COMMONWEALTH of VIRGINIA

Office of the Governor

Daniel Carey, MD
Secretary of Health and Human Resources

April 6, 2021

Francis McCullough, Associate Regional Administrator
Centers for Medicare &Medicaid Services
801 Market Street, Suite 9400
Philadelphia, PA 19107-3134

Dear Mr. McCullough:

Attached for your review and approval is amendment 21-002, entitled "Removal of the 21 Out of 60 Day Limit" to the Plan for Medical Assistance for the Commonwealth. I request that your office approve this change as quickly as possible.

Sincerely,

Daniel Carey, MD, MHCM

Attachment

cc: Karen Kimsey, Director, Department of Medical Assistance Services

COMMONWEALTH of VIRGINIA

KAREN KIMSEY
DIRECTOR

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

March 29, 2021

DECISION BRIEF FOR:
The Honorable Daniel Carey, M.D.
Secretary of Health and Human Resources

SUBJECT: AMENDMENT 21-002 to the PLAN for MEDICAL ASSISTANCE, entitled "Removal of the 21 Out of 60 Day Limit"

ACTION NEEDED
BY 04/9/2021
RETURN TO DMAS

SUMMARY

1. REQUEST: The Department of Medical Assistance Services requests the approval of this Plan amendment TN No. 21-002 – Removal of the 21 Out of 60 Day Limit.

2. RECOMMENDATION: Recommend approval of this State Plan amendment. The Agency intends to forward this SPA to the Centers for Medicare and Medicaid Services (CMS) Regional Office no later than April 15, 2021.

Karen Kimsey — 3/29/2021
Karen Kimsey, Director — Date

3. SECRETARY'S ACTION: Secretary of Health and Human Resources

Approve X Approve w/ Modifications _____ Deny _____

Daniel Carey — 4/6/21
Daniel Carey, M.D. — Date

DISCUSSION

4. BACKGROUND: The sections of the State Plan for Medical Assistance that is affected by this action are entitled "Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy and Medically Needy" and "Standards Established and Methods Used to Assure High Quality of Care".

   This state plan amendment is necessary to align with the Centers for Medicare & Medicaid Services (CMS) Medicaid Mental Health Parity Rule, issued on March 30, 2016. The overall objective of the Medicaid Mental Health Parity Rule is to ensure that accessing mental health and substance use disorder services is no more difficult than accessing medical/surgical services.

   To comply with the Medicaid Mental Health Parity Rule, the Department of Medical Assistance Services (DMAS) must remove the limit of 21 days per admission in a 60 day period for the same or similar diagnosis or treatment plan for psychiatric inpatient hospitalization, as this limit for coverage of non-psychiatric admissions was removed on July 1, 1998. (Medicaid managed care plans do not apply the limit of 21 out of 60 days, and both the limit and the change only apply to fee for service.) Psychiatric inpatient hospitalizations must be service authorized based on medical necessity and not be limited to 21 days per admission in a 60 day period. The citation for the federal regulation to remove the "21 out of 60 day limit" can be found in 42 CFR 438.910(b)(1).

   This state plan amendment also adds licensed school psychologists to the list of allowed providers of outpatient psychiatric services. This change is the result of a need identified by Child Development Clinics. Outpatient psychiatric services are provided by licensed or licensed eligible mental health professionals acting within their scope of practice. DMAS met with Department of Behavioral Health and Developmental Services (DBHDS) staff to review Board of Psychology licensing regulations and agree that while a licensed school psychologist does not meet the definition of a Licensed Mental Health Professional in accordance with DBHDS regulations, there are Medicaid covered outpatient psychiatric services that fall within the scope of practice for a licensed school psychologist.

5. AUTHORITY TO ACT: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements.

6. FISCAL/BUDGETARY IMPACT: The expected increase in annual aggregate expenditures related to for removing the limit on psychiatric inpatient hospitalization days is $38,461 in state general funds in federal fiscal year 2021. The addition of school psychologists as an allowed outpatient psychiatric services provider is not expected to increase expenditures.

7. RECOMMENDATION: Recommend approval of this State Plan amendment. This amendment needs to be forwarded to the Centers for Medicare and Medicaid Services Regional Office no later than Aril 15, 2021.

8. REFERENCES:

   1. Social Security Act, Title XIX.

   2. Code of Federal Regulations, Part 430 to End of Title 42.

   3. Code of Virginia, § 32.1-325.

Transmittal Summary

SPA 21-002

I. IDENTIFICATION INFORMATION

Title of Amendment: Removal of the 21 Out of 60 Day Limit

II. SYNOPSIS

Basis and Authority: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements.

Purpose: DMAS is requesting the regulatory changes to comply with the Centers for Medicare & Medicaid Services (CMS) Medicaid Mental Health Parity Rule issued on March 30, 2016. Removing the limits on inpatient psychiatric hospitalization helps protect the health, safety and welfare of citizens by allowing inpatient psychiatric hospitalizations to be service authorized based on medical necessity and not limited to 21 days per admission in a 60 day period for the same or similar diagnosis or treatment plan. Managed Care Organizations (MCOs) have not been applying such limitations, and have appropriately permitted hospitalizations based on medical necessity.

Substance and Analysis: The sections of the State Plan that are affected by this amendment are entitled "Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy and Medically Needy" and "Standards Established and Methods Used to Assure High Quality of Care". The language regarding the limit of 21 days per admission in a 60 day period for the same or similar diagnosis or treatment plan has been stricken. These changes also serve to update practitioner terminology, as it relates to working titles; clarify acute care hospital weekend and holiday admissions; and update the reconsideration process.

Impact: The expected increase in annual aggregate expenditures related to for removing the limit on psychiatric inpatient hospitalization days is $38,461 in state general funds in federal fiscal year 2021. The addition of school psychologists as an allowed outpatient psychiatric services provider is not expected to increase expenditures.

Prior Public Notice: Not applicable.

Public Comments and Agency Analysis: Not applicable.

Tribal Notice: See Attachment A1.

COMMONWEALTH of VIRGINIA

KAREN KIMSEY
DIRECTOR

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

Attachment A1

December 16, 2020

SUBJECT: Notice of Opportunity for Tribal Comment: – State Plan Amendments related to:

- Clarifications for Durable Medical Equipment (DME) and Supplies – Revisions
- Removal of the 21 Out of 60 Day Limit

Dear Tribal Leader and Indian Health Programs:

This letter is to notify you that the Department of Medical Assistance Services (DMAS) is planning to amend the Virginia State Plan for Medical Assistance with the Centers for Medicare and Medicaid Services (CMS). Specifically, DMAS is providing you notice about State Plan Amendments (SPAs) that the Agency will file with the CMS entitled *Clarifications for Durable Medical Equipment (DME) and Supplies – Revisions* and *Removal of the 21 Out of 60 Day Limit*.

1. DME and Supplies - Revisions: This SPA will include minor revisions made to a previously approved SPA (SPA 20-011, Clarifications for Durable Medical Equipment and Supplies, approved on October 20, 2020). Following the approval of SPA 20-011, CMS discovered duplicative wording on multiple pages of the state plan, and requested that DMAS submit a new SPA to revise the text on those pages. There is no change to the content or meaning of the state plan text as a result of these changes.

2. Removal of the 21 Out of 60 Day Limit: This SPA will allow the Virginia Medicaid program to conform to the CMS Medicaid Mental Health Parity Rule, which ensures that accessing mental health and substance use disorder services is no more difficult than accessing medical/surgical services. To comply with the Medicaid Mental Health Parity Rule, DMAS must remove a limit for psychiatric hospitalization that was previously removed for non-psychiatric admissions. The limit prevented more than 21 days in a hospital in a 60 day period for the same or similar diagnosis or treatment plan.

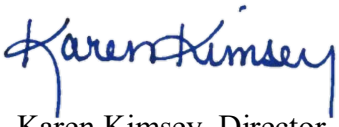
Please contact us if you would like to see the text changes or documents associated with any or all of these SPAs.

The tribal comment period for these SPAs is open through January 16, 2021. You may submit your comments directly to Jimeequa Williams, DMAS Policy Division, by phone (804) 225-3508, or via email: Jimeequa.Williams@dmas.virginia.gov. Finally, if you prefer regular mail, you may send your comments or questions to:

Virginia Department of Medical Assistance Services
Attn: Jimeequa Williams
600 East Broad Street
Richmond, VA 23219

Please forward this information to any interested party.

Sincerely,



Karen Kimsey, Director
Va. Department of Medical Assistance Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21-0002

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 3/31/2021

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 438

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ $38,461
b. FFY 2022 $ $38,461

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A&B, Supplement 1, pages 1, 2, 3, 3.1, 4. 4.1, 4.1.1, 4.2, 4.3, 4.4, 7, 8, 9, 9.1, 9.2

Attachment 3.1-C, pages 1, 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Same as box #8.

10. SUBJECT OF AMENDMENT: Removal of the 21 Out of 60 Day Limit

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: Karen Kimsey

13. TYPED NAME: Karen Kimsey

14. TITLE: Director

15. DATE SUBMITTED: 3/29/2021

16. RETURN TO

Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Instructions on Back

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY
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General

The provision of the following medically necessary services cannot be reimbursed except when they are ordered or prescribed, and directed or performed within the scope of the license of a practitioner of the healing arts: laboratory and x-ray services, family planning services, and home health services. Physical therapy services will be reimbursed only when prescribed by a physician. Inpatient acute hospitalizations will be reimbursed only if the stay has been authorized.

Inpatient hospital services provided at general acute care hospitals and free standing psychiatric hospitals. (12 VAC 30-50-100)

A. Enrolled Providers

1. ~~Preauthorization~~ Service authorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals and free-standing psychiatric hospitals. Non-authorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS) or its contractor. ~~Preauthorization~~ Service authorization shall be based on criteria specified by DMAS. ~~In conjunction with pre-authorization, an appropriate length of stay will be assigned when required, using the current HCIA Length of Stay by Diagnosis and Operation as guidelines.~~

a. Admission review.

(1) Planned/scheduled admissions. Review shall be done prior to admission to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned at the time of this review until such time as DMAS goes to a Diagnostic Related Grouping (DRG) payment methodology. At such time, only psychiatric hospitalizations will be assigned an initial length of stay. If admission is for a surgical procedure that requires ~~prior~~ service authorization, the hospital must ensure that the physician has obtained the ~~prior~~ service authorization for the planned procedure from DMAS before the requested authorization for the hospital admission is made. (Refer to 12 VAC 30-50-140). Adverse authorization decisions shall have available a reconsideration process as set out below.

(2) Unplanned/urgent or emergency admissions. These admissions will be permitted before any ~~prior~~ service authorization procedures. Review shall be performed within one working day to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned for those admissions

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which have been determined to be appropriate, until such time as DMAS goes to a full DRG payment methodology. At such time, only psychiatric admissions shall have an initial length of stay assigned. Adverse authorization decisions shall have available a reconsideration process set out below.

b. Concurrent review. Concurrent review shall be done to determine that inpatient hospitalization continues to be medically necessary. Prior to the expiration of the previously assigned initial length of stay, the provider shall be responsible for obtaining authorization for continued inpatient hospitalization. If continued impatient hospitalization is determined necessary, an additional length of stay shall be assigned. Concurrent review shall continue in the same manner until the discharge of the patient for acute inpatient hospital care. Adverse authorization decisions shall have available a reconsideration process as set out below. This element of review shall end for non-psychiatric claims with the full implementation of the DRG reimbursement methodology.

c. Retrospective review shall be performed when a provider is notified of a patient's retroactive eligibility for Medicaid coverage. It shall be the provider's responsibility to obtain authorization for covered days prior to billing DMAS for these services. Adverse authorization decisions shall have available a reconsideration process as set out below.

d. Reconsideration Process.

~~(1) Providers requesting reconsideration must do so upon verbal notification of denial.~~

~~(2) This process is available to providers when the nurse reviewers advise the providers by telephone that the medical information provided does not meet DMAS specified criteria. At this point, the provider must request by telephone a higher level of review if he disagrees with the nurse reviewers' findings. If higher review is not requested the case will be denied and denial letter generated to both the provider and recipient identifying appeal rights.~~

~~(3) If higher review is requested, the authorization request will be held in suspense and referred to the Utilization Management Supervisor (UMS). The UMS shall have one working day to render a~~

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~~decision. If the UMS upholds the adverse decision, the provider may accept that decision and the case will be denied and denial letter identifying appeal rights will be generated to both the provider and the recipient. If the provider continues to disagree with the UMS' adverse decision, he must request physician review by DMAS Medical Support. The case remains in suspense and is referred to DMAS Medical Support for the last step of reconsideration.~~

~~(4) DMAS Medical Support will review all case specific medical information. Medical Support shall have two working days to render a decision. If Medical Support upholds the adverse decision, the request for authorization will then be denied and a letter identifying appeal rights will be generated to both the provider and the recipient. The entire reconsideration process must be completed within three working days.~~

Providers shall be given the opportunity to request a reconsideration of any adverse service authorization decision. Reconsideration requests shall be reviewed by a physician. Should the case be denied, the member or provider may request an appeal by following the procedures described in the denial letter.

e. Appeals process.

(1) Recipient appeals. Upon receipt of a denial letter, recipient shall have the right to appeal the adverse decision. Under the Client Appeals regulations, at 12 VAC 30-110-Part I the recipient shall have 30 days from the date of the denial letter to file an appeal.
(2) Provider appeals. If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the date of the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered. The appeal shall be in accordance with *Code of Virginia* § 9-6.14:1 *et.seq.*

B. Out-of-state inpatient general acute care hospitals and freestanding psychiatric hospitals, enrolled providers. In addition to meeting all of the ~~pre-authorization~~ service authorization requirements specified in subsection A above, out-of-state hospitals must further demonstrate that the requested admission meets at least one of the following additional standards. 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;

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

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

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

~~E. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60 day period, for the same or similar diagnosis and/or treatment plan. The 60 day period would begin on the first hospitalization (if there are multiple~~

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~~admissions) admission date. There may be multiple admissions during this 60 day period. Claims which exceed 21 days per admission within 60 days, for the same or similar diagnosis and/or treatment plan, will not be authorized for payment. Claims which exceed 21 days per admission within 60 days with a different diagnosis and/or treatment plan, will be considered for authorization, if medically indicated. Except as previously noted, regardless of authorization for the hospitalization, the claims will be processed in accordance with the limit for 21 days in a 60 day period. Claims for stays exceeding 21 days in a 60 day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days for non-psychiatric admissions shall cease when DMAS implements a Full DRG payment methodology. EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 44l.57, payment of medical assistance services shall be made on behalf of individuals under 2l years of age, who are Medicaid eligible, for medically necessary hospitalizations in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological/psychiatric, examination. The admission and length of stay must be medically justified and pre-authorized via the admission and concurrent or retrospective review process described above. Medically unjustified days in such hospitalizations shall not be authorized for payment.~~

~~F.~~E. Mandatory lengths of stay.

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

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

~~G.~~F. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64 except as allowed under 42 CFR §438.3 (e)(2). Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section and 12VAC30-50-105.

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~~H.~~G. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, or leukemia. Transplant services for liver, heart, and bone marrow transplantation and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require ~~preauthorization~~ service authorization by DMAS medical support. 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 12VAC30-50-580.

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

I. Addiction and recovery treatment services shall be covered in inpatient facilities consistent with 12VAC30-130-5000 et seq.

Non-Cost Reporting Providers. (Non-participating/out of state). (12VAC 30-50-105)

~~A. Inpatient hospital services, when rendered by non-enrolled providers, shall not require preauthorization with the exception of transplants as described in subsection 10 below. Inpatient hospital services claims will be suspended from payment and manually reviewed for medical necessity as described in subsections 2-10 below using criteria specified by DMAS until such time as DMAS implements Full DRG payment methodology. At such time, all inpatient hospital services claims from non-cost reporting providers will suspend form payment and shall be manually reviewed for medical necessity of the admission for nonpsychiatric hospital stays and for medical necessity for the admission and length of stay for psychiatric hospital stays using criteria as designated by DMAS.~~

~~B. Medicaid inpatient hospital admissions (lengths of stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admission under four days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional~~

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

B. Inpatient hospital services rendered by nonenrolled providers shall not require service authorization with the exception of transplants as described in subsection I of this section and this subsection. However, these inpatient hospital services claims will be suspended from automated computer payment and will be manually reviewed for medical necessity as described in subsections B through I of this section using criteria specified by DMAS. 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 of the following conditions. It shall be the responsibility of the hospital, when requesting service authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization.

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 the general practice for recipients in a particular locality to use medical resources in another state.

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~~coverage when medically justified. For all admissions that exceed three days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection seven of this section.) Inpatient hospital services will be reviewed for appropriateness of the admission and length of stay.~~

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

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

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

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

~~G.~~F. ~~Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically justified.~~ The admission and length of stay must be medically justified and ~~preauthorized~~ service authorized via the admission and concurrent review processes described in subsection A of 12 VAC 30-50-100. ~~Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days shall cease with dates of service on or after July 1, 1998.~~ Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

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

~~H.~~G. Mandatory lengths of stay.

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

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

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

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~~J.~~I. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. Transplant services for liver, heart, and bone marrow transplantation and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require ~~preauthorization~~ service authorization by DMAS. Corneal transplants do not require ~~preauthorization~~ service authorization. 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.

~~K.~~J. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed, shall be subject to review of the required DMAS forms corresponding to the before mentioned 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.

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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 (1) 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, or (2) the immunization is necessary for the direct treatment of an injury; or (3) the immunization is a pneumococcal or influenza vaccination that is reasonable and necessary for the prevention of illness.

D. Outpatient psychiatric services.

1. Psychiatric services can be provided by or under the supervision of an individual licensed under state law to practice medicine or osteopathy. Only the following licensed or registered providers are permitted to provide psychiatric services under the supervision of an individual licensed under state law to practice medicine or osteopathy: ~~an LMHP, LMHP-R, LMHP- RP, or LMHP-S as defined in Attachment 3.1A&B, Supplement 1, pages 31 and 31.1~~ an LMHP, LMHP-R, LMHP-RP, or LMHP-S as defined in 12VAC35-105-20 or a licensed school psychologist in accordance with 18VAC125-20. Medically necessary psychiatric services shall be covered by DMAS or its designee and shall be directly and specifically related to an active written plan designed and signature dated by one of the healthcare professionals listed in this ~~paragraph~~ subdivision.

2. 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, abilities to learn, and/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.

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E. Any procedure considered experimental is not covered.

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

G. Physician visits to inpatient psychiatric hospital patients are restricted to medically necessary authorized (for enrolled providers)/approved (for non-enrolled providers) inpatient hospital days as determined by DMAS or its contractor.

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. ~~Reimbursement will not be provided for physician services performed in the inpatient setting for those surgical or diagnostic procedures listed on the mandatory outpatient surgery list unless the service is medically justified or meets one of the exceptions. The requirements of mandatory outpatient surgery do not apply to recipients in a retroactive eligibility period.~~ [Reserved.]

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K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys ~~and,~~ corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, ~~or~~ leukemia, or myeloma. Transplant services for ~~liver, heart, and~~ any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require ~~preauthorization~~ service authorization by DMAS. Cornea transplants do not require ~~preauthorization~~ service authorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. ~~Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate.~~ Standards for coverage of organ transplant services are in ~~Attachment 3.1-E (~~12 VAC 30-50-540 through ~~570~~ 12 VAC 580~~)~~.

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12 VAC 30-50-140. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere (continued)

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If ~~prior~~ serviced 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 may be covered, if ~~prior~~ serviced authorized, for medically necessary indications. Such procedures shall be considered 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 state of Virginia shall only be reimbursed under at least one of the following conditions. It shall be the responsibility of the hospital, when requesting ~~prior~~ service authorization for the admission, to 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; or

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

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N. In compliance with 42 CF441.200, 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~~ Service authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), Computer 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 non-emergency outpatient Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT) scans, or Positron Emission Tomography (PET) scans must obtain ~~prior~~ service 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~~ service authorization is obtained from DMAS by the referring physician.

P. Addiction and recovery treatment services shall be covered in physician services consistent with 12VAC30-130-5000 et seq.

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12 VAC 30-60 - 10. Institutional care.
Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX**.**

12 ~~Y~~VAC 30-60-20. Utilization Control: General Acute Care Hospitals (enrolled providers).

A. Prior authorization required. The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) shall not reimburse for services which are not authorized as follows:

1. DMAS shall monitor, consistent with State law, the utilization of all inpatient hospital services. All ~~planned~~ inpatient hospital stays shall be ~~preauthorized~~ service authorized prior to admission. Services rendered without such service authorization shall not be covered, except as stated in subdivision 2 of this subsection.

~~2. If a Medicaid eligible individual is admitted to inpatient hospital care, on a Saturday, Sunday or holiday, or after normal working hours, it shall be the provider's responsibility to obtain the required authorization on the next workday following such admission.~~

~~3.~~2. If a provider has rendered inpatient services to an individual who later is determined to be Medicaid eligible, it shall be the provider's responsibility to obtain the required authorization prior to billing the DMAS for these services.

3. Regardless of ~~preauthorization~~ service authorization, ~~DMAS shall review all inpatient hospital claims for individuals over the age of 21 which suspend for exceeding the 21 day limit per admission in a 60 day period for the same or similar diagnoses prior to reimbursement for the stay until such time as DMAS implements DRG payment methodology. At such time only psychiatric inpatient hospital claims will suspend for this review~~ DMAS shall review all claims which are suspended for sterilization, hysterectomy, or abortion procedures for the presence of the required federal and state forms prior to reimbursement. If the forms are not attached to the bill and not properly completed, reimbursement for the services rendered will be denied or reduced, according to DMAS policy.

~~4. DMAS shall review all claims which suspend for sterilization, hysterectomy, or abortion procedures for the presence of the required federal and state forms prior to reimbursement. If the forms are not attached to the bill and not properly completed, reimbursement for the services rendered will be denied or reduced, according to DMAS policy.~~

B. To determine that the DMAS enrolled hospital providers are in compliance with the regulations governing hospital utilization control found in ~~the *Code of Federal Regulations*, 42 CFR, Chapter IV, Subpart C, §§456.50-456.145~~ 42 CFR 456.50 through 456.145, an annual audit will be conducted of each enrolled hospital. This audit can be performed either on-site or as a desk audit. The hospital shall make all requested records available and shall provide an

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Appropriate place for the auditors to conduct such review if done on-site. The audits shall consist of review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in 42 CFR 456.100 through 456.145.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in 42 CFR 456.105 through456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and list of attendees to determine that the committee is meeting according to their Utilization Management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR 456.141 through 42CFR 456.145.

5. Topic of one on-going Medical Care Evaluation ~~Studey~~ Study to determine the hospital is incompliance with 42 CFR 456.145.

6. From a list of randomly selected paid claims, the hospital must provide a copy of the physician admission certification and written plan of care for each selected stay to determine the hospital's compliance with the 42 CFR 456.60 and 456.80. If any of the required documentation does not meet the requirements found in 42 CFR 456.60 ~~and~~ through 456.80, reimbursement may be retracted.

7. The hospital may appeal in accordance with the ~~Code of Virginia 9-6.14:1 et seq.~~ Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) any adverse ~~decisions~~ decision resulting from such audits which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.

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General

The provision of the following medically necessary services cannot be reimbursed except when they are ordered or prescribed, and directed or performed within the scope of the license of a practitioner of the healing arts: laboratory and x-ray services, family planning services, and home health services. Physical therapy services will be reimbursed only when prescribed by a physician. Inpatient acute hospitalizations will be reimbursed only if the stay has been authorized.

Inpatient hospital services provided at general acute care hospitals and free standing psychiatric hospitals. (12 VAC 30-50-100)

A. Enrolled Providers

1. Service authorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals and free-standing psychiatric hospitals. Non-authorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS) or its contractor. Service authorization shall be based on criteria specified by DMAS.

a. Admission review.

(1) Planned/scheduled admissions. Review shall be done prior to admission to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned at the time of this review until such time as DMAS goes to a Diagnostic Related Grouping (DRG) payment methodology. At such time, only psychiatric hospitalizations will be assigned an initial length of stay. If admission is for a surgical procedure that requires service authorization, the hospital must ensure that the physician has obtained the service authorization for the planned procedure from DMAS before the requested authorization for the hospital admission is made. (Refer to 12 VAC 30-50-140). Adverse authorization decisions shall have available a reconsideration process as set out below.

(2) Unplanned/urgent or emergency admissions. These admissions will be permitted before any service authorization procedures. Review shall be performed within one working day to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned for those admissions

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which have been determined to be appropriate, until such time as DMAS goes to a full DRG payment methodology. At such time, only psychiatric admissions shall have an initial length of stay assigned. Adverse authorization decisions shall have available a reconsideration process set out below.

b. Concurrent review. Concurrent review shall be done to determine that inpatient hospitalization continues to be medically necessary. Prior to the expiration of the previously assigned initial length of stay, the provider shall be responsible for obtaining authorization for continued inpatient hospitalization. If continued impatient hospitalization is determined necessary, an additional length of stay shall be assigned. Concurrent review shall continue in the same manner until the discharge of the patient for acute inpatient hospital care. Adverse authorization decisions shall have available a reconsideration process as set out below. This element of review shall end for non-psychiatric claims with the full implementation of the DRG reimbursement methodology.

c. Retrospective review shall be performed when a provider is notified of a patient's retroactive eligibility for Medicaid coverage. It shall be the provider's responsibility to obtain authorization for covered days prior to billing DMAS for these services. Adverse authorization decisions shall have available a reconsideration process as set out below.

d. Reconsideration Process.

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Providers shall be given the opportunity to request a reconsideration of any adverse service authorization decision. Reconsideration requests shall be reviewed by a physician. Should the case be denied, the member or provider may request an appeal by following the procedures described in the denial letter.

e. Appeals process.

(1) Recipient appeals. Upon receipt of a denial letter, recipient shall have the right to appeal the adverse decision. Under the Client Appeals regulations, at 12 VAC 30-110-Part I the recipient shall have 30 days from the date of the denial letter to file an appeal.
(2) Provider appeals. If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the date of the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered. The appeal shall be in accordance with *Code of Virginia* § 9-6.14:1 *et.seq*.

B. Out-of-state inpatient general acute care hospitals and freestanding psychiatric hospitals, enrolled providers. In addition to meeting all of the service authorization requirements specified in subsection A above, out-of-state hospitals must further demonstrate that the requested admission meets at least one of the following additional standards. 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;

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

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

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

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E. Mandatory lengths of stay.

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

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

F. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64 except as allowed under 42 CFR §438.3 (e)(2). Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section and 12VAC30-50-105.

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G. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, or leukemia. Transplant services for liver, heart, and bone marrow transplantation and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require service authorization by DMAS medical support. 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 12VAC30-50-580.

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

I. Addiction and recovery treatment services shall be covered in inpatient facilities consistent with 12VAC30-130-5000 et seq.

Non-Cost Reporting Providers. (Non-participating/out of state). (12VAC 30-50-105)

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

B. Inpatient hospital services rendered by nonenrolled providers shall not require service authorization with the exception of transplants as described in subsection I of this section and this subsection. However, these inpatient hospital services claims will be suspended from automated computer payment and will be manually reviewed for medical necessity as described in subsections B through I of this section using criteria specified by DMAS. 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 of the following conditions. It shall be the responsibility of the hospital, when requesting service authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization.

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 the general practice for recipients in a particular locality to use medical resources in another state.

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

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

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

F. The admission and length of stay must be medically justified and service authorized via the admission and concurrent review processes described in subsection A of 12 VAC 30-50-100. Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

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G. Mandatory lengths of stay.

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

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

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

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I. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. Transplant services for liver, heart, and bone marrow transplantation and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require service authorization by DMAS. Corneal transplants do not require service authorization. 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.

J. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed, shall be subject to review of the required DMAS forms corresponding to the before mentioned 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.

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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 (1) 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, or (2) the immunization is necessary for the direct treatment of an injury; or (3) the immunization is a pneumococcal or influenza vaccination that is reasonable and necessary for the prevention of illness.

D. Outpatient psychiatric services.

1. Psychiatric services can be provided by or under the supervision of an individual licensed under state law to practice medicine or osteopathy. Only the following licensed or registered providers are permitted to provide psychiatric services under the supervision of an individual licensed under state law to practice medicine or osteopathy: an LMHP, LMHP-R, LMHP-RP, or LMHP-S as defined in 12VAC35-105-20 or a licensed school psychologist in accordance with 18VAC125-20. Medically necessary psychiatric services shall be covered by DMAS or its designee and shall be directly and specifically related to an active written plan designed and signature dated by one of the healthcare professionals listed in this subdivision.

2. 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, abilities to learn, and/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.

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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 life to the mother if the fetus was carried to term.

G. Physician visits to inpatient psychiatric hospital patients are restricted to medically necessary authorized (for enrolled providers)/approved (for non-enrolled providers) inpatient hospital days as determined by DMAS or its contractor.

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.]

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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, ~~or~~ 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 service authorization by DMAS. Cornea transplants do not require service authorization. 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 12 VAC 30-50-540 through 12 VAC 580.

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12 VAC 30-50-140. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere (continued)

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If serviced 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 may be covered, if serviced authorized, for medically necessary indications. Such procedures shall be considered 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 state of Virginia shall only be reimbursed under at least one of the following conditions. It shall be the responsibility of the hospital, when requesting service authorization for the admission, to 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; or

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

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N. In compliance with 42 CF441.200, 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. Service authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), Computer 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 non-emergency outpatient Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT) scans, or Positron Emission Tomography (PET) scans must obtain service authorization from the Department of Medical Assistance Services (DMAS) for those scans. The servicing provider will not be reimbursed for the scan unless proper service authorization is obtained from DMAS by the referring physician.

P. Addiction and recovery treatment services shall be covered in physician services consistent with 12VAC30-130-5000 et seq.

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12 VAC 30-60 - 10. Institutional care.
Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX**.**

12 VAC 30-60-20. Utilization Control: General Acute Care Hospitals (enrolled providers).

A. Prior authorization required. The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) shall not reimburse for services which are not authorized as follows:

1. DMAS shall monitor, consistent with State law, the utilization of all inpatient hospital services. All inpatient hospital stays shall be service authorized prior to admission. Services rendered without such service authorization shall not be covered, except as stated in subdivision 2 of this subsection.

2. If a provider has rendered inpatient services to an individual who later is determined to be Medicaid eligible, it shall be the provider's responsibility to obtain the required authorization prior to billing the DMAS for these services.

3. Regardless of service authorization, DMAS shall review all claims which are suspended for sterilization, hysterectomy, or abortion procedures for the presence of the required federal and state forms prior to reimbursement. If the forms are not attached to the bill and not properly completed, reimbursement for the services rendered will be denied or reduced, according to DMAS policy.

B. To determine that the DMAS enrolled hospital providers are in compliance with the regulations governing hospital utilization control found in 42 CFR 456.50 through 456.145, an annual audit will be conducted of each enrolled hospital. This audit can be performed either on-site or as a desk audit. The hospital shall make all requested records available and shall provide an

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Appropriate place for the auditors to conduct such review if done on-site. The audits shall consist of review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in 42 CFR 456.100 through 456.145.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in 42 CFR 456.105 through456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and list of attendees to determine that the committee is meeting according to their Utilization Management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR 456.141 through 42CFR 456.145.

5. Topic of one on-going Medical Care Evaluation Study to determine the hospital is incompliance with 42 CFR 456.145.

6. From a list of randomly selected paid claims, the hospital must provide a copy of the physician admission certification and written plan of care for each selected stay to determine the hospital's compliance with the 42 CFR 456.60 and 456.80. If any of the required documentation does not meet the requirements found in 42 CFR 456.60 through 456.80, reimbursement may be retracted.

7. The hospital may appeal in accordance with the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) any adverse decision resulting from such audits which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.