12 VAC 30-100-260. Eligibility requirements. An applicant will be determined to be eligible for the HIV Premium Assistance Program if the individual:

1. Is a Virginia resident at time of application and is

   a. A citizen of the United States; or

   b. An alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, including an alien who is lawfully present in the United States pursuant to 8 USC § 1101 et seq.; or

   c. An alien lawfully admitted under authority of the Indochina Migration and Refugee Assistance Act of 1975, 22 USC § 2601 et seq.; and

2. Is certified by a licensed physician to be HIV positive;

3. Is certified by a licensed physician to be unable to work or to have a substantial likelihood of being unable to work within three months of the date of the physician's certification due to the HIV infection;

4. Is eligible for continuation of group health insurance plan benefits through the employer and the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, or for continuation of benefits under any type of health insurance plan unless DMAS has reason to believe it is not cost-effective**;**

5. Has family income no greater than [~~200~~ 250] percent of the poverty level;

6. Has countable liquid assets no more than $10,000 in value, and;

7. Is not eligible for Medicaid.

CERTIFIED:

May 2, 2000

/s/ Dennis G. Smith
Dennis G. Smith, Director
Department of Medical Assistance Services

12VAC30-50-220. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

A. Diagnostic services are provided but only when necessary to confirm a diagnosis.

B. Screening services.

1. Screening mammograms for the female recipient population aged 35 and over shall be covered, consistent with the guidelines published by the American Cancer Society.

2. Screening PSA (prostate specific antigen) and the related DRE (digital rectal examination) for males shall be covered, consistent with the guidelines published by the American Cancer Society.

3. Screening Pap smears shall be covered annually for females, consistent with the guidelines published by the American Cancer Society.

4. Screening services for colorectal cancer, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

C. Maternity length of stay and early discharge.

1. If the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery, DMAS will cover one early discharge follow-up visit as recommended by the physicians in accordance with and as indicated by the "Guidelines for Perinatal Care", 4th Edition, August 1997, as developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The mother and newborn, or the newborn alone if the mother has not been discharged, must meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge follow-up visit does not affect or apply to any usual postpartum or well-baby care or any other covered care to which the mother or newborn is entitled; it is tied directly to an early discharge.

2. The early discharge follow-up visit must be provided as directed by a physician. The physician may coordinate with the provider of his choice to provide the early discharge follow-up visit, within the following limitations. Qualified providers are those hospitals, physicians, nurse midwives, nurse practitioners, federally qualified health clinics, rural health clinics, and health departments' clinics that are enrolled as Medicaid providers and are qualified by the appropriate state authority for delivery of the service. The staff providing the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health. The visit must be provided within 48 hours of discharge.

CERTIFIED:

May 2, 2000
Date

/s/ Dennis G. Smith
Dennis G. Smith, Director
Dept. of Medical Assistance Services

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

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

1. Admission review.

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

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

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

3. Retrospective review shall be performed when a provider is notified of a patient's retroactive eligibility for Medicaid coverage. It shall be the provider's responsibility to obtain authorization for

covered days prior to billing DMAS for these services. Adverse authorization decisions shall have
available a reconsideration process as set out in subdivision 4 of this subsection.

4. Reconsideration process.

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

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

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

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

5. Appeals process.

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

12VAC30-110, the recipient shall have 30 days from the date of the denial letter to file an appeal.

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

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

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

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

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall

be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric hospitals in excess of 21 days per
admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination. The admission and length of stay must be medically justified and preauthorized via the admission and concurrent or retrospective review processes described in subsection A of this section. Medically
unjustified days in such hospitalizations shall not be authorized for payment.

E. Mandatory lengths of stay.

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

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

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

G. For the purposes of organ transplantation, all similarly situated individuals will be treated

alike. Transplant services for kidneys [, ~~and~~] 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 [~~or~~] leukemia [, or myeloma]. Transplant services for [~~liver~~, ~~heart, and~~] any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS medical support. Inpatient hospitalization related to kidney transplantation will require preauthorization at the time of admission and, concurrently, for length of stay. Cornea transplants do not require preauthorization of the procedure, but inpatient hospitalization related to such transplants will require preauthorization for admission and, concurrently, for length of stay. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow transplant/stem cell services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists,

oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-570.

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

CERTIFIED:

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_____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

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

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

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

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

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

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

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

such admissions will be denied.

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

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

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

I. Mandatory lengths of stay.

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

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

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

K. For purposes of organ transplantation, all similarly situated individuals will be treated alike.

Transplant services for kidneys [, ~~and~~]corneas, [hearts, lungs, and livers] shall be covered for all eligible persons. High dosechemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer [~~or~~] leukemia [or myeloma]. Transplant services for [~~liver, heart, and~~] any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants

do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover: procurement costs; all hospital costs from admission to discharge for the transplant procedure; total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-570.

L. In compliance with 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of

the required DMAS forms corresponding to the procedures. The claims shall suspend for manual
review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

CERTIFIED:

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_____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

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

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

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

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

D. Outpatient psychiatric services.

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

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

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

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

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

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

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

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

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

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

E. Any procedure considered experimental is not covered.

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

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

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall

be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric facilities in excess of 21 days per
admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Payments for physician visits for inpatient days shall be limited to medically necessary inpatient hospital days.

H. (Reserved.)

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

J. (Reserved.)

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys [, ~~and~~] 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 [, ~~or]~~ leukemia [,or myeloma]. Transplant services for [~~liver, heart, and]~~ any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any

other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-570.

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.

CERTIFIED:

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Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-50-560. Liver, heart, [lung], allogeneic and autologous bone marrow transplantation [~~and any other medically necessary transplantation procedures that are determined to not be experimental or investigational (coverage for persons younger than 21 years).~~]

A. Patient selection criteria for provision of liver, heart, allogeneic and autologous bone marrow transplantation [~~and any other medically necessary transplantation procedures that are determined to not be experimental or investigational~~.]

1. The following general conditions shall apply to these services:

a. Coverage shall not be provided for procedures that are provided on an investigational or experimental basis.

b. There must be no effective alternative medical or surgical therapies available with outcomes that are at least comparable.

c. The transplant procedure and application of the procedure in treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective [~~and not experimental or investigational.~~]

d. Prior authorization by the Department of Medical Assistance Services (DMAS) is required. The prior authorization request must contain the information and documentation as required by DMAS.

2. The following patient selection criteria shall apply for the consideration of authorization and coverage and reimbursement:

~~[a. The patient must be under 21 years of age at time of surgery.]~~

[~~b~~.] The patient selection criteria of the transplant center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be pre-authorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by DMAS of information submitted by the transplant team or center.

The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

[~~(1)~~ a.] Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management;

[~~(2)~~ b.] The patient is not in an irreversible terminal state, and

[~~(3)~~ c.]The transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living.

B. Facility selection criteria for liver, heart, allogeneic and autologous bone marrow transplantation [~~and any other medically necessary transplantation procedures that are determined to not be experimental or investigational (coverage for persons younger than 21 years).~~]

1. The following general conditions shall apply:

a. Procedures may be performed out of state only when the authorized transplant cannot be performed in the Commonwealth because the service is not available or, due to capacity limitations, the transplant can not be performed in the necessary time period.

b. Criteria applicable to transplantation services and centers in the Commonwealth also apply to out-of-state transplant services and facilities.

2. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

a. The transplant program staff has demonstrated expertise and experience in the medical and surgical treatment of the specific transplant procedure;

b. The transplant surgeons have been trained in the specific transplant technique at an institution with a well established transplant program for the specific procedure;

c. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

d. The facility has staff or access to staff with expertise in tissue typing, immunological and immunosuppressive techniques;

e. Adequate blood bank support services are available;

f. Adequate arrangements exist for donor procurement services;

g. Current full membership in the United Network for Organ Sharing, for the facilities where solid organ transplants are performed;

h. Membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

i. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

j. Transplant volume at the facility is consistent with maintaining quality services;

k. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

CERTIFIED:

_____

_____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-50-570. High dose chemotherapy and bone marrow/stem cell transplantation (coverage for persons over 21 years of age).

A. Patient selection criteria for high dose chemotherapy and bone marrow/stem cell transplantation (coverage for persons over 21 years of age).

1. The following general conditions shall apply to these services:

a. This must be the most effective medical therapy available yielding outcomes that are at least comparable to other therapies.

b. The transplant procedure and application of the procedure in treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective.

c. Prior authorization by the Department of Medical Assistance Services (DMAS) is required. The prior authorization request must contain the information and documentation as required by DMAS. The nearest approved and appropriate facility will be considered.

2. The following patient selection criteria shall apply for the consideration of authorization and coverage and reimbursement for individuals who have been diagnosed with lymphoma, breast cancer , [~~or]~~ leukemia [, or myeloma] and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high dose chemotherapy and bone marrow/stem cell transplant:

a. The patient selection criteria of the transplant center where the treatment is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be preauthorized only if the selection of the patient adheres to the transplant center's patient selection criteria based upon review by DMAS of information submitted by the transplant team or center.

b. The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

(1) The patient is not in an irreversible terminal state (as demonstrated in the facility's patient selection criteria); and

(2) The transplant is likely to prolong life and restore a range of physical and social functions suited to activities of daily living.

B. Facility selection criteria for high dose chemotherapy and bone marrow/stem cell transplantation for individuals diagnosed with lymphoma, breast cancer, [~~or]~~ leukemia [, or myeloma] .

1. The following general conditions shall apply:

a. Unless it is cost effective and medically appropriate, procedures may be performed out of state only when the authorized transplant cannot be performed in the Commonwealth because the service is not available or, due to capacity limitations, the transplant cannot be performed in the necessary time period.

b. Criteria applicable to transplantation services and centers in the Commonwealth also apply to out-of-state transplant services and facilities.

2. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

a. The transplant program staff has demonstrated expertise and experience in the medical treatment of the specific transplant procedure;

b. The transplant physicians have been trained in the specific transplant technique at an institution with a well established transplant program for the specific procedure;

c. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

d. The facility has staff or access to staff with expertise in tissue typing, immunological and immunosuppressive techniques;

e. Adequate blood bank support services are available;

f. Adequate arrangements exist for donor procurement services;

g. The facility has a membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

h. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

i. Transplant volume at the facility is consistent with maintaining quality services; and

j. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

CERTIFIED:

_____

_____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

[12VAC30-50-580. Other medically necessary transplantation procedures that are determined to not be experimental or investigational (coverage for persons younger than 21 years).

A. Patient selection criteria for any other medically necessary transplantation procedures that are determined to not be experimental or investigational.

1. The following general conditions shall apply to these services:

a. Coverage shall not be provided for procedures that are provided on an investigational or experimental basis.

b. There must be no effective alternative medical or surgical therapies available with outcomes that are at least comparable.

c. The transplant procedure and application of the procedure in treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective and not experimental or investigational.

d. Prior authorization by the Department of Medical Assistance Services (DMAS) is required. The prior authorization request must contain the information and documentation as required by DMAS.

2. The following patient selection criteria shall apply for the consideration of authorization and coverage and reimbursement:

a. The patient must be under 21 years of age at time of surgery.

b. The patient selection criteria of the transplant center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be pre-authorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by DMAS of information submitted by the transplant team or center.

The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

(1) Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management;

(2) The patient is not in an irreversible terminal state, and

(3) The transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living.

B. Facility selection criteria.

1. The following general conditions shall apply:

a. Procedures may be performed out of state only when the authorized transplant cannot be performed in the Commonwealth because the service is not available or, due to capacity limitations, the transplant can not be performed in the necessary time period.

b. Criteria applicable to transplantation services and centers in the Commonwealth also apply to out-of-state transplant services and facilities.

2. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

a. The transplant program staff has demonstrated expertise and experience in the medical and surgical treatment of the specific transplant procedure;

b. The transplant surgeons have been trained in the specific transplant technique at an institution with a well established transplant program for the specific procedure;

c. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

d. The facility has staff or access to staff with expertise in tissue typing, immunological and immunosuppressive techniques;

e. Adequate blood bank support services are available;

f. Adequate arrangements exist for donor procurement services;

g. Current full membership in the United Network for Organ Sharing, for the facilities where solid organ transplants are performed;

h. Membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

i. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

j. Transplant volume at the facility is consistent with maintaining quality services;

k. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.]

CERTIFIED:

____May 2, 2000_____ ____/s/ Dennis G. Smith_____
Date Dennis G. Smith, Director
Dept. of Medical Assistance Services