Virginia Regulatory Town Hall

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# Fast Track Proposed Regulation
# Agency Background Document

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| **Agency name** | DEPT OF MEDICAL ASSISTANCE SERVICES |
| **Virginia Administrative Code (VAC) citation** | 12 VAC 30-50-225, 12 VAC 30-60-120 (Inpatient Intensive Rehabilitation) and 12 VAC 30-50-200, 12 VAC 30-60-150, (Outpatient Rehabilitation) (REVISED)<br>12 VAC 30-130-10, 12 VAC 30-130-15, 12 VAC 30-130-20, 12 VAC 30-130-30, 12 VAC 30-130-40, 12 VAC 30-130-42, 12 VAC 30-130-50, 12 VAC 30-130-60 (Recommended for Repeal) |
| **Regulation titles** | Amount, Duration and Scope of Services; Standards Established to Assure High Quality of Care; and Amount, Duration and Scope of Selected Services |
| **Action title** | Inpatient and Outpatient Rehabilitation Services Update |
| **Date this document prepared** | |

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

## Brief summary

*Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes*

As a result of an internal agency review, DMAS is updating its regulations for both inpatient and outpatient rehabilitation services, including services provided in Comprehensive Outpatient Rehabilitation Facilities (CORFs). In addition, several sections of regulations in Chapter 130 are recommended for repeal and the retained requirements formerly located in Chapter 130 are moved to Chapters 50 and 60. Outdated, duplicative, and unnecessary regulatory requirements currently in Chapter 130 are repealed. This action does not make any changes in the amount, duration, or scope of rehabilitative services that are covered by DMAS. It does not make any difference in the number of rehabilitation providers who are enrolled to render these services. It also does not make any difference in how many Medicaid individuals will be found to require rehabilitation services. These changes are not expected to change expenditures for this service; therefore, this action is budget neutral.

Inpatient Rehabilitation Services

This action: (i) incorporates reference to McKesson InterQual® Criteria to define medical necessity standards; (ii) in addition to physicians, permits nurse practitioners (NPs) and physician assistants (PAs) to order rehabilitation-related services, as allowed by federal regulation and state law; (iii) establishes time frame limitations for physician verbal orders; (iv) clarifies utilization review documentation requirements for plans of care and discharge summaries, and; (v) adds language prohibiting inappropriate alteration of medical records. In addition, new regulatory text (but not new operating policies) addresses admission interdisciplinary team meetings and plans of care completion deadlines, as well as corrective plans of action requirements. DMAS is clarifying language regarding Comprehensive Outpatient Rehabilitation Facilities' (CORF) services requiring physician oversight to be consistent with federal regulations. Duplicative/repetitive language is suggested for deletion.

Outpatient Rehabilitation Services

DMAS is proposing, consistent with federal and state laws, (i) that licensed nurse practitioners (NPs) or physician assistants (PAs) may order rehabilitation services and renew plans of care time frames for acute versus non-acute diagnoses; (ii) regulatory language for current limitations related to claims and service authorization; (iii) coverage of speech-language assistants; (iv) language regarding alteration of medical records, and (v) discharge summaries. Outdated service limitations are recommended for deletion.

There is also clarification to the outpatient rehabilitation regulations as follows: (i) clarifications related to service authorization; (ii) program criteria; (iii) physician 21-day plans-of-care signature requirement; (iv) required components of plans of care, and; (v) definitions of therapy evaluations and re-evaluations.

## Statement of final agency action

*Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.*

I hereby approve the foregoing Agency Background Document with the attached amended State Plan pages, Inpatient and Outpatient Rehabilitation Services Update (12 VAC 30-50-225, 12 VAC 30-60-120 (Inpatient Intensive Rehabilitation)); (12 VAC 30-50-200, 12 VAC 30-60-150 (Outpatient Rehabilitation)) and adopt the action stated herein. DMAS is also proposing to repeal: 12 VAC 30-130 sections 10, 15, 20, 30, 40, 42, 50, 60. I certify that this final regulatory action has completed all the requirements of the *Code of Virginia* § 2.2-4012.1, of the Administrative Process Act.

Date

Cynthia B. Jones, Director

Dept. of Medical Assistance Services

## Legal basis

*Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the scope of the legal authority and the extent to which the authority is mandatory or discretionary.*

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

Title 42 of the *Code of Federal Regulations* § 440.130(d) establishes rehabilitative services as a covered service under the authority of Title XIX of the *Social Security Act*. "Rehabilitative services …. includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level".

## Purpose

*Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.*

This regulatory action updates and clarifies the provision of inpatient and outpatient rehabilitation services and provider documentation requirements, conflates several regulatory sections into fewer sections by moving some existing requirements, and repeals several regulation sections that are no longer needed. The new text addresses health and safety issues regarding physician orders by other licensed practitioners of the healing arts in order to eliminate service delays for Medicaid individuals while awaiting physician signatures in patients' records. The new additions and changes to the regulations will provide a continuum of regulatory support by encompassing existing federal regulations and clarifying current Virginia Medicaid Rehabilitation Manual interpretive guidelines.

The goals of this regulatory action are to provide overall clarification of rehabilitation requirements based on provider feedback and utilization review findings, to eliminate delays in services while obtaining necessary signed/dated orders for services, and to reduce the volume of potential monetary retractions from providers when they are audited. Providers' patient documentation is the basis for all Medicaid claims' payments and provider audit retractions.

## Rationale for using fast track process

*Please explain the rationale for using the fast track process in promulgating this regulation. Why do you expect this rulemaking to be noncontroversial?*

*Please note: If an objection to the use of the fast-track process is received within the 60-day 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, the agency 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 with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.*

The Agency is using the Fast-Track action in this case because these changes are beneficial to both providers and enrollees and no controversy is expected. The new regulations preserve the health and safety of enrollees while enabling licensed practitioners other than physicians to originate service orders as permitted by their state professional licenses. These suggested changes also provide clarification on several key issues where there has been provider confusion, such as record documentation considered suitable to support filed claims and physician admission certification for inpatient rehabilitation. The clarifications are expected to assist providers with creating and maintaining improved patient records which will ultimately avoid payment retractions from providers. These clarifications also streamline the process of service initiation and renewal of physician-ordered services to Medicaid individuals.

## Substance

*Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (Provide more detail about these changes in the "Detail of changes" section.)*

The sections of the State Plan for Medical Assistance that are affected by this action are 12 VAC 30-50-225, 12 VAC 30-60-120 (Inpatient/CORF Intensive Rehabilitation Services); and 12 VAC 30-50-200, 12 VAC 30-60-150 (Outpatient Rehabilitation Services). State regulations at 12 VAC 30-130-10, 12 VAC 30-130-15, 12 VAC 30-130-20, 12 VAC 30-130-30, 12 VAC 30-130-40, 12 VAC 30-130-42, 12 VAC 30-130-50, 12 VAC 30-130-60 (Outpatient Rehabilitation) are recommended for repeal.

DMAS has covered inpatient rehabilitation services since 1987 and outpatient rehabilitation since 1978 under the authority of 42 CFR § 440.130(d). These services are federally defined as: "…any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." Medicaid individuals may receive medically necessary rehabilitative services as a result of either illnesses or injuries.

DMAS' coverage of all Medicaid services, including these rehabilitative services, must be based upon providers' documentation of services rendered and how such documentation supports providers' claims for reimbursement. DMAS conducted an internal review of these regulations and determined that they required updating and streamlining. In instances when providers' documentation did not support their claims, then providers have been subject to repayment of some of the amounts that they have received. These repayment determinations are made in the context of either DMAS' or its contractors' audits of providers' records. This action addresses those issues and is expected to reduce provider repayments.

DMAS' coverage of these rehabilitative services depends on either physicians' or other licensed practitioners' signed orders. Other licensed practitioners can be either nurse practitioners or physician assistants who are permitted by their Commonwealth-issued professional licenses to initiate such orders. Requiring physicians' or other practitioners' orders for rehabilitation services is identical to requiring physicians' orders for prescription drugs before pharmacists are permitted to provide drugs to patients. DMAS cannot claim federal matching dollars on services that have not been appropriately ordered; therefore, it does not cover any services that have not been ordered by either physicians or other licensed practitioners of the healing arts. Permitting physicians to use their nurse practitioners or physician assistants, or both, to write and sign orders for rehabilitation services makes it easier for these enrolled providers to meet DMAS' signature time frame requirements.

These regulations set out the service limits and provider requirements for the Medicaid coverage of inpatient rehabilitation (including in Comprehensive Outpatient Rehabilitation Facility (CORFs)) and for outpatient rehabilitation services. Because these rehabilitative services regulations have not been recently substantially revised, some of the elements have become outdated as compared to current industry standards and newer care criteria. For example, several of these

changes are being proposed to match the industry standard McKesson Interqual® Criteria for prior service authorization of intensive rehabilitation/CORF and outpatient rehabilitation.

Comprehensive Outpatient Rehabilitation Facilities (CORFs), even though outpatient rehabilitation providers, render services at such an intensive rehabilitative level that they are treated in these regulations as inpatient rehabilitation facilities. CORFs are intensive day rehabilitation programs where patients receive full day long therapy services but they do not stay overnight as they would in an inpatient rehabilitation hospital.

The new regulation text intends to decrease delays in service delivery while obtaining physician signed orders for the provision of rehabilitation services. Previously, providers were required to obtain physician signed orders for many rehabilitation services. Due to changes in federal regulations and state law, physician providers can now rely upon orders from other types of licensed practitioners, including nurse practitioners and/or physician assistants, for many types of rehabilitation services.

For inpatient intensive and CORF rehabilitation services, new regulations are added and existing regulations clarified for: (i) services ordered by licensed nurse practitioners and/or physician assistants for consistency with federal regulations and state law; (ii) requirements for physician admission certification and re-certification are clarified; (iii) plans of care, 60-day renewal of plans of care are clarified; (iv) physician verbal order time frame limitations are set out; (v) utilization review plans are clarified; (vi) discharge summary requirements are clarified; (vii) interdisciplinary team meetings and plans within 7 days of admission, and; (viii) corrective action plans that are the result of quality management review activities.

For outpatient rehabilitation services, (i) new regulations are added and existing regulations are clarified for the 21-day physician plan of care signature requirement; (ii) services ordered by licensed nurse practitioners and/or physician assistants for consistency with federal regulations and state law; (iii) no guarantee of reimbursement based on service authorization limitations is added; (iv) time frame limitations are added related to claims and service authorizations; (v) direct reimbursement to enrolled rehabilitation providers for provision of services to nursing facility residents; (vi) coverage of speech-language assistants, and; (vii) therapy evaluations and re-evaluations.

The limit on covered outpatient therapy service visits (physical therapy, occupational therapy, and speech-language therapy) before requesting service prior authorization was changed in 2003 (effective July 1, 2003, VR 19:18) from 24 visits to five visits. At the time of that policy change, DMAS did not change every regulatory occurrence of the 24-visit limit. This action also corrects that oversight.

## Issues

*Please identify the issues associated with the proposed regulatory action, including:*
*1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;*
*2) the primary advantages and disadvantages to the agency or the Commonwealth; and*
*3) other pertinent matters of interest to the regulated community, government officials, and the public.*

*If there are no disadvantages to the public or the Commonwealth, please indicate.*

The primary advantages are to the Virginia Medicaid individual who needs rehabilitation services and the providers who render these services. The additional language will expedite services so individuals may begin treatment as promptly as may be needed. The primary advantage to the Virginia enrolled Medicaid provider is more access of different types of licensed practitioners to meet the physician order requirements as well as clarification of documentation requirements.

There are no disadvantages to the Medicaid individuals, Medicaid providers, or to the public or the Commonwealth. These changes represent no expansion or reduction of currently existing services. The advantage for providers and consumers is that the new regulations allow for expansion of more licensed practitioner types who can order the rehabilitation services.

## Requirements more restrictive than federal

*Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.*

There are no federal requirements concerning required time frames for the documentation of evaluations, plans of care, and discharge summaries. The documentation time frame requirements currently exist only in DMAS' guidance documents (Virginia Medicaid Rehabilitation Manual). However, providers are already familiar with these requirements so this does not create operational changes for providers.

## Localities particularly affected

*Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.*

There are no localities particularly affected as these changes apply statewide.

## Regulatory flexibility analysis

*Please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.*

The proposed regulations establish less stringent compliance requirements that afford the enrollees an opportunity to obtain quicker access and wider scope of licensed practitioners to choose

from in securing physicians' orders for rehabilitation services. Quicker and easier access to physicians or other types of licensed practitioners is expected to reduce the risk of reimbursement retractions due to providers' non-compliance with obtaining the required physician signed orders. It will also promote Medicaid individuals' more ready access to medically necessary rehabilitative services within existing required time frames.

## Economic impact

*Please identify the anticipated economic impact of the proposed regulation.*

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| **Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures** | The proposed regulations are cost neutral. |
| **Projected cost of the regulation on localities** | Not applicable as these regulations apply uniformly statewide and do not affect local governments. |
| **Description of the individuals, businesses or other entities likely to be affected by the regulation** | All inpatient and outpatient rehabilitation providers and Medicaid individuals are affected by the proposed regulations. DMAS currently has these active providers: 35 rehabilitation hospitals; 3 CORFs; 161 outpatient rehab providers.<br><br>In the first half of CY 2012, DMAS paid rehab hospitals about $8.8 M for care for 802 unduplicated recipients, and; paid $7.5 M to outpatient rehab facilities for 7,197 unduplicated recipients. There were no CORF billings in this time period. |
| **Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.** | All Virginia Medicaid enrolled rehabilitation providers.<br><br>DMAS does not retain records concerning small business among its providers. |
| **All projected costs of the regulation for affected individuals, businesses, or other entities. Please be specific. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses.** | Expedites provision of services to individuals. No change to their current policies for documentation and record keeping for administrative costs. It is not anticipated that there will be any projected costs to these providers associated with these proposed regulatory changes. |

## Alternatives

*Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.*

Proposed additions and clarifications to the Virginia Administrative Code are recommended as state regulatory support for already existing federal regulations and agency guidance document requirements.

## Family impact

*Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.*

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These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment.

## Detail of changes

*Please detail all changes that are being proposed and the consequences of the proposed changes. Detail all new provisions and/or all changes to existing sections.*

*If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all changes between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.*

| Current section number | Proposed new section number, if applicable | Current requirement | Proposed change and rationale |
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| **INPATIENT INTENSIVE AND CORF REHABILITATION SERVICES** | | | |
| 12 VAC 30-50-225 | N/A | No definitions. Medicaid covers inpatient rehab services in physical rehabilitation hospitals or units of acute care hospitals and in Comprehensive Outpatient Rehabilitation Facilities (CORFs). Intensive rehab programs must offer specified services. Person receiving rehab services must meet specified standards. Services are specified that must be offered in intensive in-patient programs. Intensive inpatient rehab must | Definition section is added to define terms referenced in current regulations. Added reference to McKesson InterQual® Criteria to establish medical necessity. Added language that the physician is responsible for inpatient rehabilitation admission and discharge orders (if verbal orders are given, written orders must be signed/dated within 72 hours of the order).<br><br>Added that NPs/PAs are permitted to authorize rehab services.<br><br>Added existing program requirement that all criteria for intensive rehabilitation services also apply to CORF's (Comprehensive Out- |

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| | | be discontinued when specific conditions exist.<br><br>An interdisciplinary coordinated team approach must be used in this service. Admissions for vocational or educational purposes will not be covered is a long standing agency policy. | patient Rehabilitation Facilities). The one exception is that only physicians shall order CORF services pursuant to federal regulation.<br><br>Moved from the agency guidance document the existing conditions that individuals must meet in order to qualify for intensive inpatient or CORF rehab services.<br><br>Added language that therapy assistants must be supervised and how such supervision must be documented.<br><br>Added language prohibiting alteration of records. Added language that service authorization does not automatically guarantee payment for services rendered.<br><br>Links to the related utilization review regulations are added for improved clarity. |
| 12 VAC 30-60-120 | N/A | Currently, these requirements are described in 42 CFR §§456.101 through 456.145 and expanded in the Virginia Medicaid Rehabilitation Manual. Currently for intensive rehabilitation services, the certification, re-certification, and orders can only be written by a physician. Currently, services can be provided in CORFs.<br><br>Current VAC language does not specify required components of the plan of care, the licensed practitioner provider, and interdisciplinary plan of care documentation.<br><br>Time limits for therapy-specific plans of care documentation, within date of admission, not stated. No provision for time limit on discharge summary.<br><br>Current VAC permits up to two weeks for the professional interdisciplinary team to meet and prepare the admission team plan of care. | Time frame for physician to document, sign and date an admission certification statement is added. Notification to DMAS or its contractor is required upon admission within 72 hours. Admissions or lengths of stay that have not been authorized by DMAS or its contractor will not be reimbursed. New addition regarding discharge summary written by all disciplines within 30 days of a participant's discharge; and language added in this section regarding reimbursement retractions.<br><br>Components of acceptable plans of care are set out in order to avoid/reduce retractions of provider payments due to inadequate/incomplete documentation.<br><br>Time limits are set for record documentation to avoid/reduce retractions of provider payments due to inadequate/incomplete documentation.<br><br>Requirement changed to within 7 days of admission for the interdisciplinary team to meet and prepare the admission team plan of care. |

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| | | Simply reading each other's medical record notes shall not constitute a team conference.<br><br>No current language in the VAC regarding plans of corrective action resulting from quality management reviews.<br><br>No current VAC language regarding specific physician services.<br><br>Current titles of state and national licensing health professional boards are outdated.<br><br>Current VAC does not address the intentional altering of records. | Added language that allows DMAS or its contractor to request a corrective action plan from the provider as a result of quality management review findings.<br><br>Specified physician services in regard to admission certification, recertification, and 60-day renewals of the plans of care.<br><br>Updated titles of state and national licensing health professional boards for physical and occupational therapists, speech-language pathologists, cognitive rehabilitation therapists, psychologists, and social workers.<br><br>Provision is added establishing the procedures providers must follow to make legitimate corrections in medical records. |
| **OUTPATIENT REHABILTIATION REGULATIONS** | | | |
| 12 VAC 30-50-200 | N/A | Medicaid covers outpatient rehabilitation (physical therapy, occupational therapy, and speech/ language therapy) services.<br><br>No previous language in this specific VAC site regarding the physician plan of care for licensed practitioner options. Twenty-four visits allowed per SFY without service (prior) authorization. Payment not to be made for claims more than 12 months after termination of services. Physicians only permitted to order therapy services. Conditions established when therapy services are to be discontinued. | Definition section is added to include definitions that were not previously included in current VAC. Locations where this service can be rendered are set out. Practitioner types who are federally authorized to order rehab services is expanded to conform to federal and state limits. Conditions are set out for the provision of therapy services and for provider qualifications. Provider documentation requirements are clarified in order to reduce payment retractions. Five therapy visits are permitted without service authorization. Added language regarding acute conditions and non-acute conditions in relation to 60- day versus 12-month plans of care. Added language that service authorization does not automatically guarantee payment for services rendered.<br><br>Re-organized existing text to improve readability. |
| 12 VAC 30-60-150 | N/A | Existing utilization review requirements for outpatient rehab services. General statements where service can be provided for Medi- | Link to 12 VAC 30-50-200 (amount, duration, and scope of covered services) is added to assist providers in understanding the connection between the two regulation sections and to avoid having to repeat those provisions in |

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| | | caid reimbursement. Receipt of any rehab service not contingent upon any others. | duplicate places. Services that are not documented in individuals' medical records shall not be reimbursed. Documentation standards are established. |
| 12 VAC 30-130 sections 10 through 130-60 (Part I) | N/A | Additional outpatient rehabilitation services requirements concerning physical, occupational, speech/ language therapies. Duplicative text. | Regulations are recommended for repeal. Requirements to be retained have been incorporated into existing Chapter 50 (covered services) and Chapter 60 (utilization review of covered services). |