12VAC30-50-10. Services provided to the categorically needy with limitations.

The following services are provided with limitations as described in Part III (12VAC30-50-100 et seq.) of this chapter:

1. Inpatient hospital services other than those provided in an institution for mental diseases.

2. Outpatient hospital services.

3. Other laboratory and x-ray services; ~~nonemergency~~ non-emergency outpatient Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), ~~Computer~~ Computerized Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), and Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury require prior authorization.

4. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

5. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with §4231 of the State Medicaid Manual (HCFA Pub. 45-4).

6. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

7. Family planning services and supplies for individuals of child-bearing age.

8. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

9. Medical and surgical services furnished by a dentist (in accordance with §1905(a)(5)(B) of the Act).

10. Medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law: podiatrists, optometrists and other practitioners.

11. Home health services: 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; home health aide services provided by a home health agency; and medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

12. Clinic services.

13. Dental services.

14. Physical therapy and related services, including occupational therapy and services for individuals with speech, hearing, and language disorders (provided by or under supervision of a speech pathologist or audiologist.

15. Prescribed drugs, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

16. Other rehabilitative services, screening services, preventive services.

17. Nurse-midwife services.

18. Case management services as defined in, and to the group specified in, 12VAC30-50-95 et seq. (in accordance with §1905(a)(19) or §1915(g) of the Act).

19. Extended services to pregnant women: pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls (see 12VAC30-50-510). (Note: Additional coverage beyond limitations.)

20. Pediatric or family nurse practitioners' service.

21. Any other medical care and any other type of remedial care recognized by state law, specified by the Secretary: transportation.

22. Program of All-Inclusive Care for the Elderly (PACE) services as described and limited in Supplement 6 to Attachment 3.1-A (12VAC30-50-32).

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

12VAC30-50-120. Other laboratory and x-ray services.

A. Services must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

B. Prior authorization is required for the following non-emergency outpatient procedures: Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), ~~Computer~~ Computerized Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. The referring physician ordering the scan must obtain the prior authorization in order for the servicing provider to be reimbursed for the scan. Non-emergency outpatient MRI, CAT and PET scans that are not prior authorized will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS).

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

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 ~~five~~ 26 sessions, without prior authorization during the first treatment year. An additional extension of up to ~~47~~ 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding year when prior authorized by DMAS or its designee. 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 or its designee 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, licensed clinical nurse specialist-psychiatric, or a licensed marriage and family therapist under the direct supervision of a psychiatrist.*

3. Psychological and psychiatric services shall be medically prescribed treatment that 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, licensed clinical nurse specialist-psychiatric, or licensed marriage and family therapist 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~~ that have been impaired;

b. Exhibits deficits in peer relations, dealing with authority; is hyperactive; has poor impulse control; is clinically depressed or demonstrates other dysfunctional

clinical symptoms having an adverse impact on attention and concentration, ability to learn, or ability to participate in employment, educational, or social activities;

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

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

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~~ non-enrolled 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~~ non-cosmetic.

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~~ demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out of state for circumstances other than these specified reasons shall not be covered.

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

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

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

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

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

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

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

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/licensed marriage and family therapists who are either independently enrolled or under the direct supervision of a licensed clinical psychologist. Psychiatric services are limited to an initial availability of ~~five~~ 26 sessions without prior authorization. An additional extension of up to ~~47~~ 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding treatment year when prior authorized by DMAS or its designee. 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, marriage and family therapists who are either independently enrolled or under the direct supervision of a licensed clinical psychologist.

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12VAC30-141-500. Benefits reimbursement.

A. Reimbursement for the services covered under FAMIS fee-for-service and PCCM and MCHIPs shall be as specified in this section.

B. Reimbursement for physician services, surgical services, clinic services, prescription drugs, laboratory and radiological services, outpatient mental health services, early intervention services, emergency services, home health services, immunizations, mammograms, medical transportation, organ transplants, skilled nursing services, well baby and well child care, vision services, durable medical equipment, disposable medical supplies, dental services, case management services, physical therapy/occupational therapy/speech-language therapy services, hospice services, school-based health services, and certain community-based mental health services shall be based on the Title XIX rates.

C. Reimbursement to MCHIPs shall be determined on the basis of the estimated cost of providing the MCHIP benefit package and services to an actuarially equivalent population. MCHIP rates will be determined annually and published 30 days prior to the effective date.

D. Exceptions.

1. Prior authorization is required after five visits in a fiscal year for physical therapy, occupational therapy and speech therapy provided by home health providers and

outpatient rehabilitation facilities and for home health skilled nursing visits. Prior authorization is required after ~~five~~ 26 visits for outpatient mental health visits in the first year of service and prior authorization is required for the following ~~nonemergency~~ non-emergency outpatient procedures: Magnetic Resonance Imaging, including Magnetic Resonance Angiography (MRA), ~~Computer~~ Computerized Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury.

2. Reimbursement for inpatient hospital services will be based on the Title XIX rates in effect for each hospital. Reimbursement shall not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made shall be final and there shall be no retrospective cost settlements.

3. Reimbursement for outpatient hospital services shall be based on the Title XIX rates in effect for each hospital. Payments made will be final and there will be no retrospective cost settlements.

4. Reimbursement for inpatient mental health services other than by free standing psychiatric hospitals will be based on the Title XIX rates in effect for each hospital. Reimbursement will not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made will be final and there will be no retrospective cost settlements.

5. Reimbursement for outpatient rehabilitation services will be based on the Title XIX rates in effect for each rehabilitation agency. Payments made will be final and there will be no retrospective cost settlements.

6. Reimbursement for outpatient substance abuse treatment services will be based on rates determined by DMAS for children ages 6 through 18. Payments made will be final and there will be no retrospective cost settlements.

7. Reimbursement for prescription drugs will be based on the Title XIX rates in effect. Reimbursements for Title XXI do not receive drug rebates as under Title XIX.

8. Reimbursement for covered prescription drugs for ~~noninstitutionalized~~ non-institutionalized FAMIS recipients receiving the fee-for-service or PCCM benefits will be subject to review and prior authorization when their current number of prescriptions exceeds nine unique prescriptions within 180 days, and as may be further defined by the agency's guidance documents for pharmacy utilization review and the prior authorization program. The prior authorization process shall be applied consistent with the process set forth in 12VAC30-50-210 A 7.

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