COMMONWEALTH of VIRGINIA

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MEMORANDUM

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

FROM: **USHA KODURU**
Assistant Attorney General

DATE: **May 17, 2017**

SUBJECT: **12 VAC 30-60-70 Fast-Track Regulation for Home Health Accrediting Organizations (4809/7916)**

I am in receipt of the attached regulation to identify the requirements for licensure, certification, or accreditation that Home Health Agencies must meet to participate as a provider of home health services in the Virginia Medicaid program. You asked the Office of the Attorney General to review and determine if DMAS has the legal authority to promulgate this regulation and if the regulation comports with state and federal law.

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

Pursuant to Va. Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the

normal promulgation process set out in this article with the initial publication of the Fast-Track regulation serving as the Notice of Intended Regulatory Action.

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

cc: Kim F. Piner, Esquire

Attachment

Proposed Text

Action:
Home Health Accrediting Organizations
Stage: Fast-Track
4/26/17 3:39 PM

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 home health agency that is licensed by the Virginia Department of Health (VDH); or that is certified by the VDH under provisions of Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act; or that is accredited ~~either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Community Health Accreditation Program (CHAP) established by the National League of Nursing~~ by any organization recognized by the Centers for Medicare and Medicaid Services (CMS) for purposes of Medicare certification. 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 that the physician shall review 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. When a patient is admitted to home health services a start-of-care comprehensive assessment must be completed no later than five calendar days after the start of care date.

3. 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 (certification) must be reviewed by the attending physician, or physician designee. The physician must sign the initial certification before the home health agency may bill DMAS.

4. A physician shall review and recertify the plan of care every 60 days. A physician recertification shall be performed within the last five days of each current 60-day certification period, i.e., between and including days 56-60. The physician recertification statement must indicate the continuing need for services and should estimate how long home health services will be needed. The physician must sign the recertification before the home health agency may bill DMAS.

5. 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.

6. 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.

7. 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 approved 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 approved 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 approved 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.