12VAC30-20-80. Coordination of Title XIX with Part A and Part B of Title XVIII.

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. All individuals eligible under the state's approved Title XIX plan except qualified disabled working individuals.

2. Qualified Medicare beneficiaries provided by §301 of P.L. 100-360 as amended by §8434 of P.L. 100-647.

3. Specified low-income Medicare beneficiary (SLMB) provided by §1905(p) of the Act.

4. Qualifying Individuals-1: The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in §1902(a)(10)(E)(iv)(I) and subject to §1933 of the Act.

~~5. Qualifying Individuals-2: The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the home health provision to the individuals described in §1902(a)(10)(E)(iv)(II) and subject to §1933 of the Act.~~

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups: Qualified Disabled & Working Individuals provided by §6408 of OBRA 1989 and Qualified Medicare beneficiaries provided by §301 of P.L. 100-360 as amended by §8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance cost. Such payments are made in behalf of the following groups:

1. All individuals eligible for Title XVIII covered services.

2. Qualified Medicare beneficiaries provided by §301 of P.L. 100-360 as amended by §8434 of P.L. 100-647.

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

_____ _____

Date

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

12VAC30-20-150. Copayments and deductibles for categorically needy and QMBs for services other than under 42 CFR 447.53.

A. The following charges are imposed on the categorically needy and Qualified Medicare Beneficiaries for services other than those provided under 42 CFR447.53.

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Inpatient Hospital	$100.00	-0-	-0-	State's average daily payment of $594 is used as basis.
Outpatient Hospital Clinic	-0-	-0-	$3.00	State's average payment of $136 is used as basis.
Clinic Visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician Office Visit	-0-	-0-	$1.00	State's average payment of $23 is used as basis.
Eye Examination	-0-	-0-	$1.00	State's payment of $30 is used as basis.
Prescriptions: Generic Brand-Name	 -0- -0-	 -0- -0-	 $1.00 $3.00	State's average per generic script of ~~$18~~ $25 is used as payment basis. State's average per brand-name script of $97 is used as payment basis
Home Health Visit	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Other Physician Service	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.)	-0-	-0-	$3.00	State's average payment $78 is used as basis.

*NOTE: The applicability of copays to emergency services is discussed further in this section.

B. The method used to collect cost sharing charges for categorically needy individuals requires that providers be responsible for collecting the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers will, based on information available to them, make a determination of the recipient's ability to pay the copayment. In the absence of knowledge or indications to the contrary, providers may accept the recipient's assertion that he or she is unable to pay the required copayment.

Recipients have been notified that inability to meet a copayment at a particular time does not relieve them of that responsibility.

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The application and exclusion of cost sharing is administered through the program's MMIS. Documentation of the certified computer system delineates, for each type of provider invoice used, protected eligible groups, protected services and applicable eligible groups and services.

Providers have been informed about: copay exclusions; applicable services and amounts; prohibition of service denial if recipient is unable to meet cost-sharing changes.

E. State policy does not provide for cumulative maximums on charges.

F. Emergency Services. No recipient copayment shall be collected for the following services:

1. Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part; and

2. All services delivered in emergency rooms.

CERTIFIED:

_____ _____

Date

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

12VAC30-20-160. Copayments and deductibles for medically needy and QMBs for services other than under 42 CFR 447.53.

A. The following charges are imposed on the medically needy and Qualified Medicare Beneficiaries for services other than those provided under 42 CFR 447.53.

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Inpatient Hospital	$100.00	-0-	-0-	State's average daily payment of $594 is used as basis.
Outpatient Hospital Clinic	-0-	-0-	$3.00	State's average payment of $136 is used as basis.
Clinic Visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician Office Visit	-0-	-0-	$1.00	State's average payment of $23 is used as basis.
Eye Examination	-0-	-0-	$1.00	State's payment of $30 is used as basis.
Prescriptions: Generic Brand-Name	 -0- -0-	 -0- -0-	 $1.00 $3.00	State's average per generic script of ~~$18~~ $25 is used as payment basis. State's average per brand-name script of $97 is used as payment basis
Home Health Visit	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Other Physician Service	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.)	-0-	-0-	$3.00	State's average payment $78 is used as basis.

*NOTE: The applicability of copays to emergency services is discussed further in this section.

B. The method used to collect cost sharing charges for medically needy individuals requires that providers be responsible for collecting the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers will, based on information available to them, make a determination of the recipient's ability to pay the copayment. In the absence of knowledge or indications to the contrary, providers may accept the recipient's assertion that he or she is unable to pay the required copayment.

Recipients have been notified that inability to meet a copayment at a particular time does not relieve them of that responsibility.

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR § 447.53(b) are described below:

The application and exclusion of cost sharing is administered through the program's MMIS. Documentation of the certified computer system delineates, for each type of provider invoice used, protected eligible groups, protected services and applicable eligible groups and services.

Providers have been informed about: copay exclusions; applicable services and amounts; prohibition of service denial if recipient is unable to meet cost-sharing changes.

E. State policy does not provide for cumulative maximums.

F. Emergency Services. No recipient copayment shall be collected for the following services:

1. Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part; and

2. All services delivered in emergency rooms.

CERTIFIED:

_____ _____

Date

Patrick W. Finnerty, 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~~ 5 sessions, ~~with one possible~~ ,without prior authorization during the first treatment year. An additional extension ~~(subject to DMAS' approval)~~ of 26 sessions during the first treatment year ~~of treatment~~ must be prior authorized by DMAS. 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.*

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, 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 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. 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 authorization for the admission, to demonstrated 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;

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

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.

*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.

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

_____ _____

Date

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

12VAC30-50-150. Medical care by other licensed practitioners within the scope of their practice as defined by state law.

A. Podiatrists' services.

1. Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by state law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity or for utilization control, or both.

B. Optometrists' services. Diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services are not provided.

D. Other practitioners' services; psychological services, psychotherapy. Limits and requirements for covered services are found under Outpatient Psychiatric Services (see 12VAC30-50-140 D).

1. These limitations apply to psychotherapy sessions provided, within the scope of their licenses, by licensed clinical psychologists or licensed clinical social workers/licensed professional counselors/licensed clinical nurse specialists-psychiatric who are either independently enrolled or under the direct supervision of a licensed clinical psychologist. Psychiatric services are limited to an initial availability of ~~26~~ 5 sessions~~, with one possible extension of 26 sessions during the first year of treatment.~~ without prior authorization. An additional extension of 26 sessions during the first year of treatment must be prior authorized by DMAS. The availability is further restricted to no more than 26 sessions each succeeding treatment year when ~~approved by the Psychiatric Review Board.~~ authorized by DMAS. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

2. Psychological testing is covered when provided, within the scope of their licenses, by licensed clinical psychologists or licensed clinical social workers/licensed professional counselors/licensed clinical nurse specialists-psychiatric who are either independently enrolled or under the direct supervision of a licensed clinical psychologist.

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

Date

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

12VAC30-50-160. Home health services.

A. Service must be ordered or prescribed and directed or performed within the scope of a license of a practitioner of the healing arts. Home health services shall be provided in accordance with guidelines found in the Virginia Medicaid Home Health Manual.

B. Nursing services provided by a home health agency.

1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

2. Patients may receive up to ~~32~~ five visits by a licensed nurse annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services. Payment shall not be made for additional service unless authorized by DMAS.

C. Home health aide services provided by a home health agency.

1. Home health aides must function under the supervision of a registered nurse.

2. Home health aides must meet the certification requirements specified in 42 CFR 484.36.

3. For home health aide services, patients may receive up to 32 visits annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.

D. Physical therapy, occupational therapy, or speech pathology services and audiology services provided by a home health agency or medical rehabilitation facility.

1. Service covered only as part of a physician's plan of care.

2. Patients may receive up to ~~24~~ five visits for each rehabilitative therapy service ordered annually without authorization. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

E. The following services are not covered under the home health services program:

1. Medical social services;

2. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private-duty nursing services, or items of comfort which have no medical necessity, such as television;

3. Community food service delivery arrangements;

4. Domestic or housekeeping services which are unrelated to patient care and which materially increase the time spent on a visit;

5. Custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care; and

6. Services related to cosmetic surgery.

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

_____ _____

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

12VAC30-50-460. Case management services for the elderly. REPEALED.

~~A. Target Group: Persons age 60 and over who have been screened through a Case Management Pilot Project approved by the Long-Term Care Council and found to be dependent in 2 or more of the following activities of daily living: (a) bathing, (b) dressing, (c) toileting, (d) transferring, (e) continence, or (f) eating.~~

~~B. Services will be provided only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:~~

~~a. Fairfax County, and the cities of Falls Church and Fairfax;~~

~~b. Planning Districts 1, 2, 3 (except for Washington County and the City of Bristol), 4, 17, 18, 22, 23.~~

~~C. Comparability of Services. Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.~~

~~D. Definition of Services:~~

~~1. Assessment: Determining client's service needs, which include psychosocial, nutritional and medical.~~

~~2. Service Planning: Developing an individualized description of what services and resources are needed to meet the service needs of the client and help access those resources.~~

~~3. Coordination & Referral: Assisting the client in arranging for appropriate services and ensuring continuity of care.~~

~~4. Follow-up & Monitoring: Assessing ongoing progress, ensuring services are delivered, and periodically reassessing need to determine appropriate revisions to the case management plan of care.~~

~~E. Qualifications of Providers. To qualify as a provider of case management for the elderly, the provider of services must ensure that claims are submitted for payment only when the services were performed by case managers meeting these qualifications. The case manager must possess a combination of work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The case manager must have these knowledge, skills, and abilities at the entry level which must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).~~

~~1. Knowledge of:~~

~~a. Aging and the impact of disabilities and illnesses on aging;~~

~~b. Conducting client assessments (including psychosocial, health and functional factors) and their uses in care planning;~~

~~c. Interviewing techniques;~~

~~d. Consumers' rights;~~

~~e. Local human and health service delivery systems, including support services and public benefits eligibility requirements;~~

~~f. The principles of human behavior and interpersonal relationships;~~

~~g. Effective oral, written, and interpersonal communication principles and techniques;~~

~~h. General principles of record documentation;~~

~~i. Service planning process and the major components of a service plan.~~

~~2. Skills in:~~

~~a. Negotiating with consumers and service providers;~~

~~b. Observing, recording and reporting behaviors;~~

~~c. Identifying and documenting a consumer's needs for resources, services and other assistance;~~

~~d. Identifying services within the established services system to meet the consumer's needs;~~

~~e. Coordinating the provision of services by diverse public and private providers;~~

~~f. Analyzing and planning for the service needs of elderly persons;~~

~~3. Abilities to:~~

~~a. Demonstrate a positive regard for consumers and their families;~~

~~b. Be persistent and remain objective;~~

~~c. Work as a team member, maintaining effective inter- and intra-agency working relationships;~~

~~d. Work independently, performing position duties under general supervision;~~

~~e. Communicate effectively, verbally and in writing.~~

~~f. Develop a rapport and to communicate with different types of persons from diverse cultural backgrounds;~~

~~g. Interview.~~

~~4. Individuals meeting all the above qualifications shall be considered a qualified case manager; however, it is preferred that the case manager possess a minimum of an undergraduate degree in a human services field, or be a licensed nurse. In addition, it is preferable that the case manager have two years of satisfactory experience in the human services field working with the elderly.~~

~~F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.~~

~~1. Eligible recipients will have free choice of the providers of case management services.~~

~~2. Eligible recipients will have free choice of the providers of other medical care under the plan.~~

~~G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.~~

~~H. Case Management services to the elderly shall be limited to no more than 6 months without authorization from the Department of Medical Assistance Services.~~

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

_____ _____

Date

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

12VAC30-60-70. Utilization control: Home health services.

A. Home health services which meet the standards prescribed for participation under Title XVIII, excluding any homebound standard, will be supplied.

B. Home health services shall be provided by a ~~licensed~~ home health agency that is certified by Medicare, licensed by the Virginia Department of Health (VDH) and accredited either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Community Health Accreditation Program (CHAP). Services shall be provided on a part-time or intermittent basis to a recipient in his place of residence. The place of residence shall not include a hospital or nursing facility. Home health services must be prescribed by a physician and be part of a written plan of care which the physician shall review, sign, and date at least every 60 days.

C. Covered services. Any one of the following services may be offered as the sole home health service and shall not be contingent upon the provision of another service.

1. Nursing services;

2. Home health aide services;

3. Physical therapy services;

4. Occupational therapy services; or

5. Speech-language pathology services.

D. General conditions. The following general conditions apply to skilled nursing, home health aide, physical therapy, occupational therapy, and speech-language pathology services provided by home health agencies.

1. The patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license. The physician may be the patient's private physician or a physician on the staff of the home health agency or a physician working under an arrangement with the institution which is the patient's residence or, if the agency is hospital-based, a physician on the hospital or agency staff.

2. Services shall be furnished under a written plan of care and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of care and must be related to the patient's condition. The initial plan of care must be reviewed, signed, and dated by the attending physician, or physician designee, no later than 21 days after the implementation of the plan of care.

3. A physician recertification shall be required at intervals of at least once every 60 days, must be signed and dated by the physician who reviews the plan of care, and should be obtained when the plan of care is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long home health services will be needed.

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

5. A written physician's statement located in the medical record must certify that:

a. The patient needs licensed nursing care, home health aide services, physical or occupational therapy, or speech-language pathology services;

b. A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and

c. These services were furnished while the individual was under the care of a physician.

6. The plan of care shall contain at least the following information:

a. Diagnosis and prognosis;

b. Functional limitations;

c. Orders for nursing or other therapeutic services;

d. Orders for home health aide services, when applicable;

e. Orders for medications and treatments, when applicable;

f. Orders for special dietary or nutritional needs, when applicable; and

g. Orders for medical tests, when applicable, including laboratory tests and x-rays.

E. Utilization review shall be performed by DMAS to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Such post payment review audits may be unannounced. Services not specifically documented in patients' medical records as having been rendered shall be deemed not to have been rendered and no reimbursement shall be provided.

F. All services furnished by a home health agency, whether provided directly by the agency or under arrangements with others, must be performed by appropriately qualified personnel. The following criteria shall apply to the provision of home health services:

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

2. Home health aide services. Home health aides must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aide services may include assisting with personal hygiene, meal preparation and feeding, walking, and taking and recording blood pressure, pulse, and respiration. Home health aide services must be provided under the general supervision of a registered nurse. A recipient may not receive duplicative home health aide and personal care aide services.

3. Rehabilitation services. Services shall be specific and provide effective treatment for patients' conditions in accordance with accepted standards of medical practice. The amount, frequency, and duration of the services shall be reasonable. Rehabilitative services shall be provided with the expectation, based on the assessment made by physicians of patients' rehabilitation potential, that the condition of patients will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with the specific diagnosis.

a. Physical therapy services shall be directly and specifically related to an active written plan of care designed and personally signed and dated by a physician after any needed consultation with a physical therapist licensed by the Board of Physical Therapy. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Physical Therapy, or a physical therapy assistant who is licensed by the Board of Physical Therapy and is under the direct supervision of a physical therapist licensed by the Board of Physical Therapy. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This supervisory visit shall not be reimbursable.

b. ~~Occupational therapy services shall be directly and specifically related to an active written plan of care designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This supervisory visit shall not be reimbursable.~~

Occupational therapy services shall be directly and specifically related to an active written plan of care designed by a physician after any needed consultation with an occupational therapist registered and licensed by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and licensed by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine, or an occupational therapy assistant who is certified by the National Board for Certification in Occupational Therapy under the

direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant, such services shall be provided under the supervision of a qualified occupational therapist, as defined above, who makes an onsite supervisory visit at least once every 30 days. This supervisory visit shall not be reimbursable.

c. Speech-language pathology services shall be directly and specifically related to an active written plan of care designed and personally signed and dated by a physician after any needed consultation with a speech-language pathologist licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology.

4. A visit shall be defined as the duration of time that a nurse, home health aide, or rehabilitation therapist is with a client to provide services prescribed by a physician and that are covered home health services. Visits shall not be defined in measurements or increments of time.

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

_____ _____

Date

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

12VAC30-110-1210. Twelve-month extension of eligibility for medical assistance. REPEALED.

~~A. Requirements. Notwithstanding any provision of the State Plan for Medical Assistance, each family which was receiving AFDC as a participant in VIEW immediately preceding the month in which such family becomes ineligible for AFDC shall, subject to these provisions and without any reapplication for benefits, remain eligible for medical assistance for up to 12 consecutive months immediately succeeding AFDC termination. Individuals who have been eligible for the entire first six months may be eligible for continuation of transitional medical assistance for the second six months if they meet the additional eligibility requirements listed in subdivision C 2 of this section.~~

~~B. Notice of benefits. In the notice of termination of AFDC benefits sent to a family meeting the requirements of subsection A of this section, the local department of social services shall notify the family of its right to transitional medical assistance and include in such notice a description of the reporting requirements of 12VAC30-110-1230 B and the circumstances described in this section under which such transitional assistance may be terminated.~~

~~C. Eligibility for medical assistance under VIEW.~~

~~1. First six-month period. A participant of VIEW whose AFDC is terminated, either voluntarily or involuntarily, shall receive medical assistance, including transitional medical assistance for families with a working parent who becomes ineligible for AFDC financial assistance because of increased earnings, unless:~~

~~a. The family ceases to include a child, or~~

~~b. The caretaker-relative refuses to apply for health coverage offered by an employer as provided in 12VAC30-110-1220 B.~~

~~2. Second six-month period. For families who received medical assistance during the entire first six-month period under subdivision C 1 of this section, the following applies.~~

~~a. Subject to subdivisions 2 b and c of this subsection, assistance to a family during the second six-month period shall terminate at the close of the first month in which:~~

~~(1) No child resides with the family, whether or not the child is (or would, if needy, be) a dependent child under AFDC;~~

~~(2) The family income exceeds 185% of the federal poverty level during the immediately preceding three-month period;~~

~~(3) The caretaker relative fails to meet the reporting requirements specified in 12VAC30-110-1230 B. Medical assistance under this provision shall terminate at the close of the sixth, eighth or eleventh month of the 12-month period if the family fails to make the required report to the local department of social services, by the deadline specified in 12VAC30-110-1230 B, unless the family has established good cause for the failure to report on a timely basis.~~

~~b. Written notice before termination. No termination of assistance under these provisions shall become effective until the local department of social services provides the family with notice of the grounds for the termination.~~

~~c. Continuation in certain cases until redetermination.~~

~~(1) If a child is ineligible to receive transitional medical assistance under this section, but may be eligible for assistance under the State Plan for Medical Assistance because the child is described in clause (i) of §1905(a) of the Social Security Act (42 USC §1396d(a)) or clause (i)(IV), (i)(VI), (i)(VII), or (ii)(IX) of §1902(a)(10)(A) of the Social Security Act (42 USC §1396a(a)(10)(A)), the local department of social services shall not discontinue transitional medical assistance until that department has determined that the child is ineligible for medical assistance under the State Plan for Medical Assistance.~~

~~(2) If an individual ceases to receive transitional medical assistance under this section, but may be eligible for medical assistance under the State Plan for Medical Assistance because the individual is within a category of person for which medical assistance under the State Plan for Medical Assistance is available under §1902(a)(10)(A) or (C) of the Social Security Act (42 USC §1396a(a)(10)(A) or (C)), the local department of social services shall not discontinue transitional assistance until that department determines that the individual is ineligible for medical assistance under the State Plan for Medical Assistance.~~

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

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Date

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

12 VAC 30-120-50. Personal care services.

The following requirements govern the provision of personal care services.

A. General. Personal care services may be offered to individuals as an alternative to institutional care. Personal care may be offered either as the sole home and community-based care service that avoids institutionalization or in conjunction with adult day health care, respite care, or PERS.

Recipients may continue to work or attend post-secondary school, or both, while they receive services under this waiver. The personal care attendant who assists the recipient may accompany that person to work or school or both and may assist the person with personal needs while the individual is at work or school or both. DMAS will also pay for any personal care services that the attendant gives to the enrolled recipient to assist him in getting ready for work or school or both or when he returns home.

DMAS will review the recipient's needs and the complexity of the disability when determining the services that will be provided to the recipient in the workplace or school or both.

DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973. For example, if the recipient's only need is for assistance during lunch, DMAS would not pay for the attendant to be with the recipient for any hours extending beyond lunch. For a recipient whose speech is such that they cannot be understood without an interpreter (not translation of a foreign language), or the recipient is physically unable to speak or make himself understood even with a communication device, the attendant's services may be necessary for the length of time the recipient is at work or school or both. DMAS will reimburse for the attendant's services unless the attendant is required to assist the recipient for the length of time the recipient is at work or school or both as a part of the ADA or the Rehabilitation Act.

The provider agency must develop an individualized plan of care that addresses the recipient's needs at home and work and in the community.

DMAS will not pay for the attendant to assist the enrolled recipient with any functions related to the recipient completing his job or school functions or for supervision time during work or school or both.

B. Special provider participation conditions. The personal care provider shall:

1. Operate from a business office.;

2. Employ (or subcontract with) and directly supervise a registered nurse who will provide ongoing supervision of all personal care aides.

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

b. The registered nurse shall have a satisfactory work record, as evidenced by two references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

c. The registered nurse supervisor shall make an initial home assessment visit on or before the start of care for all new recipients admitted to personal care, when a recipient is readmitted after being discharged from services, or if he is transferred to another provider or ADHC.

d. The registered nurse supervisor shall make supervisory visits as often as needed, but no fewer visits than provided as follows, to ensure both quality and appropriateness of services.

(1) A minimum frequency of these visits is every 30 days for recipients with a cognitive impairment and every ~~60~~ 90 days for recipients who do not have a cognitive impairment.

(2) The initial home assessment visit by the registered nurse shall be conducted to create the plan of care and assess the recipient's needs. The registered nurse shall return for a follow-up visit within 30 days after the initial visit to assess the recipient's needs and make a final determination that there is no cognitive impairment. This determination must be documented in the recipient's record by the registered nurse. Recipients who are determined to have a cognitive impairment will continue to have supervisory visits every 30 days.

(3) If there is no cognitive impairment, the registered nurse may give the recipient or caregiver or both the option of having the supervisory visit every ~~60~~ 90 days or any increment in between, not to exceed ~~60~~ 90 days. The registered nurse must document in the recipient's record this conversation and the option that was chosen.

(4) The provider agency has the responsibility of determining if 30-day registered nurse supervisory visits are appropriate for the recipient. The provider agency may offer the extended registered nurse visits, or the agency may choose to continue the 30-day supervisory visits based on the needs of the individual. The decision must be documented in the recipient's record.

(5) If a recipient's personal care aide is supervised by the provider's registered nurse less often than every 30 days and DMAS or the designated preauthorization contractor determines that the recipient's health, safety or welfare is in jeopardy, DMAS, or the designated preauthorization contractor, may require the provider's registered nurse to supervise the personal care aide every 30 days or more frequently than what has been determined by the registered nurse. This will be documented and entered in the recipient's record.

e. During visits to the recipient's home, a registered nurse shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to

the recipient's current functioning status, medical, and social needs. The personal care aide's record shall be reviewed and the recipient's (or family's) satisfaction with the type and amount of service discussed. The registered nurse summary shall note:

(1) Whether personal care services continue to be appropriate,

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

(3) Any special tasks performed by the aide and the aide's qualifications to perform these tasks~~,~~;

(4) Recipient's satisfaction with the service~~,~~;

(5) Hospitalization or change in the medical condition or functioning status~~,~~ of the recipient;

(6) Other services received by the recipient and the amount~~,~~; and

(7) The presence or absence of the aide in the home during the registered nurse's visit.

f. A registered nurse shall be available to the personal care aide for conference pertaining to individuals being served by the aide and shall be available to aides by telephone at all times that the aide is providing services to personal care recipients.

g. The registered nurse supervisor shall evaluate the aides' performance and the recipient's needs to identify any insufficiencies in the aides' abilities to function competently and shall provide training as indicated. This shall be documented in the recipient's record.

h. If there is a delay in the registered nurses’ supervisory visits, because the recipient was unavailable, the reason for the delay must be documented in the recipient’s record.

3. Employ and directly supervise personal care aides who provide direct care to personal care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with qualifications required by DMAS. Each aide shall:

a. Be able to read and write~~.~~ in English to the degree necessary to perform the expected tasks;

b. Complete a minimum of 40 hours of training consistent with DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards~~.~~;

c. Be physically able to do the work~~.~~;

d. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record

check shall be available for review by DMAS staff who are authorized by the agency to review these files;

e. Not be: (i) the parents of minor children who are receiving waiver services or (ii) spouses of individuals who are receiving waiver services; and

f. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care. These family members must meet the same requirements as aides who are not family members.

C. Required documentation ~~in~~ for recipients' records. The provider agency shall maintain all records of each personal care recipient. These records shall be separate from those of nonhome and community-based care services, such as companion or home health services. These records shall be reviewed periodically by the DMAS staff who are authorized by the agency to review these files. At a minimum the record shall contain:

1. The most recently updated Long-Term Care Uniform Assessment Instrument, the Medicaid-Funded Long-Term Care Service Authorization form (DMAS-96), the Screening Team Service Plan ~~of~~ for Medicaid-Funded Long-Term Care (DMAS-97), all provider agency plans of care, and all Patient Information forms (DMAS-122);

2. The initial assessment by a registered nurse completed prior to or on the date that services are initiated~~.~~;

3. Registered nurses' notes recorded and dated during significant contacts with the personal care aide and during supervisory visits to the recipient's home~~.~~;

4. All correspondence to the recipient, DMAS~~.~~, and the designated preauthorization contractor;

5. Reassessments made during the provision of services~~.~~;

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

7. All personal care aide records. The personal care aide record shall contain:

a. The specific services delivered to the recipient by the aide and the recipient's responses~~,~~ to this service;

b. The aide's daily arrival and departure times~~,~~;

c. The aide's weekly comments or observations about the recipient, including observations of the recipient's physical and emotional condition, daily activities, and responses to services rendered~~,~~; and

d. The aide's and recipient's or responsible caregiver’s weekly signatures, including the date, to verify that personal care services have been rendered during that week as documented in the record. An employee of the provider cannot sign for the recipient unless he is a family member of the recipient;

Signatures, times and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.; and

8. All recipient progress reports.

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

Date

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

12VAC30-120-490. Definitions.

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

"Committee for recipient" means a person who has been legally invested with the authority, and charged with the duty of managing the estate or making decisions to promote the well-being of a person who has been determined by the circuit court to be totally incapable of taking care of his person or handling and managing his estate because of mental illness or mental retardation. A committee shall be appointed only if the court finds that the person's inability to care for himself or handle and manage his affairs is total.

"Current functional status" means the individual's degree of dependency in performing activities of daily living (ADL).

"DMAS" means the Department of Medical Assistance Services.

"DRS" means the Department of Rehabilitative Services. DRS currently operates the Personal Assistance Services Program, which is a state-funded program that provides a limited amount of personal care services to Virginians.

"DSS" means the Department of Social Services.

<u>“Family or caregiver” means a spouse, parent, adult child, or guardian. A family or caregiver may direct the care on behalf of the recipient if a recipient is incapable of directing his own care.</u>

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

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

"Home and community-based care" means a variety of in-home and community-based services reimbursed by DMAS (personal care, adult day health care, respite care, and assisted living,) authorized under a Social Security Act §1915(c) waiver designed to offer

individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services in order to avoid nursing facility placement. The Nursing Home Preadmission Screening Team or DMAS shall give prior authorization for any Medicaid-funded home and community-based care.

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

"Nursing Home Preadmission Screening (NHPAS)" means the process to (i) evaluate the medical, nursing, and social needs of individuals referred for preadmission screening, (ii) analyze what specific services the individuals need, (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs, and (iv) authorize Medicaid funded nursing facility or community-based care for those individuals who meet nursing facility level of care and require that level of care.

"Nursing Home Preadmission Screening Team" means the entity contracted with DMAS which is responsible for performing nursing home preadmission screening. For individuals in the community, this entity is a committee comprised of staff from the local health department and local DSS. For individuals in an acute care facility who require screening, the entity is a team of nursing and social work staff. A physician shall be a member of both the local committee or acute care team.

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

"Personal attendant" means, for purposes of this part and exemption from Worker's Compensation, a domestic servant. Consumers shall be restricted from employing more than two personal attendants simultaneously at any given time.

"Personal attendant services" or "PAS" means long-term maintenance or support services necessary to enable the mentally alert and competent individual to remain at or return home rather than enter a nursing care facility. Personal attendant services include hands-on care specific to the needs of a medically stable, physically disabled individual. Personal attendant services include assistance with ADLs, bowel/bladder programs, range of motion exercises, routine wound care which does not include sterile technique, and

external catheter care as further defined in the Consumer-Directed PAS Manual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical function. When specified, supportive services may include assistance with IADLs which are incidental to the care furnished, or which are essential to the health and welfare of the recipient. Personal attendant services shall not include either practical or professional nursing services as defined in Chapters 30 and 34 of Title 54.1 of the Code of Virginia, as appropriate.

"Plan of care" or "POC" means the written plan of services certified by the screening team physician and approved by DMAS as needed by the individual to ensure optimal health and safety for the delivery of home and community-based care.

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

"Service coordination provider" means the provider contracted by DMAS that is responsible for ensuring that the assessment, development and monitoring of the plan of care, management training, and review activities as required by DMAS are accomplished. Individuals employed by the service coordination provider shall meet the knowledge, skills, and abilities as further defined in this part.

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

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire which assesses an individual's social, physical health, mental health, and functional abilities. The UAI is used to gather information for the determination of an individual's care needs and service eligibility, and for planning and monitoring an individual's care across various agencies for long-term care services.

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

_____ _____

Date

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

12VAC30-120-500. General coverage and requirements for consumer-directed PAS as a home and community-based care waiver service.

A. Coverage statement. Coverage of consumer-directed PAS shall be provided under the administration of the DMAS to disabled and elderly individuals who must be mentally alert and have no cognitive impairments who would otherwise require the level of care provided in a nursing facility. Individuals must be able to manage their own affairs without help from another individual ~~and not have a guardian or committee. If disabled, individuals receiving services must be at least 18 years of age.~~ Individuals eligible for consumer-directed PAS must have the capability to hire and train their own personal attendants and supervise the attendant's performance. If a recipient is incapable of directing his own care, a spouse, parent, adult child, or guardian may direct the care on behalf of the recipient.

B. Individuals receiving services under this waiver must meet the following requirements:

1. Individuals receiving services under this waiver must be eligible under one of the following eligibility groups: aged, blind or disabled recipients eligible under 42 CFR 435.121, and the special home and community-based waiver group at 42 CFR 435.217 which includes individuals who would be eligible under the State Plan if they were institutionalized.

2. Under this waivered service, the coverage groups authorized under §1902(a)(10)(C)(i)(III) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules.

3. Virginia shall reduce its payment for home and community-based care services provided for an individual by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made according to the guidelines in 42 CFR 435.735. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after deducting the amounts as specified in 42 CFR 435.726, listed below:

a. For individuals to whom §1924(d) applies and for whom Virginia waives the requirement for comparability pursuant to §1902(a)(10)(B), deduct the following in the respective order:

(1) An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a non-institutionalized individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the

following limits: (i) for individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for individuals employed at least eight but less than 20 hours, earned income shall be disregarded up to a maximum of 200% of SSI. However, in no case, shall the total amount of income (both earned and unearned) disregarded for maintenance exceed 300% of SSI.

(2) For an individual with only a spouse at home, the community spousal income allowance determined in accordance with §1924(d) of the Social Security Act.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with §1924(d) of the Social Security Act.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but covered under the Plan.

b. For individuals to whom §1924(d) does not apply, deduct the following in the respective order:

(1) An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a non-institutionalized individual. Working individuals have a greater need due to expenses of employment; therefore, an additional amount of income shall be deducted. Earned income shall be deducted within the following limits: (i) for individuals employed 20 hours or more, earned income shall be disregarded up to a maximum of 300% of SSI and (ii) for individuals employed at least eight but less than 20 hours, earned income shall be disregarded up to a maximum of 200% of SSI. However, in no case, shall the total amount of income (both earned and unearned) disregarded for maintenance exceed 300% of SSI.

(2) For an individual with a family at home, an additional amount for the maintenance needs of the family which shall be equal to the medically needy income standard for a family of the same size.

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but covered under the state Medical Assistance Plan.

C. Assessment and authorization of home and community-based care services.

1. To ensure that Virginia's home and community-based care waiver programs serve only individuals who would otherwise be placed in a nursing facility, home and community-based care services shall be considered only for individuals who are seeking nursing

facility admission or for individuals who are at imminent risk of nursing facility admission in the near future. "Imminent risk" is defined as within one month. Home and community-based care services shall be the critical service that enables the individual to remain at home rather than being placed in a nursing facility.

2. The individual's status as an individual in need of home and community-based care services shall be determined by the NHPAS Team after completion of a thorough assessment of the individual's needs and available support. Screening and preauthorization of home and community-based care services by the NHPAS Team or DMAS staff is mandatory before Medicaid will assume payment responsibility of home and community-based care services.

3. An essential part of the NHPAS Team's assessment process is determining the level of care required by applying existing criteria for nursing facility care according to established nursing home preadmission screening processes.

4. The team shall explore alternative settings or services to provide the care needed by the individual. If nursing facility placement or a combination of other services are determined to be appropriate, the screening team shall initiate referrals for service. If Medicaid-funded home and community-based care services are determined to be the critical service to delay or avoid nursing facility placement, the screening team shall develop an appropriate plan of care and initiate referrals for service.

5. The annual cost of care for home and community-based care services for a recipient shall not exceed the average annual cost of nursing facility care. For purposes of this subdivision, the annual cost of care for home and community-based care services for a recipient shall include all costs of all Medicaid covered services which would actually be received by the recipient. The average annual cost of nursing facility care shall be determined by DMAS and shall be updated annually.

6. Home and community-based care services shall not be provided to any individual who resides in a board-and-care facility or adult care residences (ACRs) nor who is an inpatient in general acute care hospitals, skilled or intermediate nursing facilities, or intermediate care facilities for the mentally retarded. Additionally, home and community-based care services shall not be provided to any individual who resides outside of the physical boundaries of the Commonwealth, with the exception of brief periods of time as approved by DMAS. Brief periods of time may include, but are not necessarily restricted to, vacation or illness.

7. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by the NHPAS Team.

8. Any authorization and POC for home and community-based care services will be subject to the approval of DMAS prior to Medicaid reimbursement for waiver services.

12VAC30-120-520. Personal attendant services (PAS).

A. Consumer-directed PAS may be offered to individuals in their homes as an alternative to more costly institutional nursing facility care. When the individual referred for consumer-directed PAS is already receiving another home and community-based care service, the DMAS utilization review staff shall assess the individual to determine the eligibility for consumer-directed PAS and authorize it if necessary to avoid more costly nursing facility care. In no event shall the services exceed cost effectiveness for this individual.

B. In addition to the general requirements above, to be enrolled as a Medicaid service coordination provider and maintain provider status, the following requirements shall be met:

1. The service coordination provider shall operate from a business office.

2. The service coordination provider must have sufficient qualified staff who will function as service coordinators to perform the needed POC development and monitoring, reassessments, service coordination, and support activities as required by the Consumer-Directed Personal Attendant Services Program.

3. It is preferred that the individual employed by the service coordination provider possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth of Virginia. In addition, it is preferable that the individual have two years of satisfactory experience in the human services field working with persons with severe physical disabilities or the elderly. The individual shall possess a combination of work experience and relevant education which indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be documented on the application form, found in supporting documentation. or observed during the interview. Observations during the interview must be documented. The knowledge, skills, and abilities shall include, but not necessarily be limited to:

a. Knowledge of:

(1) Types of functional limitations and health problems that are common to different disability types and the aging process, as well as strategies to reduce limitations and health problems;

(2) Physical assistance typically required by people with severe physical disabilities or elderly persons, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications commonly used and required by people with physical disabilities or elderly persons which reduces the need for human help and improves safety;

(4) Various long-term care program requirements, including nursing home and adult care residence placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance services;

(5) DMAS consumer directed personal attendant services program requirements, as well as the administrative duties for which the recipient will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;

(7) Interviewing techniques;

(8) The recipient's right to make decisions about, direct the provisions of, and control his attendant care services, including hiring, training, managing, approving time sheets, and firing an attendant;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with recipients and service providers;

(2) Observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to persons with severe disabilities or elderly persons; and

(4) Identifying services within the established services system to meet the recipient's needs;

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for persons who have visual impairments;

(2) Demonstrate a positive regard for recipients and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, verbally and in writing; and

(6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds.

4. If the service coordinator staff employed by the service coordination provider is not a registered nurse, the service coordination provider must have registered nurse (RN) consulting services available, either by a staffing arrangement or through a contracted consulting arrangement. The RN consultant is to be available as needed to consult with recipients/service coordination providers on issues related to the health needs of the recipient.

5. Service coordination provider duties.

a. The service coordination provider must make an initial, comprehensive home visit to develop the POC with the recipient or family or caregiver and provide management training. Recipients or family or caregiver who cannot receive management training at the time of the initial visit must receive management training within seven days of the initial visit. After the initial visit, two routine onsite visits must occur in the recipient's home within 60 days of the initiation of care or the initial visit to monitor the POC. The service coordination provider will continue to monitor the POC on an as needed basis, not to exceed a maximum of one routine onsite visit every 30 days but no less than the minimum of one routine onsite visit every 90 days per recipient. The initial comprehensive visit is done only once upon the recipient's entry into the program. If a waiver recipient changes service coordination provider agencies the new service coordination provider shall bill for a reassessment in lieu of a comprehensive visit.

b. A reevaluation of the recipient's level of care will occur six months after initial entry into the program, and subsequent reevaluations will occur at a minimum of every six months. During visits to the recipient's home, the service coordination provider shall observe, evaluate and document the adequacy and appropriateness of personal attendant services with regard to the recipient's current functioning and cognitive status, medical and social needs. The service coordination provider shall discuss the recipient's satisfaction with the type and amount of service. The service coordination provider's summary shall include, but not necessarily be limited to:

(1) Whether personal attendant services continue to be appropriate and medically necessary to prevent institutionalization;

(2) Whether the POC is adequate to meet the needs of the recipient;

(3) Any special tasks performed by the attendant and the attendant's qualifications to perform these tasks;

(4) Recipient's or family or caregiver satisfaction with the service;

(5) Hospitalization or change in medical condition, functioning or cognitive status;

(6) Other services received and their amount; and

(7) The presence or absence of the attendant in the home during the service coordinator's visit.

5. The service coordination provider shall be available to the recipient by telephone.

6. The service coordination provider will submit a criminal record check pertaining to the personal attendant on behalf of the recipient and report findings of the criminal record check to the recipient or family or caregiver. Personal attendants will not be reimbursed for services provided to the recipient effective with the date the criminal record check confirms a personal attendant has been found to have been convicted of a crime as described in 12VAC30-90-180.

7. The service coordination provider shall verify biweekly timesheets signed by the recipient or family or caregiver and the personal attendant to ensure the number of approved hours on the POC are not exceeded. If discrepancies are identified, the service coordination provider will contact the recipient or family or caregiver to resolve discrepancies and will notify the fiscal agent. If a recipient or family or caregiver is consistently being identified as having discrepancies in his timesheets, the service coordination provider will contact DMAS to resolve the situation. Service coordination providers shall not verify timesheets for personal attendants who have been convicted of crimes described in 12VAC30-90-180 and will notify the fiscal agent.

C. The service coordination provider shall maintain a personal attendant registry. The registry shall contain names of persons who have experience with providing personal attendant services or who are interested in providing personal attendant services. The registry shall be maintained as a supportive source for the recipient who may use the registry to obtain names of potential personal attendants.

D. The service coordination provider shall maintain all records of each consumer-directed PAS recipient. At a minimum these records shall contain:

1. All copies of the completed UAIs, the Long-Term Care Preadmission Screening Authorization (DMAS-96), all plans of care, and all DMAS-122's.

2. All DMAS utilization review forms.

3. Service coordination provider's notes contemporaneously recorded and dated during any contacts with the recipient and during visits to the recipient's home.

4. All correspondence to the recipient and to DMAS.

5. Reassessments made during the provision of services.

6. Records of contacts made with family, physicians, DMAS, formal, informal service providers and all professionals concerning the recipient.

7. All training provided to the personal attendant or attendants on behalf of the recipient.

8. All recipient progress reports, as specified in subsection E of this section.

9. All management training provided to the recipients or family or caregivers, including the recipient's or family or caregiver's responsibility for the accuracy of the timesheets.

E. The service coordination provider is required to submit to DMAS biannually, for every recipient, a recipient progress report, an updated UAI, and any monthly visit/progress reports. This information is used to assess the recipient's ongoing need for Medicaid-funded long-term care and appropriateness and adequacy of services rendered.

F. Recipients or family or caregiver will hire their own personal attendants and manage and supervise the attendants' performance.

1. Attendant qualifications include, but shall not be necessarily limited to the following requirements. The attendant must:

a. Be 18 years of age or older;

b. Have the required skills to perform attendant care services as specified in the recipient's POC;

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

d. Possess a valid social security number;

e. Submit to a criminal records check. The personal attendant will not be compensated for services provided to the recipient if the records check verifies the personal attendant has been convicted of crimes described in 12VAC30-90-180;

f. Be willing to attend training at the recipient's or family or caregiver's request;

g. Understand and agree to comply with the DMAS Consumer-Directed PAS Program requirements; and

h. Be willing to register in a personal attendant registry, which will be maintained by the provider agency chosen by the recipient.

2. Restrictions. Attendants shall not be ~~members of the recipients' family. Family is defined as a parent or stepparent, spouse, children or stepchildren, siblings or stepsiblings, grandparents or stepgrandparents, grandchildren, or stepgrandchildren~~. a parent or step-parent of a minor child or a recipient's spouse. In addition, anyone who has legal guardianship or is a committee for the recipient shall also be prohibited from being an attendant under this program.

G. The recipient's inability to obtain personal attendant services and substitution of attendants. The service coordination provider shall note on the Plan of Care what constitutes the recipient's backup plan in case the personal attendant does not report for work as expected or terminates employment without prior notice. Upon the recipient's request, the service coordination provider shall provide the recipient with a list of persons on the personal attendant registry who can provide temporary assistance until the attendant returns or the recipient is able to select and hire a new personal attendant. If a recipient is consistently unable to hire and retain the employment of an attendant to provide personal attendant services, the service coordination provider must:

1. Contact DMAS to transfer the recipient to a provider which provides Medicaid-funded agency-directed personal care services. The service coordination provider will make arrangements to have the recipient transferred, or

2. Contact the local health department and request a Nursing Home Preadmission Screening to determine if another long-term care option is appropriate.

12VAC30-120-530. Fiscal services.

A. DMAS shall be permitted to contract for the services of a fiscal agent. The fiscal agent will be reimbursed by the DMAS to perform certain tasks as an agent for the recipient/employer who is receiving consumer-directed PAS. The fiscal agent will handle responsibilities for the recipient for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all these duties.

B. A fiscal agent may be a state agency or other organization, and will sign a contract with the DMAS that clearly defines the roles and tasks expected of the fiscal agent and the DMAS and enroll as a provider of consumer-directed PAS. Roles and tasks which

will be defined for the fiscal agent in the contract will consist of but not necessarily be limited to the following:

1. The fiscal agent will file for and obtain employer agent status with the federal and state tax authorities;

2. Once the recipient has been authorized to receive consumer-directed PAS, the fiscal agent will register the recipient or family or caregiver as an employer, including providing assistance to the recipient or family or caregiver in completing forms required to obtain employer identification numbers from federal agencies, state agencies, and unemployment insurance agencies;

3. The fiscal agent will prepare and maintain original and file copies of all forms needed to comply with federal, state, and local tax payment, payment of unemployment compensation insurance premiums, and all other reporting requirements of employers;

4. Upon receipt of the required completed forms from the recipient, the fiscal agent will remit the required forms to the appropriate agency and maintain copies of the forms in the recipient's file. The fiscal agent will return copies of all forms to the recipient or family or caregiver for the recipient's or family or caregiver’s permanent personnel records;

5. The fiscal agent will prepare all unemployment tax filings on behalf of the recipient as employer, and make all deposits of unemployment taxes withheld according to the appropriate schedule;

6. The fiscal agent will receive and verify the attendant biweekly timesheets do not exceed the maximum hours approved for the recipient and will process the timesheets.

7. The fiscal agent will prepare and process the payroll for the recipient's attendants, performing appropriate income tax, FICA and other withholdings according to federal and state regulations. Withholdings include, but are not limited to, all judgments, garnishments, tax levies or any related holds on the funds of the attendants as may be required by local, state, or federal law;

8. The fiscal agent will prepare payrolls for the recipient's personal attendant according to approved time sheets and after making appropriate deductions;

9. The fiscal agent will make payments on behalf of the recipient for FICA (employer and employee shares), unemployment compensation taxes, and other payments required and as appropriate;

10. The fiscal agent will distribute biweekly payroll checks to the recipient's attendants on behalf of the recipient;

11. The fiscal agent will maintain accurate payroll records by preparing and submitting to DMAS, at the time the fiscal agent bills DMAS for personal attendant services, an accurate accounting of all payments on personal attendants to whom payments for services were made, including a report of FICA payments for each covered attendant;

12. The fiscal agent will maintain such other records and information as DMAS may require, in the form and manner prescribed by DMAS;

13. The fiscal agent will generate W-2 forms for all personal attendants who meet statutory threshold amounts during the tax year;

14. The fiscal agent will establish a customer service mechanism in order to respond to calls from recipients and personal attendants regarding lost or late checks, or other questions regarding payments that are not related to the authorization amounts generated from DMAS;

15. The fiscal agent will keep abreast of all applicable state and federal laws and regulations relevant to the responsibilities it has undertaken with regard to these filings;

16. The fiscal agent will use program-designated billing forms or electronic billing to bill DMAS; and

17. The fiscal agent will be capable of requesting electronic transfer of funds from DMAS.

C. The fiscal agent and all subcontracting bookkeeping firms, as appropriate, will maintain the confidentiality of Medicaid information in accordance with the following:

1. The fiscal agent agrees to ensure that access to Medicaid information will be limited to the fiscal agent. The fiscal agent shall take measures to prudently safeguard and protect unauthorized disclosure of the Medicaid information in its possession. The fiscal agent shall establish internal policies to ensure compliance with federal and state laws and regulations regarding confidentiality including, but not limited to, 42 CFR Part 431, Subpart F, and Chapter 26 (§2.1-377 et seq.) of Title 2.1 of the Code of Virginia. In no event shall the fiscal agent provide, grant, allow, or otherwise give, access to Medicaid information to anyone without the express written permission of the DMAS Director. The fiscal agent shall assume all liabilities under both state and federal law in the event that the information is disclosed in any manner.

2. Upon the fiscal agent receiving any requests for Medicaid information from any individual, entity, corporation, partnership or otherwise, the fiscal agent must notify DMAS of such requests within 24 hours. The fiscal agent shall ensure that there will be no disclosure of the data except through DMAS. DMAS will treat such requests in accordance with DMAS policies.

3. In cases where the information requested by outside sources can be released under the Freedom of Information Act (FOIA), as determined by DMAS, the fiscal agent shall provide support for copying and invoicing such documents.

D. A contract between the fiscal agent and the recipient or family or caregiver will be used to clearly express those aspects of the employment relationship that are to be handled by the fiscal agent, and which are to be handled by the recipient or family or caregiver. The contract will reflect that the fiscal agent is performing these tasks on behalf of the recipient or family or caregiver who is the actual employer of the attendant. Before the recipient begins receiving services, the fiscal agent will send the contract to the recipient or family or caregiver to review and sign. The fiscal agent must have a signed contract with the recipient or family or caregiver prior to the reimbursement of personal attendant services.

12VAC30-120-540. Recipient or family or caregiver responsibilities.

A. The recipient or family or caregiver must be authorized for consumer-directed PAS and successfully complete management training performed by the service coordinator before the recipient or family or caregiver can hire a personal attendant.

B. The recipient or family or caregiver is the employer in this program and is responsible for hiring, training, supervising and firing personal attendants. Specific duties include checking references of personal attendants, determining that personal attendants meet basic qualifications, training personal attendants, supervising the personal attendants' performance, and submitting timesheets to the service coordinator and fiscal agent on a consistent and timely basis. The recipient or family or caregiver must have an emergency back-up plan in case the personal attendant does not show up for work as expected or terminates employment without prior notice.

C. The recipient or family or caregiver shall cooperate with the development of the plan of care with the service coordination provider, who monitors the plan of care and provides supportive services to the recipient. The recipient or family or caregiver shall also cooperate with the fiscal agent, who handles fiscal responsibilities on behalf of the recipient. Recipients or family or caregiver who do not cooperate with the service coordination provider and fiscal agent will be disenrolled from consumer-directed PAS.

D. Recipients or family or caregiver will acknowledge they will not knowingly continue to accept consumer-directed personal attendant services when the services are no longer appropriate or necessary for their care needs and will inform the service coordination provider.

12VAC30-120-550. DMAS termination of eligibility to receive home and community-based care services.

A. DMAS shall have the ultimate responsibility for assuring appropriate placement of the recipient in home and community-based care services and the authority to terminate such services to the recipient for any of these reasons, but not necessarily limited to the provisions of this section.

B. Reasons eligibility for consumer-directed PAS may be terminated:

1. The home and community-based care service is not the critical alternative to prevent or delay institutional (nursing facility) placement.

2. The recipient no longer meets the nursing ~~or prenursing facility~~ level of care ~~or cognitive criteria~~ for consumer-directed PAS or does not have family or caregiver to direct his care. ~~An individual who meets this requirement does not have a cognitive impairment while having the ability to independently manage a personal attendant.~~

3. The recipient's environment does not provide for his health, safety, and welfare.

4. An appropriate and cost-effective POC cannot be developed.

C. DMAS shall notify the recipient by letter. The effective date of termination shall be at least 10 days from the date of the termination notification letter. At the same time, DMAS will also advise the recipient in writing of his right to appeal the decision.

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

_____ _____

Date

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

12VAC30-130-50. Authorization for services.

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, ~~school divisions,~~ or home health agencies shall include authorization for up to ~~24~~ 5 visits by each ordered rehabilitative service annually. School based rehabilitation services shall not be subject to any prior authorization requirements. The provider shall maintain documentation to justify the need for services. A visit shall be defined as the treatment session that a rehabilitative therapist is with a client to provide services prescribed by the physician. Visits shall not be defined as modality-specific or in measurements or in increments of time.

B. The provider shall request from DMAS authorization for visits deemed necessary by a physician beyond the number of visits not requiring preauthorization ~~(24).~~ (5). Documentation for medical justification must include personally signed and dated (as in 12VAC30-130-10 B) physician orders or a plan of care signed and dated by the physician which includes the elements described in 12VAC30-130-42. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS. Care rendered beyond the ~~24~~ 5 visits allowed annually which have not been authorized by DMAS shall not be approved for payment.

C. Payment shall not be made for requests submitted more than 12 months after the termination of services.

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

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