COMMONWEALTH of VIRGINIA

Office of the Attorney General

Mark R. Herring
Attorney General

900 East Main Street
Richmond, Virginia 23219
804-786-2071
FAX 804-786-1991
Virginia Relay Services
800-828-1120

MEMORANDUM

TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **USHA KODURU**
Assistant Attorney General

DATE: **September 12, 2019**

SUBJECT: **12 VAC 30-50-100 Fast-Track Regulations for Removal of the 21 out of 60 Day Limit. (5331/8680)**

I am in receipt of the attached regulations to comply with CMS's Medicaid Mental Health Parity Rule. You asked the Office of the Attorney General to review and determine if DMAS has the legal authority to amend these regulations and if the regulations comport with state and federal law.

Based on my review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325, has the authority to promulgate this regulation subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority. This regulation amends the State Plan; therefore, approval by the Centers for Medicare and Medicaid Services also will be required and has been obtained.

Pursuant to Va. Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the Fast-Track regulation serving as the Notice of Intended Regulatory Action.

If you have any questions or need additional information about this regulation, please contact me at 786-4074.

cc: Kim F. Piner, Esquire

Attachment

Action:
Removal of the 21 Out of 60 Day Limit
Stage: Fast-Track
8/21/19 1:26 PM [latest]
Part III
Amount, Duration, and Scope of Services

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

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

1. Admission review.

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

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

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

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

4. Reconsideration process.

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

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

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

~~support. If higher level review is requested, the authorization request will be held in suspense and referred to DMAS medical support for the last step of reconsideration.~~

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

Providers shall be given the opportunity to request a reconsideration of any adverse service authorization decision. Reconsideration requests shall be reviewed by a physician. Should the case be denied, appeal rights are generated on the letter sent to the member and provider.

5. Appeals process.

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

b. Provider appeals. If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the date of the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered. The appeal shall be held in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

B. Out-of-state inpatient general acute care hospitals and freestanding psychiatric hospitals, enrolled providers. In addition to meeting all of the ~~preauthorization~~ service authorization requirements specified in subsection A of this section, out-of-state hospitals must further demonstrate that the requested admission meets at least one of the following additional standards. Services provided out of state for circumstances other than these specified reasons shall not be covered.

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

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

3. 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; or

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

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

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

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

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

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

E.~~F.~~ Mandatory lengths of stay.

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

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

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

G.~~H.~~ For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require ~~preauthorization~~ service authorization by DMAS medical support. Inpatient hospitalization related to kidney transplantation will require ~~preauthorization~~ service authorization at the time of admission and, concurrently, for length of stay. Cornea transplants do not require ~~preauthorization~~ service authorization of the procedure, but inpatient hospitalization related to such transplants will require ~~preauthorization~~ service authorizationfor admission and, concurrently, for length of stay. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

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

I.~~J.~~ Addiction and recovery treatment services shall be covered in inpatient facilities consistent with 12VAC30-130-5000 et seq.

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

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

B. Inpatient hospital services rendered by nonenrolled providers shall not require ~~prior~~ serviceauthorization with the exception of transplants as described in subsection ~~K~~I of this section and this subsection. However, these inpatient hospital services claims will be suspended from automated computer payment and will be manually reviewed for medical necessity as described in subsections B through ~~K~~I of this section using criteria specified by DMAS. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the

Commonwealth of Virginia shall only be reimbursed under at least one of the following conditions. It shall be the responsibility of the hospital, when requesting ~~prior~~ service authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization.

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

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

3.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;

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

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

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

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

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

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

~~H~~F. ~~Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be reimbursed. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically justified.~~ The admission and length of stay must be medically justified and ~~preauthorized~~ service authorized via the admission and concurrent review processes described in subsection A of 12VAC30-50-100. ~~Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days shall cease with dates of service on or after July 1, 1998.~~ Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

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

~~I~~G. Mandatory lengths of stay.

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

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

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

~~K~~I. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require ~~preauthorization~~ service authorizationby DMAS. Cornea transplants do not require ~~preauthorization~~ service authorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

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

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

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

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

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

D. Outpatient psychiatric services.

1. Psychiatric services can be provided by or under the supervision of an individual licensed under state law to practice medicine or osteopathy. Only the following licensed providers are permitted to provide psychiatric services under the supervision of an individual licensed under state law to practice medicine or osteopathy: ~~(i) a licensed clinical psychologist; (ii) a LMHP-RP, as defined in 12VAC30-50-130; (iii) a licensed clinical social worker; (iv) a LMHP-S, as defined in 12VAC30-50-130; (v) a licensed professional counselor; (vi) a LMHP-R, as defined in 12VAC30-50-130; (vii) a licensed clinical nurse specialist-psychiatric; (viii) a licensed marriage and family therapist; or (ix) a licensed substance abuse professional.~~ an LMHP, LMHP-R, LMHP-RP, or LMHP-S as defined in 12VAC35-105-20. Medically necessary psychiatric services shall be covered by DMAS or its designee and shall be directly and specifically related to an active written plan designed and signature dated by one of the health care professionals listed in this subdivision.

2. Psychiatric services shall be considered appropriate when an individual meets the following criteria:

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

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

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

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

E. Any procedure considered experimental is not covered.

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

G. Physician visits to inpatient psychiatric hospital patients ~~over the age of 21 are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses or treatment plan and is further~~ are restricted to medically necessary authorized (for enrolled providers)/approved (for nonenrolled providers) inpatient psychiatric hospital days as determined by ~~the Program~~ DMAS or its contractor.

~~EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in freestanding psychiatric facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a psychiatric assessment. Payments for physician visits for inpatient days shall be limited to medically necessary inpatient hospital days.~~

H. (Reserved.)

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

J. (Reserved.)

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require ~~preauthorization~~ service authorization by DMAS. Cornea transplants do not require ~~preauthorization~~ service authorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

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

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

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

M. Admitting physicians shall comply with the requirements for coverage of out-of-state inpatient hospital services. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the

Commonwealth of Virginia shall only be reimbursed under at least one the following conditions. It shall be the responsibility of the hospital, when requesting ~~prior~~ service authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out of state for circumstances other than these specified reasons shall not be covered.

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

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

3. 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; or

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

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

O. Prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. The referring physician ordering nonemergency outpatient Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT) scans, or Positron Emission Tomography (PET) scans must obtain prior authorization from the Department of Medical Assistance Services (DMAS) for those scans. The servicing provider will not be reimbursed for the scan unless proper prior authorization is obtained from DMAS by the referring physician.

P. Addiction and recovery treatment services shall be covered in physician services consistent with 12VAC30-130-5000 et seq.

12VAC30-60-20. Utilization control: general acute care hospitals; enrolled providers.

A. The 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 ~~preauthorized~~ service authorized prior to admission. Services rendered without such ~~prior~~ service authorization shall not be covered, except as stated in ~~subdivisions~~ subdivision 2 ~~and 3~~ of this subsection.

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

~~3. If a Medicaid eligible individual is admitted to inpatient hospital care on a Saturday, Sunday, holiday, or after normal working hours, the provider shall be responsible for obtaining the required authorization on the next work day following such admission, in accordance with 12VAC30-50-105, subsection G.~~

43. Regardless of ~~preauthorization~~ service authorization, ~~in the following cases hospital inpatient claims shall continue to be suspended for DMAS review before reimbursement is approved. DMAS shall review all claims for individuals over the age of 21 which are suspended for exceeding the 21-day limit per admission in a 60-day period for the same or similar diagnoses prior to reimbursement for the stay. This suspension shall cease for nonpsychiatric hospitalizations with dates of service on or after July 1, 1998.~~ 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 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 the 42 CFR 456.105 through 456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and lists 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 456.145.

5. Topic of one ongoing Medical Care Evaluation Study to determine the hospital is in compliance with the 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 the 42 CFR 456.60 through 456.80, reimbursement may be retracted.

7. The hospitals 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.