12VAC30-120-70. Definitions.

The following words and terms, when used in this part, shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living (ADL)" means personal care tasks, i.e., bathing, dressing, toileting, transferring, bowel/bladder control, and eating/feeding. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services.

"Adult" means an individual who either is 21 years of age or is past 21 years of age.

"Child" means an individual who has not yet reached his 21st birthday.

"Congregate living arrangement" means one in which two or more recipients live in the same household and may share receipt of health care services from the same provider or providers.

"Congregate private duty nursing" means nursing provided to two or more recipients in a group setting.

"DMAS" means the Department of Medical Assistance Services.

"Environmental modifications" means physical adaptations to a house, or place of residence, which shall be necessary to ensure the individual's health or safety, or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual. Such modifications must exceed reasonable

accommodation requirements of the Americans with Disabilities Act (42 USC §1201 et seq.).

"Health care coordinator" means the registered nurse who is responsible for ensuring that the assessment, care planning, monitoring, and review activities as required by DMAS are accomplished. This individual may be either an employee of DMAS or a DMAS contractor.

"Health care coordination" means a comprehensive needs assessment, determination of cost effectiveness, and the coordination of the service efforts of multiple providers in order to avoid duplication of services and to ensure the individual's access to and receipt of needed services.

"Instrumental activities of daily living (IADL)" means social tasks, i.e., meal preparation, shopping, housekeeping, laundry, money management. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services. Meal preparation is planning, preparing, cooking and serving food. Shopping is getting to and from the store, obtaining/paying for groceries and carrying them home. Housekeeping is dusting, washing dishes, making beds, vacuuming, cleaning floors, and cleaning kitchen/bathroom. Laundry is washing/drying clothes. Money management is paying bills, writing checks, handling cash transactions, and making change.

"Medical equipment and supplies" means those articles prescribed by the attending physician, generally recognized by the medical community as serving a diagnostic or therapeutic purpose and as being a medically necessary element of the home care plan.

Items covered are medically necessary equipment and supplies needed to assist the individual in the home environment, without regard to whether those items are covered by the Plan.

"Objective Scoring Criteria" means the evaluative tool to be used to determine the appropriateness for an individual's admission to these services.

"Personal assistance" means care provided by an aide or respiratory therapist trained in the provision of assistance with ADLs or IADLs.

"Plan of care" means the written plan of services and supplies certified by the attending physician needed by the individual to ensure optimal health and safety for an extended period of time.

"Primary caregiver" means either a family member or other person who takes primary responsibility for providing assistance to the recipient or recipients for care they are unable to provide for himself or themselves.

"Private duty nursing" means individual and continuous nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.

"Providers" means those individuals or facilities registered, licensed, or certified, or both, as appropriate, and enrolled by DMAS to render services to Medicaid recipients eligible for services.

"Respite care services" means temporary skilled nursing services designed to relieve the family of the care of the technology assisted individual for a short period or periods of time (a maximum of 15 days per year or 360 hours per 12-month period). In a congregate

living arrangement, this same limit shall apply per household. Respite care shall be provided in the home of the individual's family or caretaker.

"Routine respiratory therapy" means services that can be provided on a regularly scheduled basis. Therapy interventions may include: (i) monitoring of oxygen in blood; (ii) evaluation of pulmonary functioning; and (iii) maintenance of respiratory equipment.

"State Plan for Medical Assistance" or "the Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Technology assisted" means any individual defined as chronically ill or severely impaired who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability and whose illness or disability would, in the absence of services approved under this waiver, require admission to or prolonged stay in a hospital, nursing facility, or other medical long-term care facility.

“Transition funding” means funding to assist individuals returning to the community from institutions with the costs incurred as part of transition to a home or apartment in the community. For the purposes of transition funding, an institution is an intermediate care facility for the mentally retarded (ICF/MR), a nursing facility, or a specialized care facility/hospital as defined at 42 CFR 435.1009. Transition funding would not apply to an acute care admission to a hospital.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date	Patrick W. Finnerty, Director Dept. of Medical Assistance Services

12VAC30-120-90. Covered services and provider requirements.

A. Private duty nursing service shall be covered for individuals enrolled in the technology assisted waiver services. This service shall be provided through either a home health agency licensed or certified by the Virginia Department of Health for Medicaid participation and with which DMAS has a contract for private duty nursing or a day care center licensed by the Virginia Department of Social Services which employs registered nurses and is enrolled by DMAS to provide congregate private duty nursing. At a minimum, the private duty nurse shall either be a licensed practical nurse or a registered nurse with a current and valid license issued by the Virginia State Board of Nursing.

1. For individuals under 21 whether living separately or congregately, during the first 30 days after the individual's admission to the waiver service, private duty nursing is covered for 24 hours per day if needed and appropriate to assist the family in adjustment to the care associated with technology assistance. After 30 days, private duty nursing shall be reimbursed for a maximum of 16 hours per 24-hour period per household. The department may grant individual exceptions, not to exceed 30 total days per annum, to these maximum limits based on documented emergency needs of the individual and the case, which continue to meet requirements for cost effectiveness of community services. Such consideration of documented emergency needs shall not include applicable additional emergency costs.

2. For individuals over the age of 21 years whether living separately or congregately, private duty nursing shall be reimbursed for a maximum of 16 hours within a 24-hour

period per household provided that the cost-effectiveness standard is not exceeded for the individual's care.

3. In no instance, shall DMAS approve an ongoing plan of care or ongoing multiple plans of care per household which result in approval of more than 16 hours of private duty nursing in a 24-hour period per household.

4. Individuals who no longer meet the patient qualifications for either children or adults cited in 12VAC30-120-80 may be eligible for private duty nursing for the number of hours per 24-hour period previously approved in the plan of care not to exceed two weeks from the date the attending physician certifies the cessation of daily technology assistance.

5. The hours of private duty nursing approved for coverage shall be limited by either medical necessity or cost effectiveness or both.

6. Congregate private duty nursing shall be limited to a maximum ratio of one private duty nurse to two waiver recipients. When three or more waiver recipients share a home, ratios will be determined by the combined needs of the residents.

B. Provided that the cost-effectiveness standard shall not be exceeded, respite care service shall be covered for a maximum of 360 hours within a 12-month period per household for individuals who are qualified for technology assisted waiver services and who have a primary caregiver, other than the provider, who requires relief from the burden of caregiving. This service shall be provided by skilled nursing staff (registered

nurse or licensed practical nurse licensed to practice in the Commonwealth) under the direct supervision of a home health agency licensed or certified by the Virginia Department of Health for Medicaid participation and with which DMAS has a contract to provide private duty nursing.

C. Provided that the cost-effectiveness standard shall not be exceeded, durable medical equipment and supplies shall be provided for individuals qualified for technology services. All durable medical equipment and supplies, including nutritional supplements, which are covered under the State Plan and those medical equipment and supplies, including such items which may be defined as assistive technology and environmental modifications which are not covered under the State Plan but are medically necessary and cost effective for the individual's maintenance in the community, shall be covered. This service shall be provided by persons qualified to render it.

Durable medical equipment and supplies shall be necessary to maintain the individual in the home environment.

1. Medical equipment and supplies shall be prescribed by the attending physician and included in the plan of care, and must be generally recognized as serving a diagnostic or therapeutic purpose and being medically necessary for the home care of the individual.

2. Vendors of durable medical equipment and supplies related to the technology upon which the individual is dependent shall have a contract with DMAS to provide services.

3. In addition to providing the ventilator or other respiratory-deviced support and associated equipment and supplies, the vendor providing the ventilator shall ensure the following:

a. 24 hour on-call for emergency services;

b. Technicians to make regularly scheduled maintenance visits at least every 30 days and more often if called;

c. Replacement or repair of equipment and supplies as required; and

d. Respiratory therapist registered or certified with the National Board for Respiratory Care (NBRC) on call 24 hours per day and stationed within two hours of the individual's home to facilitate immediate response. The respiratory therapist shall be available for routine respiratory therapy as well as emergency care. In the event that the Department of Health Professions implements through state law a regulation requiring registration, certification or licensure for respiratory therapists to practice in the Commonwealth, DMAS shall require all respiratory therapists providing services to this technology assisted population to be duly registered, licensed or certified.

D. Provided that the cost-effectiveness standard shall not be exceeded, personal assistance services shall be covered for individuals over the age of 21 who require some assistance with activities of daily living and instrumental activities of daily living but do not require and are able to do without skilled interventions during portions of their day or are able to self perform a portion of their ADLs or IADLs or direct their skilled care

needs during the period when personal assistance would be provided. Personal assistance services shall be rendered by a provider who has a DMAS provider agreement to provide personal care, home health care, and private duty nursing. At a minimum, the staff providing personal assistance must have been certified through coursework as either personal care aides, home health aides, homemakers, personal care attendants, or registered or certified respiratory therapists.

E. Transition funding is available to assist individuals returning to the community from institutions with the costs incurred as part of transition to a home or apartment in the community. The total amount of funding is $4,000 per-person lifetime limit coverage of one-time transition costs to residents of nursing homes or intermediate care facilities for the mentally retarded who are Medicaid recipients and are able to return to their home communities. Allowable costs include 1) security deposits that are required to obtain a lease on an apartment or home; 2) essential furnishings (bed, chair, dining table and chairs, eating utensils, food preparation items, telephone) and moving expenses required to occupy and use a community domicile; 3) set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); 4) health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy; 5) fees to obtain a copy of a birth certification or an identification card or driver's license.

The expenses must be reasonable and may not include recreational or diversional items or expenses related to on-going rent or housing costs, food, or clothing expenses. This service does not include services or items that are covered under other waiver services

such as chore, homemaker, home modifications and adaptations, or supplies and equipment.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-120-140. Definitions.

"Acquired Immune Deficiency Syndrome" or "AIDS" means the most severe manifestation of infection with the Human Immunodeficiency Virus (HIV). The Centers for Disease Control and Prevention (CDC) lists numerous opportunistic infections and cancers that, in the presence of HIV infection, constitute an AIDS diagnosis.

"Activities of daily living" or "ADL" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is part of determining appropriate level of care and service needs.

"Agency-directed services" means services for which the provider agency is responsible for hiring, training, supervising, and firing of the staff.

"Appeal" means the process used to challenge DMAS when it takes action or proposes to take action that will adversely affect, reduce, or terminate the receipt of benefits.

"Asymptomatic" means without symptoms. This term is usually used in the HIV/AIDS literature to describe an individual who has a positive reaction to one of several tests for HIV antibodies but who shows no clinical symptoms of the disease.

"Case management" means continuous reevaluation of need, monitoring of service delivery, revisions to the plan of care and coordination of services for individuals enrolled in the HIV/AIDS waiver.

"Case manager" means the person who provides services to individuals who are enrolled in the waiver that enable the continuous assessment, coordination, and monitoring of the needs of the individuals who are enrolled in the waiver. The case manager must possess a combination of work experience and relevant education that indicates that the case manager possesses the knowledge, skills, and abilities at entry level, as established by the Department of Medical Assistance Services in 12VAC30-120-170 to conduct case management.

"Cognitive impairment" means a severe deficit in mental capability that affects areas such as thought processes, problem solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

"Consumer-directed services" means services for which the individual or family/caregiver is responsible for hiring, training, supervising, and firing of the staff.

"Consumer-directed (CD) services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the consumer-directed plan of care, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed personal assistance and respite care services. The CD services facilitator cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver who is responsible for employing the assistant.

"Current functional status" means the degree of dependency in performing activities of daily living.

"DMAS" means the Department of Medical Assistance Services.

"DMAS-96 form" means the Medicaid Funded Long-Term Care Service Authorization Form, which is a part of the preadmission screening packet and must be completed by a Level One screener on a Preadmission Screening Team. It designates the type of service the individual is eligible to receive.

"DMAS-122 form" means the Patient Information Form used by the provider and the local DSS to exchange information regarding the responsibility of a Medicaid-eligible individual to make payment toward the cost of services or other information that may affect the eligibility status of an individual.

"DSS" means the Department of Social Services.

"Designated preauthorization contractor" means the entity that has been contracted by DMAS to perform preauthorization of services.

"Enteral nutrition products" means enteral nutrition listed in the durable medical equipment manual that is prescribed by a physician to be necessary as the primary source of nutrition for the individual's health care plan (due to the prevalence of conditions of wasting, malnutrition, and dehydration) and not available through any other food program.

"Fiscal agent" means an agency or organization that may be contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of the individual who is receiving consumer-directed personal assistance services and consumer-directed respite services.

"HIV-symptomatic" means having the diagnosis of HIV and having symptoms related to the HIV infection.

"Home and community-based care" means a variety of in-home and community-based services reimbursed by DMAS (case management, personal care, private duty nursing, respite care consumer-directed personal assistance, consumer-directed respite care, and enteral nutrition products) authorized under a Social Security Act §1915 (c) AIDS Waiver designed to offer individuals an alternative to inpatient hospital or nursing facility placement. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid inpatient hospital or nursing facility placement. DMAS, or the designated preauthorization contractor, shall give prior authorization for any Medicaid-reimbursed home and community-based care.

"Human Immunodeficiency Virus (HIV)" means the virus which leads to acquired immune deficiency syndrome (AIDS). The virus weakens the body's immune system and, in doing so, allows "opportunistic" infections and diseases to attack the body.

"Instrumental activities of daily living" or "IADL" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.

"Participating provider" means an individual, institution, facility, agency, partnership, corporation, or association that has a valid contract with DMAS and meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS to provide Medicaid waiver services.

"Personal assistant" means a domestic servant for purposes of this part and exemption from Worker's Compensation.

"Personal services" or "PAS" means long-term maintenance or support services necessary to enable an individual to remain at or return home rather than enter an inpatient hospital or a nursing facility. Personal assistance services include care specific to the needs of a medically stable, physically disabled individual. Personal assistance services include, but are not limited to, assistance with ADLs, bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical function. When specified, supportive services may include assistance with IADLs that are incidental to the care furnished or that are essential to the health and welfare of the individual. Personal assistance services shall not include either practical or professional nursing services as defined in Chapters 30 and 34 of Title 54.1 of the Code of Virginia, as appropriate.

"Personal care agency" means a participating provider that renders services designed to offer an alternative to institutionalization by providing eligible individuals with personal care aides who provide personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable the individual to remain at or return home rather than enter an inpatient hospital or a nursing facility. Personal care services are provided to individuals in the areas of activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. It shall be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

"Plan of care" means the written plan developed by the provider related solely to the specific services required by the individual to ensure optimal health and safety for the delivery of home and community-based care.

"Preadmission Screening Authorization Form" means a part of the preadmission screening packet that must be filled out by a Level One screener on a preadmission screening team. It gives preadmission authorization to the provider and the individual for Medicaid services, and designates the type of service the individual is authorized to receive.

"Preadmission screening committee/team" or "PAS committee" or "PAS team" means the entity contracted with DMAS that is responsible for performing preadmission screening. For individuals in the community, this entity is a committee comprised of a nurse from the local health department and a social worker from the local department of social services. For individuals in an acute care facility who require preadmission screening, this entity is a team of nursing and social work staff. A physician must be a member of both the local committee and the acute care team.

"Preadmission screening" or "PAS" means the process to (i) evaluate the functional, nursing, and social needs of individuals referred for preadmission screening; (ii) analyze what specific services the individuals need; (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs; and (iv) develop the service plan.

"Private duty nursing" means individual and continuous nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.

"Program" means the Virginia Medicaid program as administered by the Department of Medical Assistance Services.

"Reconsideration" means the supervisory review of information submitted to DMAS or the designated preauthorization contractor in the event of a disagreement of an initial decision that is related to a denial in the reimbursement of services already rendered by a provider.

"Respite care" means services specifically designed to provide a temporary, periodic relief to the primary caregiver of an individual who is incapacitated or dependent due to AIDS. Respite care services include assistance with personal hygiene, nutritional support and environmental maintenance authorized as either episodic, temporary relief or as a routine periodic relief of the caregiver.

"Respite care agency" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing eligible individuals with respite care aides who provide respite care services.

"Service plan" means the written plan of services certified by the PAS team physician as needed by the individual to ensure optimal health and safety for the delivery of home and community-based care.

"State Plan for Medical Assistance" or "the Plan" or "the State Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

“Transition funding” means funding to assist individuals returning to the community from institutions with the costs incurred as part of transition to a home or apartment in the community. For the purposes of transition funding, an institution is an intermediate care facility for the mentally retarded (ICF/MR), a nursing facility, or a specialized care facility/hospital as defined at 42 CFR 435.1009. Transition funding would not apply to an acute care admission to a hospital.

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that assesses an individual's social, physical health, mental health, and functional abilities.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-120-201. Private duty nursing services.

A. General. Private duty nursing services shall be offered to individuals enrolled in the HIV/AIDS waiver when such services are deemed necessary by the attending physician to avoid institutionalization by assessing and monitoring the medical condition, providing interventions, and communicating with the physician regarding changes in the individual's status. The hours of private duty nursing shall be limited by medical necessity. The purpose of private duty nursing is to provide for ongoing monitoring, continued nursing supervision, and skilled care. This service should not be authorized when intermittent skilled nursing visits could be utilized. Private duty nursing services should not be provided simultaneously with LPN respite care.

B. Special provider participation conditions. To be approved for private duty nursing contracts with DMAS, the private duty nursing provider shall:

1. Be a home health agency licensed or certified by the Virginia Department of Health for Medicaid participation and with which DMAS has a signed participation agreement for private duty nursing services.

2. Demonstrate prior successful health care delivery.

3. Operate from a business office.

4. Employ (or subcontract with) and directly supervise a registered nurse or a licensed practical nurse.

a. The registered nurse shall be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, nursing facility, or as an LPN.

b. The LPN shall be currently licensed to practice in the Commonwealth.

C. Limits to services.

1. Private duty nursing shall be reimbursed for a maximum of 16 hours within a 24-hour period per household.

2. In no instance shall the designated preauthorization contractor approve an ongoing plan of care or ongoing multiple plans of care per household that result in approval of more than 16 hours of private duty nursing in a 24-hour period per household.

3. Congregate private duty nursing. When two waiver individuals share a residence, there shall be a maximum ratio of one private duty nurse to two waiver individuals. When three or more waiver individuals share a residence, ratios will be determined by the combined needs of the individuals.

D. Provider reimbursement.

1. All private duty nursing services shall be reimbursed at an hourly rate determined by DMAS.

2. If the AIDS Waiver individual needs skilled nursing and has another payer (Medicare or private insurance), the skilled nursing must be covered by the other payer or payers first. Whatever skilled nursing services are not covered under the primary insurance, Medicaid may cover. There shall be no duplication of nursing services with other payers or other Medicaid State Plan services.

3. RN/LPN shall not practice without signed physician orders specifically identifying skilled tasks to be performed for the individual.

4. The registered nurse shall review the medications and treatments rendered by the LPN every 60 days and verify the physician's orders.

E. Assessment and plan of care requirements.

1. The case manager shall be responsible for ensuring that the assessment, care planning, monitoring, and review activities required by DMAS are accomplished and documented, consistent with DMAS requirements.

2. Development of the plan of care.

a. Upon completion of the required assessments and a determination that the individual needs substantial and ongoing skilled nursing care, the hours of nursing service required shall be developed and approved by the designated preauthorization contractor.

b. At a minimum, the plan of care shall include:

(1) Identification of the type, frequency, and amount of nursing care needed. This shall include the name of the provider agency, whether the nurse is an RN or LPN, and verification that the nurse is licensed to practice in the Commonwealth.

(2) Identification of the type, frequency, and amount of care that the family or other informal caregivers shall provide.

F. Individual selection of waiver services.

1. The case manager shall give the legally competent individual, or the individual's legal guardian, or the parent of a minor child, the choice of waiver services or institutionalization. This choice must be documented.

2. If waiver services are chosen, the individual applicant or his legally responsible entity will also be given the opportunity to choose the providers of services if more than one provider is available to render the services. This choice must also be documented. If more than one waiver individual will reside in the home, one waiver provider shall be chosen to provide all private duty nursing services for all waiver individuals in the home. Only one nurse will be authorized to care for every two waiver individuals in a residence. In the instance when more than two waiver individuals share a residence, nursing ratios will be determined by the designated preauthorization contractor based on the needs of all the individual living together.

3. The designated preauthorization contractor or DMAS shall review and approve the assessment and plan of care prior to the individual's admission to community waiver

services, and prior to Medicaid payment for any services related to the waiver plan of care.

G. Reevaluation requirements and utilization review.

1. The need for reevaluations shall be determined by the case manager, registered nurse, DMAS, or the designated preauthorization contractor. Reevaluations shall be conducted by these professionals as required by the individual's needs and situation and at any time when a change in the individual's condition indicates the need for reevaluation.

2. Utilization review shall be conducted by DMAS on all providers to ensure consumer satisfaction, the adherence to state and federal provider qualifications, and documentation requirements. DMAS will also ensure the appropriate billing practices for waiver services.

H. Registered nurse supervisory duties.

1. The registered nurse shall make, at a minimum, a visit every 30 days to the individual's home to assess the individual's/caregiver's satisfaction with the services being provided.

2. The registered nurse shall review medications and treatments rendered by the private duty nurse every 60 days and verify orders with the physician signature.

3. The registered nurse shall review all discharge orders written upon the individual's discharge from the hospital and provide a copy of such orders to the private duty nurse rendering care to the individual in his home.

a. The RN shall make an initial assessment visit prior to the start of care for any individual admitted to private duty nursing.

b. During visits to the individual's home, the registered nurse shall observe, evaluate, and document the adequacy and appropriateness of private duty nursing services with regard to the individual's current functioning status, medical, and social needs. The individual's or family's satisfaction with the type and amount of service must be discussed. The registered nurse shall document in a summary note:

(1) Whether private duty nursing services continue to be appropriate;

(2) Whether the plan of care is adequate to meet the individual's needs or if changes need to be made to the plan of care;

(3) The individual's satisfaction with the service;

(4) Any hospitalization or change in the medical condition or functioning status of the individual; and

(5) Other services received and their amount.

I. Required documentation for individuals' records. The provider agency shall maintain all records of each individual receiving private duty nursing. These records shall be separate from those of other nonhome and community-based care services, such as companion or home health services. These records shall be reviewed periodically by the

DMAS staff who are authorized by DMAS to review these files during utilization review. At a minimum, the record shall contain:

1. The most recently updated Long-Term Care Uniform Assessment Instrument (UAI), documentation of any inpatient hospital admissions, the Medicaid-Funded Long-Term Care Service Authorization Form (DMAS-96), the Screening Team Service Plan for Medicaid-Funded Long-Term Care (DMAS-97), all Home Health Certification and Plans of Care (CMS-485), Skills Checklist for Private Duty Nursing (DMAS-259), all Patient Information Forms (DMAS-122) and all signed physician's orders.

2. The initial assessment by the registered nurse completed prior to or on the date services were initiated.

3. Registered nurses' notes recorded and dated during visits to the individual's home. The registered nurses' notes shall contain:

a. The specific services delivered to the individual and the individual's response;

b. Comments or observations about the individual. Comments shall include but not be limited to observation of the individual's physical and emotional condition, daily activities, and the individual's response to the services rendered;

c. The signature by the registered nurse or the licensed practical nurse and the individual at least once a week to verify that private duty nursing services have been rendered. This record must be maintained in the individual's record.

4. All correspondence to the individual, DMAS, and the designated preauthorization contractor.

5. Reassessments made during the provision of services.

6. Significant contacts made with family, physicians, DMAS, the designated preauthorization contractor, formal and informal service providers and all professionals related to the individual's Medicaid services or medical care.

Copies of all nurses' records shall be subject to review by state and federal Medicaid representatives.

If an individual who is receiving private duty nursing is also receiving any other service (meals on wheels, companion, home health services, etc.), the nurse record shall indicate that these services are also being received by the individual.

There should be no duplication of nursing services with other Medicaid State Plan services or payors.

J. Transition funding is available to assist individuals returning to the community from institutions with the costs incurred as part of transition to a home or apartment in the community. The total amount of funding is $4,000 per-person lifetime limit coverage of one-time transition costs to residents of nursing homes or intermediate care facilities for the mentally retarded who are Medicaid recipients and are able to return to their home communities. Allowable costs include 1) security deposits that are required to obtain a

lease on an apartment or home; 2) essential furnishings (bed, chair, dining table and chairs, eating utensils, food preparation items, telephone) and moving expenses required to occupy and use a community domicile; 3) set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); 4) health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy; 5) fees to obtain a copy of a birth certification or an identification card or driver's license.

The expenses must be reasonable and may not include recreational or diversional items or expenses related to on-going rent or housing costs, food, or clothing expenses. This service does not include services or items that are covered under other waiver services such as chore, homemaker, home modifications and adaptations, or supplies and equipment.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-120-211. Definitions.

"Activities of daily living" or "ADL" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Appeal" means the process used to challenge adverse actions regarding services, benefits and reimbursement provided by Medicaid pursuant to ~~12VAC30-110~~ 12VAC30-110-10, et.seq. and 12VAC30-20-500 through 12VAC30-20-560.

"Assistive technology" or "AT" means specialized medical equipment and supplies to include devices, controls, or appliances, specified in the consumer service plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the Medicaid State Plan.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county under Chapter 15 (§37.1-242 et seq.) of Title 37.1 of the Code of Virginia that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the locality that it serves.

"CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Case management" means the assessing and planning of services; linking the individual to services and supports identified in the consumer service plan; assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the consumer service plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the consumer service plan.

"Case manager" means the individual on behalf of the community services board or behavioral health authority possessing a combination of mental retardation work experience and relevant education that indicates that the individual possesses the knowledge, skills and abilities, at entry level, as established by the Department of Medical Assistance Services in 12VAC30-50-450.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities or cities and counties under Chapter 10 (§37.1-194 et seq.) of Title 37.1 of the Code of Virginia, that plans, provides, and

evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion" means, for the purpose of these regulations, a person who provides companion services.

"Companion services" means nonmedical care, support, and socialization, provided to an adult (age 18 and over). The provision of companion services does not entail hands-on nursing care. It is provided in accordance with a therapeutic goal in the consumer service plan and is not purely diversional in nature.

"Comprehensive assessment" means the gathering of relevant social, psychological, medical and level of care information by the case manager and is used as a basis for the development of the consumer service plan.

"Consumer-directed services" means services for which the individual or family/caregiver is responsible for hiring, training, supervising, and firing of the staff.

"Consumer-directed (CD) services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.

"Consumer service plan" or "CSP" means documents addressing needs in all life areas of individuals who receive mental retardation waiver services, and is comprised of individual service plans as dictated by the individual's health care and support needs. The individual service plans are incorporated in the CSP by the case manager.

"Crisis stabilization" means direct intervention to persons with mental retardation who are experiencing serious psychiatric or behavioral challenges that jeopardize their current community living situation, by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by the Department of Medical Assistance Services.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DMHMRSAS staff" means persons employed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level.

"Developmental risk" means the presence before, during or after an individual's birth of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through existing diagnostic and evaluative criteria.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts or special opportunities to eligible individuals or family/caregivers as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual or family/caregiver, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's or family/caregiver's use of the providers' services.

"Enroll" means that the individual has been determined by the case manager to meet the eligibility requirements for the MR Waiver and DMHMRSAS has verified the availability of a MR Waiver slot for that individual.

"Entrepreneurial model" means a small business employing eight or fewer individuals who have disabilities on a shift and usually involves interactions with the public and with coworkers without disabilities.

"Environmental modifications" means physical adaptations to a house, place of residence, or vehicle that are necessary to ensure the individual's health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines that prescribe preventive and treatment services for Medicaid-eligible children as defined in 12VAC30-50-130.

"Facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.

"Fiscal agent" means an agency or organization within DMAS or contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed personal assistance, respite, and companion services.

"Health and safety standard" means that an individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written individual service plan.

"Home and community-based waiver services" or "waiver services" means the range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to persons with mental retardation and children younger than age six who are at developmental risk who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR.)

"ICF/MR" means a facility or distinct part of a facility certified by the Virginia Department of Health, as meeting the federal certification regulations for an Intermediate Care Facility for the Mentally Retarded and persons with related conditions. These facilities must address the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, and must provide active treatment.

"Individual" means the person receiving the services or evaluations established in these regulations.

"Individual service plan" or "ISP" means the service plan related solely to the specific waiver service. Multiple ISPs help to comprise the overall consumer service plan.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.

"ISAR" means the Individual Service Authorization Request and is the DMAS form used by providers to request prior authorization for MR waiver services.

"Mental retardation" or "MR" means mental retardation as defined by the American Association on Mental Retardation (AAMR).

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and DMHMRSAS, and has a current, signed provider participation agreement with DMAS.

"Pend" means delaying the consideration of an individual's request for services until all required information is received by DMHMRSAS.

"Personal assistance services" means assistance with activities of daily living, instrumental activities of daily living, access to the community, self-administration of medication, or other medical needs, and the monitoring of health status and physical condition.

"Personal assistant" means a person who provides personal assistance services.

"Personal emergency response system (PERS)" is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Preauthorized" means that an individual service has been approved by DMHMRSAS prior to commencement of the service by the service provider for initiation and reimbursement of services.

"Prevocational services" means services aimed at preparing an individual for paid or unpaid employment. The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage.

"Qualified mental retardation professional" means a professional possessing: (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

"Residential support services" means support provided in the individual's home by a DMHMRSAS-licensed residential provider or a DSS-approved provider of adult foster care services. This service is one in which training, assistance, and supervision is routinely provided to enable individuals to maintain or improve their health, to develop skills in activities of daily living and safety in the use of community resources, to adapt their behavior to community and home-like environments, to develop relationships, and participate as citizens in the community.

"Respite services" means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care.

"Skilled nursing services" means services that are ordered by a physician and required to prevent institutionalization, that are not otherwise available under the State Plan for Medical Assistance and that are provided by a licensed registered professional nurse, or by a licensed practical nurse under the supervision of a licensed registered professional nurse, in each case who is licensed to practice in the Commonwealth.

"Slot" means an opening or vacancy of waiver services for an individual.

"State Plan for Medical Assistance" or "Plan" means the regulations identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supported employment" means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual with mental retardation to maintain paid employment.

"Support plan" means the report of recommendations resulting from a therapeutic consultation.

"Therapeutic consultation" means activities to assist the individual, family/caregivers, staff of residential support, day support, and any other providers in implementing an individual service plan.

“Transition funding” means funding to assist individuals returning to the community from institutions with the costs incurred as part of transition to a home or apartment in the community. For the purposes of transition funding, an institution is an intermediate care facility for the mentally retarded (ICF/MR), a nursing facility, or a specialized care facility/hospital as defined at 42 CFR 435.1009. Transition funding would not apply to an acute care admission to a hospital.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-120-249. Therapeutic consultation.

A. Service description. Therapeutic consultation provides expertise, training and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual. The specialty areas are (i) psychology, (ii) behavioral consultation, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering. The need for any of these services, is based on the individual's CSP, and provided to those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their ability to function in the community. Therapeutic consultation services may be provided in the individual's home, and in appropriate community settings and are intended to facilitate implementation of the individual's desired outcomes as identified in his CSP.

B. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the CSP cannot be implemented effectively and efficiently without such consultation from this service.

1. The individual's therapeutic consultation ISP must clearly reflect the individual's needs, as documented in the social assessment, for specialized consultation provided to family/caregivers and providers in order to implement the ISP effectively.

2. Therapeutic consultation services may not include direct therapy provided to waiver individuals or monitoring activities, and may not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance.

C. Service units and service limitations. The unit of service shall equal one hour. The services must be explicitly detailed in the ISP. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic consultation may not be billed solely for purposes of monitoring. Only behavioral consultation may be offered in the absence of any other waiver service when the consultation is determined to be necessary to prevent institutionalization.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, professionals rendering therapeutic consultation services shall meet all applicable state licensure or certification requirements. Persons providing rehabilitation consultation shall be rehabilitation engineers or certified rehabilitation specialists. Behavioral consultation may be performed by professionals based on the professionals' work experience, education, and demonstrated knowledge, skills, and abilities.

The following documentation is required for therapeutic consultation:

1. An ISP, that contains at a minimum, the following elements:

a. Identifying information:

b. Targeted objectives, time frames, and expected outcomes;

c. Specific consultation activities; and

d. A written support plan detailing the interventions or support strategies.

2. Ongoing documentation of consultative services rendered in the form of contact-by-contact or monthly notes that identify each contact.

3. If the consultation service extends beyond the one year, the ISP must be reviewed by the provider with the individual receiving the services and the case manager, and this written review must be submitted to the case manager, at least annually, or more as needed. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and are to be forwarded to the case manager. Any changes to the ISP must be reviewed with the individual or family/caregiver.

4. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain a copy of the completed DMAS-122 from the case manager.

5. A written support plan, detailing the interventions and strategies for providers and family/caregivers to use to better support the individual in the service; and

6. A final disposition summary that must be forwarded to the case manager within 30 days following the end of this service.

E. Transition funding is available to assist individuals returning to the community from institutions with the costs incurred as part of transition to a home or apartment in the community. The total amount of funding is $4,000 per-person lifetime limit coverage of one-time transition costs to residents of nursing homes or intermediate care facilities for the mentally retarded who are Medicaid recipients and are able to return to their home communities. Allowable costs include 1) security deposits that are required to obtain a lease on an apartment or home; 2) essential furnishings (bed, chair, dining table and chairs, eating utensils, food preparation items, telephone) and moving expenses required to occupy and use a community domicile; 3) set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); 4) health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy; 5) fees to obtain a copy of a birth certification or an identification card or driver's license.

The expenses must be reasonable and may not include recreational or diversional items or expenses related to on-going rent or housing costs, food, or clothing expenses. This service does not include services or items that are covered under other waiver services such as chore, homemaker, home modifications and adaptations, or supplies and equipment.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date	Patrick W. Finnerty, Director Dept. of Medical Assistance Services

12VAC30-120-700. Definitions.

"Activities of daily living (ADL)" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. A recipient's degree of independence in performing these activities is a part of determining appropriate level of care and services.

"Assistive technology" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the consumer service plan but not available under the State Plan for Medical Assistance that enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live or that are necessary to their proper functioning.

"Attendant care" means long-term maintenance or support services necessary to enable the recipient to remain at or return home rather than enter or remain in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The recipient will be responsible for hiring, training, supervising and firing the personal attendant. If the recipient is unable to independently manage his own attendant care, a family caregiver can serve as the employer on behalf of the recipient. Recipients with cognitive impairments will not be able to manage their own care.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county or combination of counties or cities or cities and counties under §37.1-194 et seq. of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"CARF" means Commission on Accreditation of Rehabilitation Facilities.

"Case manager" means the individual on behalf of the community services board or behavioral health authority staff possessing a combination of mental retardation work experience and relevant education that indicates that the individual possesses the knowledge, skills and abilities, at the entry level, as established by the Department of Medical Assistance Services, 12VAC30-50-450.

"Centers for Medicare and Medicaid Services" or "CMS" means the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Community-based care waiver services" or "waiver services" means the range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to developmentally disabled recipients who would otherwise require the level of care provided in an ICF/MR.

"Community Services Board" or "CSB" means the local agency established by a city or county or combination of counties or cities, or cities and counties, under §37.1-194 et seq. of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion aide" means, for the purpose of these regulations, a domestic servant who is also exempt from workers' compensation.

"Companion services" means nonmedical care, supervision and socialization, provided to a functionally or cognitively impaired adult. The provision of companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the consumer service plan. This shall not be the sole service used to divert recipients from institutional care.

"Consumer-directed companion care" means nonmedical care, supervision and socialization provided to a functionally or cognitively impaired adult. The provision of companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the consumer service plan. This shall not be the sole service used to divert recipients from institutional care. The recipient will be responsible for hiring, training, supervising, and firing the companion. If the recipient is unable to independently manage his own consumer-directed care, a family caregiver can serve as the employer on behalf of the recipient.

"Consumer-directed respite care" means services given to caretakers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence or need for relief of those persons residing with the recipient who normally provide the care. The recipient will be responsible for hiring, training, supervising, and firing the personal attendant. If the recipient is unable to independently manage his own consumer-directed respite care, a family caregiver can serve as the employer on behalf of the recipient.

"Consumer-directed (CD) services facilitator" means the provider contracted by DMAS that is responsible for ensuring development and monitoring of the CSP, management training, and review activities as required by DMAS for attendant care, consumer-directed companion care, and consumer-directed respite care services.

"Consumer service plan" or "CSP" means that document addressing all needs of recipients of home and community-based care developmental disability services, in all life areas. Supporting documentation developed by service providers is to be incorporated in the CSP by the support coordinator. Factors to be considered when these plans are developed may include, but are not limited to, recipients' ages and levels of functioning.

"Crisis stabilization" means direct intervention to persons with developmental disabilities who are experiencing serious psychiatric or behavioral problems, or both, that jeopardize their current community living situation. This service must provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize recipients and strengthen the current living situations so that recipients can be maintained in the community during and beyond the crisis period.

"Current functional status" means recipients' degree of dependency in performing activities of daily living.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means individuals who perform utilization review, recommendation of preauthorization for service type and intensity, and review of recipient level of care criteria.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self care, physical development, services and support activities.

"Environmental modifications" means physical adaptations to a house, place of residence, vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure recipients' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to recipients.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines which prescribe specific preventive and treatment services for Medicaid-eligible children.

"Family/caregiver training" means training and counseling services provided to families or caregivers of recipients receiving services in the IFDDS Waiver.

"Fiscal agent" means an agency or organization contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of recipients who are receiving consumer-directed attendant, respite, and companion services.

"Home" means, for purposes of the IFDDS Waiver, an apartment or single family dwelling in which no more than two individuals who require services live with the exception of siblings living in the same dwelling with family. This does not include an assisted living facility or group home.

"Home and community-based care" means a variety of in-home and community-based services reimbursed by DMAS as authorized under a §1915(c) waiver designed to offer recipients an alternative to institutionalization. Recipients may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid ICF/MR placement.

"IFDDS Waiver" means the Individual and Family Developmental Disabilities Support Waiver.

"In-home residential support services" means support provided in the developmentally disabled recipient's home, which includes training, assistance, and supervision in enabling the recipient to maintain or improve his health; assisting in performing recipient care tasks; training in activities of daily living; training and use of community resources; providing life skills training; and adapting behavior to community and home-like environments.

"Instrumental activities of daily living (IADL)" means social tasks (e.g., meal preparation, shopping, housekeeping, laundry, money management). A recipient's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Legal guardian" means a person who has been legally invested with the authority and charged with the duty to take care of, manage the property of, and protect the rights of a recipient who has been declared by the circuit court to be incapacitated and incapable of administering his own affairs. The powers and duties of the guardian are defined by the court and are limited to matters within the areas where the recipient has been determined to be incapacitated.

"Mental retardation" means, as defined by the American Association on Mental Retardation (AAMR), being substantially limited in present functioning as characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction,

health and safety, functional academics, leisure, and work. Mental retardation manifests itself before age 18. A diagnosis of mental retardation is made if the person's intellectual functioning level is approximately 70 to 75 or below, as diagnosed by a licensed clinical professional; and there are related limitations in two or more applicable adaptive skill areas; and the age of onset is 18 or below. If a valid IQ score is not possible, significantly subaverage intellectual capabilities means a level of performance that is less than that observed in the vast majority of persons of comparable background. In order to be valid, the assessment of the intellectual performance must be free of errors caused by motor, sensory, emotional, language, or cultural factors.

"MR Waiver" means the mental retardation waiver.

"Nursing services" means skilled nursing services listed in the consumer service plan which are ordered by a physician and required to prevent institutionalization, not otherwise available under the State Plan for Medical Assistance, are within the scope of the state's Nurse Practice Act ~~([~~Chapters Chapter 30 (§54.1-3000 et seq.)] and the Drug Control Act [Chapter 34 (§54.1-3400 et seq.)~~)~~] of the Code of Virginia, and are provided by a registered professional nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state.

"Participating provider" means an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS, and has a current, signed contract with DMAS.

"Personal attendant" means, for purposes of this regulation, a domestic servant who is also exempt from Workers' Compensation.

"Personal care agency" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing eligible recipients with personal care aides who provide personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable recipients to remain in or return to the community rather than enter an Intermediate Care Facility for the Mentally Retarded. Personal care services include assistance with activities of daily living, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes and in the community.

"Personal emergency response system (PERS)" is an electronic device that enables certain recipients at high risk of institutionalization to secure help in an emergency. PERS services are limited to those recipients who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Qualified mental health professional" means a professional having: (i) at least one year of documented experience working directly with recipients who have developmental disabilities; (ii) at least a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or

psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession.

"Related conditions" means those persons who have autism or who have a severe chronic disability that meets all of the following conditions identified in 42 CFR 435.1009:

1. It is attributable to:

a. Cerebral palsy or epilepsy; or

b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

a. Self-care.

b. Understanding and use of language.

c. Learning.

d. Mobility.

e. Self-direction.

f. Capacity for independent living.

"Respite care" means services provided to unpaid caretakers of eligible recipients who are unable to care for themselves that is provided on an episodic or routine basis because of the absence of or need for relief of those persons residing with the recipient who normally provide the care.

"Respite care agency" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing respite care services to eligible recipients for their caregivers.

"Screening" means the process to evaluate the medical, nursing, and social needs of recipients referred for screening; determine Medicaid eligibility for an ICF/MR level of care; and authorize Medicaid-funded ICF/MR care or community-based care for those recipients who meet ICF/MR level of care eligibility and require that level of care.

"Screening team" means the entity contracted with DMAS which is responsible for performing screening for the IFDDS Waiver.

"State Plan for Medical Assistance" or "the Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Support coordination" means the assessment, planning, linking, and monitoring for recipients referred for the IFDDS community-based care waiver. Support coordination: (i) ensures the development, coordination, implementation, monitoring, and modification of consumer service plans; (ii) links recipients with appropriate community resources and supports; (iii) coordinates service providers; and (iv) monitors quality of care. Support coordination providers cannot be service providers to recipients in the IFDDS Waiver with the exception of consumer-directed service facilitators.

"Supporting documentation" means the specific service plan developed by the recipient service provider related solely to the specific tasks required of that service provider. Supporting documentation helps to comprise the overall CSP for the recipient.

"Supported employment" means training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable a recipient to maintain paid employment.

"Therapeutic consultation" means consultation provided by members of psychology, social work, behavioral analysis, speech therapy, occupational therapy, therapeutic recreation, or physical therapy disciplines or behavior consultation to assist recipients, parents, family members, in-home residential support, day support and any other providers of support services in implementing a CSP.

“Transition funding” means funding to assist individuals returning to the community from institutions with the costs incurred as part of transition to a home or apartment in the

community. For the purposes of transition funding, an institution is an intermediate care facility for the mentally retarded (ICF/MR), a nursing facility, or a specialized care facility/hospital as defined at 42 CFR 435.1009. Transition funding would not apply to an acute care admission to a hospital.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-120-776. Companion care agency-directed model of care.

A. Service description. Companion care is a covered service when its purpose is to supervise or monitor those individuals who require the physical presence of an aide to ensure their safety during times when no other supportive individuals are available.

B. Criteria.

1. The inclusion of companion care in the CSP is appropriate only when the recipient cannot be left alone at any time due to mental or severe physical incapacitation. This includes recipients who cannot use a phone to call for help due to a physical or neurological disability. Recipients can only receive companion care due to their inability to call for help if PERS is not appropriate for them.

2. Recipients who have a current, uncontrolled medical condition which would make them unable to call for help during a rapid deterioration can be approved for companion care if there is documentation that the recipient has had recurring attacks during the two-month period prior to the authorization of companion care. Companion care shall not be covered if required only because the recipient does not have a telephone in the home or because the recipient does not speak English.

3. There must be a clear and present danger to the recipient as a result of being left unsupervised. Companion care cannot be authorized for persons whose only need for companion care is for assistance exiting the home in the event of an emergency.

C. Service units and service limitations.

1. The amount of companion care time included in the CSP must be no more than is necessary to prevent the physical deterioration or injury to the recipient. In no event may the amount of time relegated solely to companion care on the CSP exceed eight hours per day.

2. A companion care aide cannot provide supervision to recipients who are on ventilators or continuous tube feedings or those who require suctioning of their airways.

3. Companion care will be authorized for family members to sleep either during the day or during the night when the recipient cannot be left alone at any time due to the recipient's severe agitation and physically wandering behavior. Companion aide services must be necessary to ensure the recipient's safety if the recipient cannot be left unsupervised due to health and safety concerns.

4. Companion care can be authorized when no one else is in the home who is competent to call for help in an emergency.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, providers must meet the following qualifications:

1. Companion aide qualifications. Agencies must employ individuals to provide companion care who meet the following requirements:

a. Be at least 18 years of age;

b. Possess basic reading, writing, and math skills;

c. Be capable of following a care plan with minimal supervision;

d. Submit to a criminal history record check. The companion will not be compensated for services provided to the recipient if the records check verifies the companion has been convicted of crimes described in §32.1-162.9:1 of the Code of Virginia;

e. Possess a valid Social Security number; and

f. Be capable of aiding in the activities of daily living or instrumental activities of daily living.

2. Companions will be employees of agencies that will contract with DMAS to provide companion services. Agencies will be required to have a companion care supervisor to monitor companion care services. The supervisor must be a certified Home Health Aide, an LPN, or an RN, and must have a current license or certification to practice in the Commonwealth.

3. The provider agency must conduct an initial home visit within the first three days of initiating companion care services to document the efficacy and appropriateness of services and to establish a service plan for the recipient. The agency must provide follow-up home visits to monitor the provision of services every four months or as often as needed. The recipient must be reassessed for services every six months.

E. Transition funding is available to assist individuals returning to the community from institutions with the costs incurred as part of transition to a home or apartment in the community. The total amount of funding is $4,000 per-person lifetime limit coverage of one-time transition costs to residents of nursing homes or intermediate care facilities for the mentally retarded who are Medicaid recipients and are able to return to their home communities. Allowable costs include 1) security deposits that are required to obtain a lease on an apartment or home; 2) essential furnishings (bed, chair, dining table and chairs, eating utensils, food preparation items, telephone) and moving expenses required to occupy and use a community domicile; 3) set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); 4) health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy; 5) fees to obtain a copy of a birth certification or an identification card or driver's license.

The expenses must be reasonable and may not include recreational or diversional items or expenses related to on-going rent or housing costs, food, or clothing expenses. This service does not include services or items that are covered under other waiver services such as chore, homemaker, home modifications and adaptations, or supplies and equipment.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Services