the record at least every two weeks, as a part of the team conference.

8.1 Rehabilitation services are medically prescribed treatment for improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. The rules pertaining to them are:

A. Rehabilitative Nursing

Rehabilitative Nursing requires education, training, or experience that provides special knowledge and clinical skills to diagnose nursing needs and treat individuals who have health problems characterized by alteration in cognitive and functional ability. Rehabilitative Nursing are those services furnished a patient which meet all of the following conditions:

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1. The services shall be directly and specifically related to an active written treatment plan approved by a physician after any needed consultation with a registered nurse who is experienced in rehabilitation.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a registered nurse or licensed professional nurse, nursing assistant, or rehabilitation technician under the direct supervision of a registered nurse who is experienced in rehabilitation.

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis, and

4. The service shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative nursing services which can only be provided in an intensive rehabilitation setting.

B. Physical Therapy: Physicial therapy services are those furnished a patient which meet all of the following conditions:

l. The service shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a physicial therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physicial therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a physicial therapist licensed by the Board of Medicine;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

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C. Occupational Therapy: Occupational therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a occupational therapist registered and certified by the American Occupational Therapy Certification Board;

2. The services shall by of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

D. Speech-Language Therapy: Speech-Language Therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

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4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

E. Cognitive Rehabilitation: Cognitive Rehabilitation services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a clinical psychologist experienced in working with the neurologically impaired and licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be rendered after a neuropsychological evaluation administered by a clinical psychologist or physician experienced in the administration of neuropsychological assessments and licensed by the Board of Medicine and in accordance with a plan of care based on the findings of the neuropsychological evaluation;

3. Cognitive rehabilitation therapy services may be provided by occupational therapists, speech-language pathologists, and psychologists who have experience in working with the neurologically impaired when provided under a plan recommended and coordinated by a physician or clinical psychologist licensed by the Board of Medicine;

4. The cognitive rehabilitation services shall be an integrated part of the total patient care plan and shall relate to information processing deficits which are consequence of and related to a neurologic event;

5. The services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning, memory, discrimination and behavior; and

6. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis.

F. Psychology: Psychology services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

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b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified psychologist as required by state law, a licensed clinical social worker, a licensed professional counselor, or a licensed clinical nurse specialist-psychiatric;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

7. Social work services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified social worker as required by state law;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

8. Recreational therapy are those services furnished a patient which meet all of the following conditions:

a. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

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b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services are performed as an integrated part of a comprehensive rehabilitation plan of care by a recreation therapist certified with the National Council for Therapeutic Recreation at the professional level;

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3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

I. Prosthetic/Orthotic Services

1. Prosthetic services furnished to a patient include prosthetic devices that replace all or part of an external body member, and services necessary to design the device, including measuring, fitting, and instructing the patient in its use;

2. Orthotic device services furnished to a patient include orthotic devices that support or align extremities to prevent or correct deformities, or improve functioning, and services necessary to design the device, including measuring, fitting and instructing the patient in its use; and

3. Maxillofacial Prosthetic and related dental services are those services that are specifically related to the improvement of oral function not to include routine oral and dental care.

4. The services shall be directly and specifically related to an active written treatment plan approved by a physician after consultation with a prosthetist, orthotist, or a licensed, board eligible prosthodontist, certified in Maxillofacial prosthetics.

5. The services shall be provided with the expectation, based on the assessment made by physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance.

6. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical and dental practice; this includes the requirement that the amount, frequency, and duration of the services be reasonable.

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12VAC 30-60-130. Hospice services.

A Admission criteria

1. Service election. To be eligible for hospice coverage under Medicare or Medicaid, the recipient shall be "terminally ill", defined as having a life expectancy of six months or less, and, and except for individuals under 21 years of age, elect to receive hospice services rather than active treatment for the illness. Both the attending physician (if the individual has an attending physician) and the hospice medical director, or the attending physician and the physician member of the interdisciplinary team, must initially certify the life expectancy. The election statement shall include (i) identification of the hospice that will provide care to the individual; (ii) the individual's or representative's acknowledgement that he has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the individual's terminal illness; (iii) with the exception of children, defined as persons younger than 21 years of age, acknowledgement that certain Medicaid services are waived by the election; (iv) the effective date of the election; and (v) the signature of the individual or representative.

2. Service revocation. The recipient shall have the right to revoke his election of hospice services at any time during the covered hospice periods. DMAS shall be contacted if the recipient revokes his hospices services. If the recipient reelects the hospice services, the hospice periods will begin as an initial time frame. Therefore, the above certification and time requirements will apply. The recipient cannot retroactively receive hospice benefits from previously unused hospice period. The recipient's written revocation statement shall be maintained in the recipient's medical record.

B. General conditions. The general conditions provided in this subsection apply to nursing care, medical social services, physician services, counseling services, short-term inpatient care, durable medical equipment and supplies, drugs and biologicals, home health aide and homemaker services, and rehabilitation services.

The recipient shall be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license. The hospice medical director or the physician member of the interdisciplinary team shall be a licensed doctor of medicine or osteopathy. Hospice services may be provided in the recipient's home or in a freestanding hospice, hospital or nursing facility.

The hospice shall obtain the written certification that an individual is terminally ill in accordance with the following procedures:

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1. For the initial 90-day benefit period of hospice coverage, a Medicaid written certification (DMAS 420) shall be signed and dated by the medical director of the hospice and the attending physician, or the physician member of the hospice interdisciplinary team and the attending physician, at the beginning of the certification period. This initial certification shall be submitted for preauthorization within 14 days from the physician's signature date. This certification shall be maintained in the recipient's medical record.

2. For the subsequent 90-day hospice period, a Medicaid written certification (DMAS 420) shall be signed and dated before or on the begin date of the 90-day hospice period by the medical director of the hospice or the physician member of the hospice's interdisciplinary team. The certification shall include the statement that the recipient's medical prognosis is that his life expectancy is six months or less. This certification of continued need for hospice services shall be maintained in the recipient's medical record.

3. After the second 90-day hospice period and until the recipient is no longer in the Medicaid hospice program, a Medicaid written certification shall be signed and dated every 60 days on or before the begin date of the 60-day period. This certification statement shall be signed and dated by the medical director of the hospice or the physician member of the hospice's interdisciplinary team. The certification shall include the statement that the recipient's medical prognosis is that his life expectancy is six months or less. This certification shall be maintained in the recipient's medical record.

C. Utilization review. Authorization for hospice services requires an initial preauthorization by DMAS and physician certification of life expectancy. Utilization review will be conducted to determine if services were provided by the appropriate provider and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the recipients' medical records as having been rendered shall be deemed not to have been rendered and no coverage shall be provided. All hospice services shall be provided in accordance with guidelines established in the Virginia Medicaid Hospice Manual.

D. Hospice services are a medically directed, interdisciplinary program of palliative services for terminally ill people and their families, emphasizing pain and symptom control. The rules pertaining to them are:

1. Interdisciplinary team. An interdisciplinary team shall include at least the following individuals: a physician (either a hospice employee or a contract physician), a registered nurse, a social worker, and a pastoral or other counselor. Other professionals may also be members of the interdisciplinary team depending on the terminally ill recipient's medical needs.

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2. Nursing care. Nursing care shall be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

3. Medical social services. Medical social services shall be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

4. Physician services. Physician services shall be performed by a professional who is licensed to practice, who is acting within the scope of his license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team shall be a licensed doctor of medicine or osteopathy.

5. Counseling services. Counseling services shall be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him to adjust to the individual's approaching death. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

6. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

7. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

8. Drugs and biologicals. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

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9. Home health aide and homemaker services. Home health aides providing services to hospice recipients shall meet the qualifications specified for home health aides by 42 CFR 484.80. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services shall be provided under the general supervision of a registered nurse.

10. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

a. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

(1) The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board;

(2) The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above; and

(3) The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice, including the requirement that the amount, frequency, and duration of the services shall be reasonable.

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b. Physical therapy services shall be those furnished a patient which meet all of the following conditions:

(1) The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

(2) The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a physical therapist licensed by the Board of Medicine; and

(3) The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice, including the requirement that the amount, frequency, and duration of the services shall be reasonable.

c. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

(1) The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology;

(2) The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology; and

(3) The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice, including the requirement that the amount, frequency, and duration of the services shall be reasonable.

11. Documentation of hospice services shall be maintained in the recipient's medical record. Coordination of patient care between all health care professionals should be maintained in the recipient's medical record.

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Q. General Outpatient Physical Rehabilitation Services

1. Scope

A. Medicaid covers general outpatient physical rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals and by rehabilitation agencies which have a provider agreement with the Department of Medical Assistance Services (DMAS).

B. Outpatient rehabilitative services shall be prescribed by a physician and be part of a written plan of care.

C. Outpatient rehabilitative services shall be provided in accordance with guidelines found in the Virginia Medicaid Rehabilitation Manual, with the exception of such services provided in school divisions which shall be provided in accordance with guidelines found in the Virginia Medicaid School Division Manual. Utilization review shall include determinations that providers meet all the requirements of Virginia state regualtions found at VR 460-04-3.1300. Utilization review shall be performed to ensure that services are appropriately provided and that services provided to Medicaid recipients are medically necessary and appropriate.

2. Covered Outpatient Rehabilitative Services.

A. Covered outpatient rehabilitative services shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service. Such services may be provided by outpatient settings of hospitals, rehabilitation agencies, and home health agencies.

D. Covered outpatient rehabilitative services for long-term, chronic conditions shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service. Such services may be provided by outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, and school divisions.

3. Eligibility Criteria for Outpatient Rehabilitative Services. To be eligible for general outpatient rehabilitative services, the patient must require at least one of the following services: physical therapy, occupational therapy, and speech-language pathology services. All rehabilitative services must be prescribed by a physician.

3. Criteria for the Provision of Outpatient Rehabilitative Services. All practitioners and providers of services shall be required to meet State and Federal licensing and/or certification requirements. Services not specifically documented in patient's medical record as having been rendered shall be deemed not to have been rendered, and no coverage shall be provided.

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A. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

B. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist as defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

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3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that amount, frequency, and duration of the services shall be reasonable.

C. Speech-language therapy services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

5. Authorization for Services

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, home health agencies, or school divisions shall include authorization for up to twenty-four (24) visits (without authorization) by each ordered rehabilitative service annually. The provider shall maintain documentation to justify the need for services. A visit shall be defined as the duration of time that a rehabilitative therapist is with a client to provide services prescribed by the physician. Visits shall not be defined in measurements or increments of time.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized. Documentation for medical justification must include physician orders or a plan of care signed by the physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS. Periods of care beyond those allowed which have not been authorized by DMAS shall not be approved for payment.

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6. Documentation Requirements.

   A. Documentation of general outpatient rehabilitative services provided by a hospital-based outpatient setting, home health agency, school division, or a rehabilitation agency shall, at a minimum:

      1. describe the clinical signs and symptoms of the patient's condition;

      2. include an accurate and complete chronological picture of the patient's clinical course and treatments;

      3. document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

      4. include a copy of the physician's orders and plan of care;

      5. include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

      6. describe changes in each patient's condition and response to the rehabilitative treatment plan; and

      7. describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

   B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

7. Service Limitations. The following general conditions shall apply to reimbursable physical rehabilitative services:

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

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B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

D. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and include the frequency and duration for services.

E. 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 patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Rehabilitation care is to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

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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 treamtne sercies are designed to address the special needs of children. TFC case management focuses on a continuity of services, is goal directed and results oriented. 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. 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 recipient'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 (FAPT) 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 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 a more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs, or group homes. The child must have 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. The child must display moderate impairment with one or more of the following moderate risk factors, as documented on the state designated uniform assessment instrument:

(1) Needs instensive supervision to prevent harmful consequences;
(2) Moderate/frequent disruptive or noncompliant behaviors in home setting which 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 or problems with authority, impulsivity, and caregiver issues, as documented on the state designated uniform assessment instrument. For example, the child must:

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(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. The 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.

1. FC Case Management Admission Documentation Required. Before Medicaid preauthorization will be granted, the referring entity must submit to DMAS 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 together; AND

b. All of the following docuementation:

(1) 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 (Pshychosocial and Environmental Problems); and Axis V (Global Assessment of Functioning;

(2) Description of the child's immediate behavior prior to admission;

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d. Description of alternatives 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.

1. 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 documenteation enumerated above will result in denial of payments or recovery 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.

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ALTERNATIVE BENEFITS
REPEALED IN SPA TN 14-10, EFFECTIVE 1/1/2014
ALTERNATIVE BENEFITS

DISEASE MANAGEMENT—REPEALED

This page replaces pages 57 through 64 of 64 of Attachment 3.1-C.

Next page is Supplement 1 to Attachment 3.1-C Nursing Facility Criteria