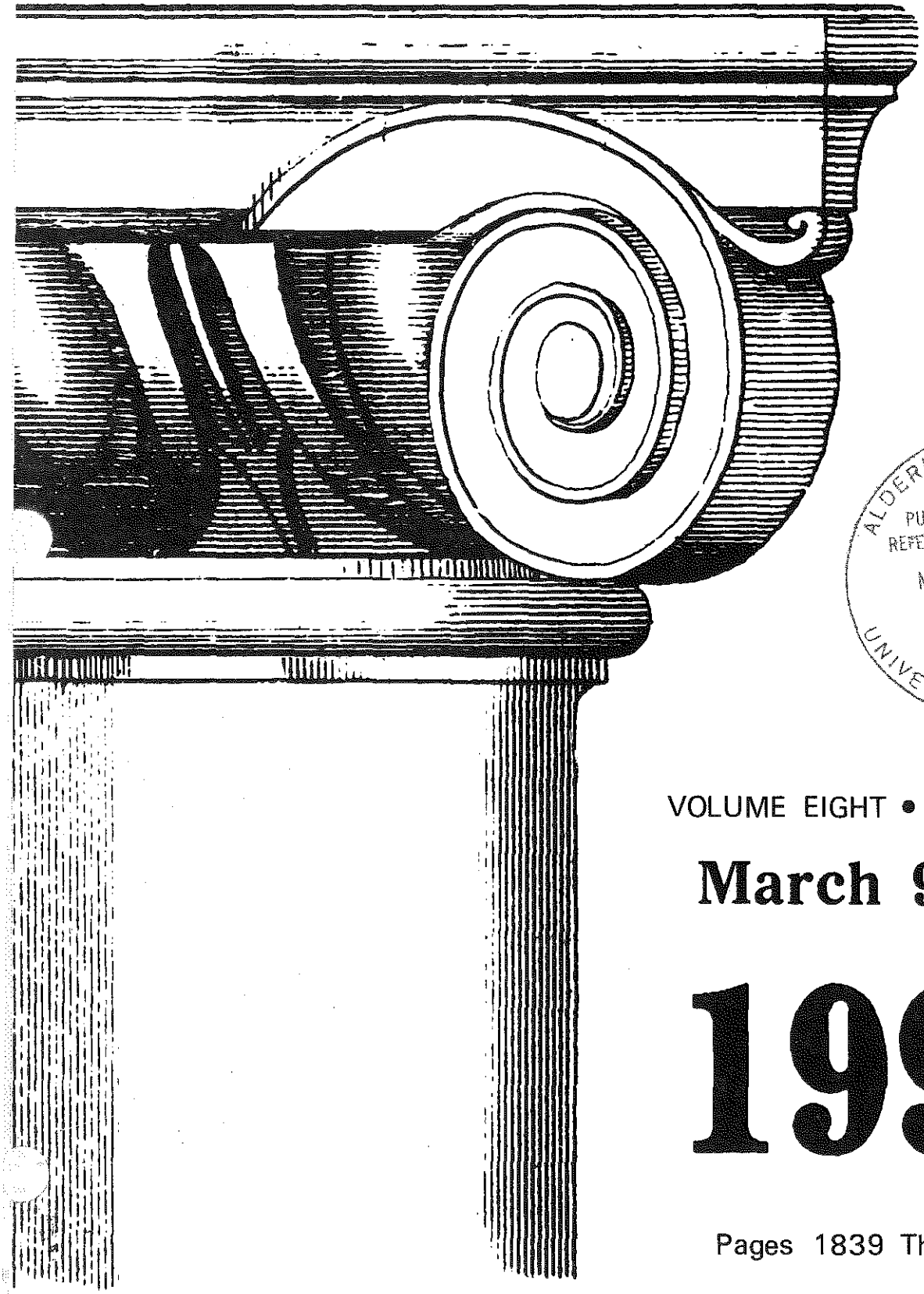
THE VIRGINIA REGISTER

OF REGULATIONS



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VIRGINIA REGISTER

The *Virginia Register* is an official state publication issued every other week throughout the year. Indexes are published quarterly, and the last index of the year is cumulative.

The *Virginia Register* has several functions. The full text of all regulations, both as proposed and as finally adopted or changed by amendment are required by law to be published in the *Virginia Register of Regulations.*

In addition, the *Virginia Register* is a source of other information about state government, including all Emergency Regulations issued by the Governor, and Executive Orders, the Virginia Tax Bulletin issued periodically by the Department of Taxation, and notices of all public hearings and open meetings of state agencies.

ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS

An agency wishing to adopt, amend, or repeal regulations must first publish in the Virginia Register a notice of proposed action; a basis, purpose, impact and summary statement; a notice giving the public an opportunity to comment on the proposal, and the text of the proposed regulations.

Under the provisions of the Administrative Process Act, the Registrar has the right to publish a summary, rather than the full text, of a regulation which is considered to be too lengthy. In such case, the full text of the regulation will be available for public inspection at the office of the Registrar and at the office of the promulgating agency.

Following publication of the proposal in the *Virginia Register,* sixty days must elapse before the agency may take action on the proposal.

During this time, the Governor and the General Assembly will review the proposed regulations. The Governor will transmit his comments on the regulations to the Registrar and the agency and such comments will be published in the *Virginia Register.*

Upon receipt of the Governor's comment on a proposed regulation, the agency (i) may adopt the proposed regulation, if the Governor has no objection to the regulation; (ii) may modify and adopt the proposed regulation after considering and incorporating the Governor's suggestions, or (iii) may adopt the regulation without changes despite the Governor's recommendations for change.

The appropriate standing committee of each branch of the General Assembly may meet during the promulgation or final adoption process and file an objection with the *Virginia Registrar* and the promulgating agency. The objection will be published in the *Virginia Register.* Within twenty-one days after receipt by the agency of a legislative objection, the agency shall file a response with the Registrar, the objecting legislative Committee, and the Governor

When final action is taken, the promulgating agency must again publish the text of the regulation, as adopted, highlighting and explaining any substantial changes in the final regulation. A thirty-day final adoption period will commence upon publication in the *Virginia Register.*

The Governor will review the final regulation during this time and if he objects, forward his objection to the Registrar and the agency. His objection will be published in the *Virginia Register.* If the Governor finds that changes made to the proposed regulation are substantial, he may suspend the regulatory process for thirty days and require the agency to solicit additional public comment on the substantial changes.

A regulation becomes effective at the conclusion of this thirty-day final adoption period, or at any other later date specified by the promulgating agency, unless (i) a legislative objection has been filed, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the twenty-one day extension period; or (ii) the Governor exercises his authority to suspend the regulatory process for solicitation of additional public comment, in which event the regulation, unless withdrawn, becomes effective on the date specified which date shall be after the expiration of the period for which the Governor has suspended the regulatory process.

Proposed action on regulations may be withdrawn by the promulgating agency at any time before the regulation becomes final.

EMERGENCY REGULATIONS

If an agency determines that an emergency situation exists, it then requests the Governor to issue an emergency regulation. The emergency regulation becomes operative upon its adoption and filing with the Registrar of Regulations, unless a later date is specified. Emergency regulations are limited in time and cannot exceed a twelve-months duration. The emergency regulations will be published as quickly as possible in the *Virginia Register.*

During the time the emergency status is in effect, the agency may proceed with the adoption of permanent regulations through the usual procedures (See "Adoption, Amendment, and Repeal of Regulations," above). If the agency does not choose to adopt the regulations, the emergency status ends when the prescribed time limit expires.

STATEMENT

The foregoing constitutes a generalized statement of the procedures to be followed. For specific statutory language, it is suggested that Article 2 of Chapter 1.1:1 (§§ 9-6.14:6 through 9-6.14:9) of the Code of Virginia be examined carefully.

CITATION TO THE VIRGINIA REGISTER

The Virginia Register is cited by volume, issue, page number, and date. **1:3 VA.R. 75-77 November 12, 1984** refers to Volume 1, Issue 3, pages 75 through 77 of the Virginia Register issued on November 12, 1984.

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VIRGINIA REGISTER OF REGULATIONS

PUBLICATION DEADLINES AND SCHEDULES

March 1992 through June 1993

MATERIAL SUBMITTED BY Noon Wednesday	PUBLICATION DATE
Volume 8 - 1992	
Mar. 18	Apr. 6
Apr. 1	Apr. 20
Apr. 15	May 4
Apr. 29	May 18
May 13	June 1
May 27	June 15
Index 3 - Volume 8	
June 10	June 29
June 24	July 13
July 8	July 27
July 22	Aug. 10
Aug. 6	Aug. 24
Aug. 19	Sept. 7
Sept. 2	Sept. 21
Final Index - Volume 8	
Volume 9 - 1992-93	
Sept. 16	Oct. 5
Sept. 30	Oct. 19
Oct. 14	Nov. 2
Oct. 28	Nov. 16
Nov. 11	Nov. 30
Nov. 25	Dec. 14
Dec. 9	Dec. 28
Index 1 - Volume 9	
Dec. 23	Jan. 11, 1993
Jan. 6	Jan 25
Jan. 20	Feb. 8
Feb. 3	Feb. 22
Feb. 17	Mar. 1
Mar. 3	Mar. 15
Mar. 17	Mar. 29
Index 2 - Volume 9	
Mar. 31	Apr. 12
Apr. 14	Apr. 26
Apr. 28	May 10
May 12	May 24
May 26	June 7
June 9	June 21
Index 3 - Volume 9	

TABLE OF CONTENTS

NOTICES OF INTENDED REGULATORY ACTION

PROPOSED REGULATIONS

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

DEPARTMENT OF STATE POLICE

DEPARTMENT OF TREASURY (STATE TREASURER)

FINAL REGULATIONS

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES (BOARD OF)

DEPARTMENT OF AIR POLLUTION CONTROL (STATE BOARD)

DEPARTMENT OF GENERAL SERVICES

DEPARTMENT OF HEALTH (STATE BOARD OF)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

BOARD OF MEDICINE

BOARD OF NURSING

Table of Contents

Table of Contents

NOTICES OF INTENDED REGULATORY ACTION

Symbol Key †
† Indicates entries since last publication of the Virginia Register

STATE AIR POLLUTION CONTROL BOARD

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Air Pollution Control Board intends to consider amending regulations entitled: **VR 120-01. Regulations for the Control and Abatement of Air Pollution.** The purpose of the proposed action is to provide the latest edition of referenced technical and scientific documents and to incorporate newly promulgated federal New Source Performance Standards and National Emission Standards for Hazardous Air Pollutants. A public meeting will be held on April 8, 1992, at 10 a.m. in House Committee Room 1, State Capitol, Richmond, Virginia, to receive input on the development of the proposed regulation.

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Written comments may be submitted until April 8, 1992, to Director of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240.

Contact: Karen G. Sabasteanski, Policy Analyst, Division of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240, telephone (804) 786-2378.

STATE LOTTERY DEPARTMENT (STATE LOTTERY BORD)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Lottery Board intends to consider amending regulations entitled: **VR 447-01-2. Administration Regulations; VR 447-02-1. Instant Game Regulations; and VR 447-02-2. On-line Game Regulations.** The purpose of the proposed action is to (i) introduce subscription services, a new on-line lottery program; (ii) clarify the prize amount that can be paid by lottery retailers as a result of implementation of Pick 4; and (iii) conform existing regulations to current law.

Statutory Authority: § 58.1.4007 of the Code of Virginia.

Written comments may be submitted until March 13, 1992.

Contact: Barbara L. Robertson, Lottery Staff Officer, 2201 West Broad Street, Richmond, VA 23220, telephone (804) 367-9433.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (STATE BOARD)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Mental Health, Mental Retardation and Substance Abuse Services Board intends to consider promulgating regulations entitled: **Certification of Therapeutic Consultation and Residential Services.** The purpose of the proposed action is to promulgate permanent regulations which set requirements for providers of therapeutic consultation and residential services under the Mental Retardation waiver.

Statutory Authority: §§ 37.1-10 and 37.1-179.1 of the Code of Virginia.

Written comments may be submitted until March 10, 1992, to Ben Saunders, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214.

Contact: Rubyjean Gould, Director of Administrative Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3915.

BOARD OF NURSING HOME ADMINISTRATORS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Nursing Home Administrators intends to consider amending regulations entitled: **VR 500-02-2:1. Regulations of the Board of Nursing Home Administrators.** The purpose of the proposed action is to provide flexibility by including another route to licensure through relaxed qualifications.

Statutory Authority: §§ 54.1-100 through 54.1-114, 54.1-2400 through 54.1-2403, 54.1-2500 through 54.1-2510, and 54.1-3100 through 54.1-3103 of the Code of Virginia.

Written comments may be submitted until March 12, 1992.

Contact: Meredyth P. Partridge, Executive Director, Board of Nursing Home Administrators, 1601 Rolling Hills Drive, Richmond, Virginia 23229, telephone (804) 662-9111.

BOARD OF PROFESSIONAL COUNSELORS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Professional Counselors intends to consider amending regulations entitled: **560-01-02. Regulations Governing the Practice of Professional Counseling.** The purpose of the proposed action is to consider the deletion of oral examinations for professional counselor licensure. The board is extending the period of comment to allow for additional public input regarding oral examinations.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Written comments may be submitted until March 10, 1992.

Contact: Evelyn B. Brown, Executive Director, Board of Professional Counselors, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9912.

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Social Services intends to consider amending regulations entitled: **VR 615-08-01. Virginia Energy Assistance Program.** The purpose of the proposed action is to plan policies and procedures for implementation in the 1992-93 program year. Based on problems identified, procedural modification will occur. Regulatory requirements are contained in Title VI of the Human Services Reauthorization Act of 1990 (Public Law 101-501).

Statutory Authority: § 63.1-25 of the Code of Virginia.

Written comments may be submitted until March 10, 1992, to Charlene H. Chapman, Virginia Department of Social Services, Division of Benefit Programs, 8007 Discovery Drive, Richmond, VA 23229-8699.

Contact: Peggy Friedenberg, Legislative Analyst, Bureau of Governmental Affairs, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

DEPARTMENT OF WASTE MANAGEMENT (VIRGINIA WASTE MANAGEMENT BOARD)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Virginia Waste Management Board intends to consider amending regulations entitled: **VR 672-20-10. Solid Waste Management Regulations.** The purpose of the proposed action is to update the 1988 regulations including requirements of the newly promulgated federal Solid Waste Disposal Facility Criteria.

Statutory Authority: § 10.1-1402 of the Code of Virginia.

Written comments may be submitted until April 1, 1992.

Contact: Wladimir Gulevich, Department of Waste Management, 101 N. 14th Street, 11th Floor, Monroe Building, Richmond, VA 23219, telephone (804) 225-2667.

VIRGINIA DEPARTMENT OF
YOUTH & FAMILY SERVICES
Youth Begins With You.

BOARD OF YOUTH AND FAMILY SERVICES

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Youth and Family Services intends to consider promulgating regulations entitled: **Regulations for State Reimbursement of Local Juvenile Residential Facility Construction Costs.** The purpose of the proposed action is to (i) provide guidelines evaluating requests for reimbursement of local facility construction costs; (ii) include criteria for assessing need and establishing priorities; (iii) ensure the fair and equitable distribution of state funds provided for reimbursing local facility construction costs; and (iv) provide criteria for private construction of detention or other residential facilities.

Statutory Authority: §§ 16.1-313, 16.1-322.5 through 16.1-322.7 and 66-10 of the Code of Virginia.

Written comments may be submitted until March 16, 1992.

Contact: Paul Steiner, Policy Coordinator, P.O. Box 3AG, Richmond, VA 23208, telephone (804) 371-0700.

For information concerning Proposed Regulations, see information page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates proposed new text. Language which has been stricken indicates proposed text for deletion.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: **State Plan for Medical Assistance Relating to Inpatient Outlier Adjustments.**
VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until May 8, 1992.
(See Calendar of Events section for additional information)

Summary:

The purpose of this proposal is to promulgate permanent regulations to supersede the existing emergency regulations.

The section of the State Plan affected by this action is the Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care (Attachment 4.19A).

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) § 4604 required that State Plans, which reimburse inpatient hospital services on a prospective basis, provide for an outlier adjustment payment for certain medically necessary inpatient hospital services. Specifically, these services involve exceptionally high costs or exceptionally long lengths of stay for (i) infants younger than one year of age in all hospitals, and (ii) children younger than one year of age in disproportionate share hospitals. The Plan, prior to the existing emergency regulation, provided for an outlier adjustment for exceptionally high costs for infants younger than one year of age in disproportionate share hospitals only.

Supplement 1 to Attachment 3.1 A & B (the Amount, Duration, and Scope of Services) currently provides for unlimited medically necessary days for children younger than 21 years because of the well child screening program (Early and Periodic Screening, Diagnosis, and Treatment). This language is being incorporated into Attachment 4.19 A at the direction of the Health Care Financing Administration.

VR 460-02-4.1910. Methods and Standards for Establishing Payment

The state agency will pay the reasonable cost of inpatient hospital services provided under the Plan. In reimbursing hospitals for the cost of inpatient hospital services provided to recipients of medical assistance.

I. For each hospital also participating in the Health Insurance for the Aged Program under Title XVIII of the Social Security Act, the state agency will apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the inpatient routine services costs for medical assistance recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII inpatient routing service charges or patient days as well as Title XVIII inpatient routine service cost.

II. For each hospital not participating in the Program under Title XVIII of the Act, the state agency will apply the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost apportionment methods in 42 CFR 447.250, or (b) the "Gross RCCAC method" of cost apportionment applied as follows: For a reporting period, the total allowable hospital inpatient charges; the resulting percentage is applied to the bill of each inpatient under the Medical Assistance Program.

III. For either participating or nonparticipating facilities, the Medical Assistance Program will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2), and/or lesser of reasonable cost or customary charges in 42 CFR 447.250.

IV. The state agency will apply the standards and principles as described in the state's reimbursement plan approved by the Secretary, HHS on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in paragraphs I and II above.

V. The reimbursement system for hospitals includes the following components:

(1) Hospitals were grouped by classes according to number of beds and urban versus rural. (Three groupings for rural–0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban–0 to 100, 101 to 400, 401 to 600, and over 600 beds.) Groupings are similar to those used by the Health Care Financing Administration (HCFA) in determining routine cost limitations.

(2) Prospective reimbursement ceilings on allowable operating costs were established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982, were subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, was based on available, allowable cost data for all hospitals in calendar year 1981. Individual hospital operating costs were advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs were standardized using SMSA wage indices, and a median was determined for each group. These medians were readjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping has a series of ceilings representing one of each SMSA area. The wage index is based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

Effective July 1, 1986, and until June 30, 1988, providers subject to the prospective payment system of reimbursement had their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This method uses an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Chase Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year began.

The prospective operating cost rate is based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

The prospective operating cost ceiling is determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The allowance for inflation percent of change for the quarter in which the provider's new fiscal year began is added to this base to determine the new operating cost ceiling. This new ceiling was effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the base for computing the next prospective year ceiling.

Effective on and after July 1, 1988, and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation will be based on the percent of change in the moving average of the Data Resources, Incorporated Health Care Cost HCFA-Type Hospital Market Basket determined in the quarter in which the provider's new fiscal year begins. Such providers will have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988, for all such hospitals will be adjusted to reflect this change.

Effective on and after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation will be based on the percent of change in the moving average of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for Virginia, as developed by Data Resources, Incorporated, determined in the quarter in which the provider's new fiscal year begins. Such providers will have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989, for all such hospitals will be adjusted to reflect this change.

The new method will still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

(3) Subsequent to June 30, 1982, the group ceilings should not be recalculated on allowable costs, but should be updated by the escalator.

(4) Prospective rates for each hospital should be based upon the hospital's allowable costs plus the escalator, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment should be made to prospective rates.

Depreciation, capital interest, and education costs approved pursuant to HIM-15 (Sec. 400), should be considered as pass throughs and not part of the calculation.

(5) An incentive plan should be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 25% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive should be calculated based on the annual cost report.

The table below presents three examples under the new plan:

Group Ceiling	Hospital's Allowable Cost Per Day	Difference $	Difference % of Ceiling	Sliding Scale Incentive $	Sliding Scale Incentive % of Difference
$230	$230	0	0	0	0
$230	207	23.00	10%	2.30	10%
$230	172	57.50	25%	14.38	25%
$230	143	76.00	33%	19.00	25%

(6) There will be special consideration for exception to the median operating cost limits in those instances

where extensive neonatal care is provided.

(7) Hospitals which have a disproportionately higher level of Medicaid patients and which exceed the ceiling shall be allowed a higher ceiling based on the individual hospital's Medicaid utilization. This shall be measured by the percent of Medicaid patient days to total hospital patient days. Each hospital with a Medicaid utilization of over 8.0% shall receive an adjustment to its ceiling. The adjustment shall be set at a percent added to the ceiling for each percent of utilization up to 30%.

Disproportionate share hospitals defined.

Effective July 1, 1988,[1] the following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment.

A. Criteria.

1. A Medicaid inpatient utilization rate in excess of 8.0% for hospitals receiving Medicaid payments in the Commonwealth, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subsection A 2 does not apply to a hospital:

a. At which the inpatients are predominantly individuals under 18 years of age; or

b. Which does not offer nonemergency obstetric services as of December 21, 1987.

B. Payment adjustment.

1. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the individual hospital's Medicaid utilization. The Medicaid utilization shall be determined by dividing the total number of Medicaid inpatient days by the number of inpatient days. Each hospital with a Medicaid utilization of over 8.0% shall receive a disproportionate share payment adjustment. The disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8.0%, times (ii) the lower of the prospective operating cost rate or ceiling.

2. A payment adjustment for hospitals meeting the eligibility criteria in subsection A above and calculated under subsection B 1 above shall be phased in over a 3-year period. As of July 1, 1988,[2] the adjustment shall be at least one-third the amount of the full payment adjustment; as of July 1, 1989, the payment shall be at least two-thirds the full payment adjustment; and as of July 1, 1990, the payment shall be the full amount of the payment adjustment. However, for each year of the phase-in period, no hospital shall receive a disproportionate share payment adjustment which is less than it would have received if the payment had been calculated pursuant to § V (5) of Attachment 4.19A to the State Plan in effect before July 1, 1988.

~~(8) DMAS shall pay to disproportionate share hospitals (as defined in § V (7) above) an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs for individuals under one year of age. The adjustment shall be calculated as follows:~~

~~(a) Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals under one year of age. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.~~

~~(b) Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals under one year of age. Any hospital which qualifies for the extensive neonatal care provision (as governed by § V (6) above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals under one year of age.~~

~~(c) Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in subdivision (b) above.~~

~~(d) DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital.~~

~~Pursuant to section 1 of Supplement 1 to Attachment 3.1 A and B, there is no limit on length of time for medically necessary stays for individuals under one year of age.~~

(8) Outlier adjustments.

a. DMAS shall pay to all enrolled hospitals an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under one year of age.

b. DMAS shall pay to disproportionate share hospitals (as defined in V (7) above) an outlier adjustment in payment amount for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under six years of age.

c. The outlier adjustment calculation.

(1) Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

(2) Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. Any hospital which qualifies for the extensive neonatal care provision (as governed by V (6) above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals identified in (8) a or b above.

(3) Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in (8) c (2) above.

(4) DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital.

d. Pursuant to § 1 of Supplement 1 to Attachment 3.1 A & B, there is no limit on length of time for medically necessary stays for individuals under six years of age. This section provides that consistent with the EPSDT program referred to in 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 acute care 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. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

VI. In accordance with Title 42 §§ 447.250 through 447.272 of the Code of Federal Regulations which implements § 1902(a)(13)(A) of the Social Security Act, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that shall be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards. To establish these rates Virginia uses the Medicare principles of cost reimbursement in determining the allowable costs for Virginia's prospective payment system. Allowable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of changes in financial position, and footnotes to the financial statements;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Home office cost report, if applicable; and

6. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

Although utilizing the cost apportionment and cost finding methods of the Medicare Program, Virginia does not adopt the prospective payment system of the Medicare

Program enacted October 1, 1983.

VII. Revaluation of assets.

A. Effective October 1, 1984, the valuation of an asset of a hospital or long-term care facility which has undergone a change of ownership on or after July 18, 1984, shall be the lesser of the allowable acquisition cost to the owner of record as of July 18, 1984, or the acquisition cost to the new owner.

B. In the case of an asset not in existence as of July 18, 1984, the valuation of an asset of a hospital or long-term care facility shall be the lesser of the first owner of record, or the acquisition cost to the new owner.

C. In establishing an appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable prior to July 1, 1986) the base to be used for such computations shall be limited to A or B above.

D. Costs (including legal fees, accounting and administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) shall be reimbursable only to the extent that they have not been previously reimbursed by Medicaid.

E. The recapture of depreciation up to the full value of the asset is required.

F. Rental charges in sale and leaseback agreements shall be restricted to the depreciation, mortgage interest and (if applicable prior to July 1, 1986) return on equity based on cost of ownership as determined in accordance with A and B above.

VIII. Refund of overpayments.

A. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

B. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule.

If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services ("the director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

D. Extension request documentation.

In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

E. Interest charge on extended repayment.

Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's

determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal factfinding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

IX. Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals, which are exempted from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding sections I, II, III, IV, V, VI, VII, VIII and excluding V(6). Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are exempt from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports annually utilizing the applicable Medicare cost reporting forms (HCFA 2552 series) and the Medicaid forms (MAP-783 series).

A new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by the DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating cost or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of IX.

X. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

XI. Pursuant to Item 389 E4 of the 1988 Appropriation Act (as amended), effective July 1, 1988, a separate group ceiling for allowable operating costs shall be established for state-owned university teaching hospitals.

XII. Nonenrolled providers.

A. Hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the DMAS average reimbursable inpatient cost-to-charge ratio, updated annually, for enrolled hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Hospitals that are not enrolled shall submit claims using the required DMAS invoice formats. Such claims must be submitted within 12 months from date of services. A hospital is determined to regularly treat Virginia Medicaid recipients and shall be required by DMAS to enroll if it provides more than 500 days of care to Virginia Medicaid recipients during the hospitals' financial fiscal year. A hospital which is required by DMAS to enroll shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding Sections I, II, III, IV, V, VI, VII, VIII, IX, and X. The hospital shall be placed in one of the DMAS peer groupings which most nearly reflects its licensed bed size and location (Section V.(1) above). These hospitals shall be required to maintain separate cost accounting records, and to file separate cost reports annually, utilizing the applicable Medicare cost reporting forms, (HCFA 2552 Series) and the Medicaid forms (MAP-783 Series).

B. A newly enrolled facility shall have an interim rate determined using the provider's most recent filed Medicare cost report or a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider shall be limited to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates shall be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of XII.A.

C. Once a hospital has obtained the enrolled status, 500 days of care, the hospital must agree to become enrolled as required by DMAS to receive reimbursement. This status shall continue during the entire term of the provider's current Medicare certification and subsequent recertification or until mutually terminated with 30 days written notice by either party. The provider must maintain this enrolled status to receive reimbursement. If an enrolled provider elects to terminate the enrolled agreement, the nonenrolled reimbursement status will not be available to the hospital for future reimbursement, except for emergency care.

D. Prior approval must be received from the DMAS Health Services Review Division when a referral has been made for treatment to be received from a nonenrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.

E. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an

exception basis and reimbursing for these services on an individually, negotiated rate basis.

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Title of Regulation: **State Plan for Medical Assistance Relating to Reimbursement Adjustment for Nonemergency Emergency Room Care.**
VR 460-02-4.1920. Methods and Standards Used for Establishing Payment Rates–Other Types of Care.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until May 8, 1992.
(See Calendar of Events section for additional information)

Summary:

The purpose of this proposal is to promulgate permanent regulations to supersede the identical emergency regulation.

The section of the State Plan affected by this proposed regulation is Attachment 4.19 B Methods and Standards for Establishing Payment Rates–Other Types of Care. The amendments adjust the reimbursement for nonemergency services when rendered by emergency rooms (ER) and ER physicians.

Inappropriate use of the emergency room for nonemergency primary care has been a problem for hospitals, physicians, and third-party payers. Such inappropriate use results in higher medical costs, decreased efficiency of care and service delivery compared to care delivered by the patient's primary care physician, and the overcrowding of emergency room facilities.

Effective July 1, 1991, the Department of Medical Assistance Services (DMAS) began implementing a reimbursement reduction for nonemergency services provided in the emergency room setting. The reimbursement reduction is applied to both the facility fee and the physician fee. The intent of the program is to ensure nonemergency services provided in the emergency room are reimbursed at a rate approximating the reimbursement for that service had it been provided in a more appropriate setting, for example, the physician's office. The reimbursement rate may be conditional upon the review of emergency-related diagnosis or trauma diagnosis codes and the necessary documentation supporting the need for emergency services. The appropriate reimbursement rate is assigned by the Medicaid claims processing system, in conjunction with a manual review of selected claims, based upon the International Classification of Diseases, 9th Revision, Clinical Modification coding methodology (ICD-9-CM). Two categories are used: (i) pay the claim at the existing emergency rate for emergency services; (ii) pay the claim at the nonemergency rate for nonemergency services.

The reimbursement categories are based upon the ICD-9-CM diagnosis code. These codes are determined by the physician's diagnosis and assigned by the facility prior to the submission of the claim. For this program, DMAS assigned ICD-9-CM codes to two lists, one representing diagnosis codes that are true emergencies and the other, diagnosis codes that may be true emergencies if they meet certain criteria. Diagnosis codes that appear on the second list are reviewed to determine the emergency or nonemergency nature of the visit. Diagnosis codes that were not assigned to either list represent diagnoses for which the emergency room is not the most appropriate setting for care.

The review of the diagnosis codes to determine the list to which they were assigned was accomplished by a DMAS work group comprised of experienced physicians and nurse utilization review analysts. Information was obtained from other Medicaid agencies with similar programs in place. In addition, consultation and advice was sought from representatives of hospitals and emergency room physicians through the Virginia Hospital Association (VHA) and the American College of Emergency Room Physicians (ACEP).

VR 460-02-4.1920. Methods and Standards used for Establishing Pyament Rates–Other Types of Care.

The policy and the method to be used in establishing payment rates for each type of care or service (other than inpatient hospitalization, skilled nursing and intermediate care facilities) listed in § 1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs:

a. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

b. Participation in the program will be limited to providers of services who accept, as payment in full, the state's payment plus any copayment required under the State Plan.

c. Payment for care or service will not exceed the amounts indicated to be reimbursed in accord with the policy and methods described in this Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.304(a). The state agency has continuing access to data identifying the maximum charges allowed: such data will be made available to the Secretary, HHS,

upon request.

d. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

The services that are cost reimbursed are:

~~(1)~~ *1.* Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals

~~(2) Home health care services~~

~~(3)~~ *2.* Outpatient hospital services excluding laboratory

a. Definitions. The following words and terms, when used in this regulation, shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency room and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury which has occurred less than 72 hours prior to the emergency room visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency rooms and reimburse for nonemergency care rendered in emergency rooms at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services rendered in emergency rooms which DMAS determines were nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services determined by the attending physician which may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for (2) above. Services not meeting certain criteria shall be paid under the methodology of (1) above. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion,

loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

~~(4)~~ *3.* Rural health clinic services provided by rural health clinics or other federally qualified health centers defined as eligible to receive grants under the Public Health Services Act §§ 329, 330, and 340.

~~(5)~~ *4.* Rehabilitation agencies

~~(6)~~ *5.* Comprehensive outpatient rehabilitation facilities

~~(7)~~ *6.* Rehabilitation hsopital outpatient services.

e. Fee-for-service providers. (1) Payment for the following services shall be the lowest of: State agency fee schedule, actual charge (charge to the general public), or Medicare (Title XVIII) allowances:

(a) Physicians' services (Supplement 1 has obstetric/pediatric fees.)

The following limitations shall apply to emergency physician services.

Definitions. The following words and terms, when used in this regulation, shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury which has occurred less than 72 hours prior to the emergency room visit.

Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency rooms and reimburse physicians for nonemergency care rendered in emergency rooms at a reduced rate.

(i) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services rendered in emergency rooms which DMAS determines are nonemergency care.

(ii) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(iii) Services determined by the attending physician which may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for (ii) above. Services not meeting certain criteria shall be paid under the methodology of (i) above. Such criteria shall include, but not be limited to:

a. The initial treatment following a recent obvious injury.

b. Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

c. The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

d. A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

e. Services provided for acute vital sign changes as specified in the provider manual.

f. Services provided for severe pain when combined with one or more of the other guidelines.

(iv) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(v) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

(b) Dentists' services

(c) Mental health services including:

Community mental health services

Services of a licensed clinical psychologist

Mental health services provided by a physician

(d) Podiatry

(e) Nurse-midwife services

(f) Durable medical equipment

(g) Local health services

(h) Laboratory services (Other than inpatient hospital)

(i) Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)

(j) X-Ray services

(k) Optometry services

(l) Medical supplies and equipment.

(2) Hospice services payments must be no lower than the amounts using the same methodology used under part A of Title XVIII, and adjusted to disregard offsets attributable to Medicare coinsurance amounts.

f. Payment for pharmacy services shall be the lowest of items (1) through (5) (except that items (1) and (2) will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.331 (c) if the brand cost is greater than the HCFA upper limit of VMAC cost) subject to the conditions, where applicable, set forth in items (6) and (7) below:

(1) The upper limit established by the Health Care Financing Administration (HCFA) for multiple source drugs pursuant to 42 CFR §§ 447.331 and 447.332, as determined by the HCFA Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

(2) The Virginia Maximum Allowable Cost (VMAC) established by the agency plus a dispensing fee, if a legend drug, for multiple source drugs listed on the VVF.

(3) The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percent discount established by the methodology set out in (a) through (c) below. (Pursuant to OBRA 90 § 4401, from January 1, 1991, through December 31, 1994, no changes in reimbursement limits or dispensing fees shall be made which reduce such limits or fees for covered outpatient drugs).

(a) Percent discount shall be determined by a statewide survey of providers' acquisition cost.

(b) The survey shall reflect statistical analysis of actual provider purchase invoices.

(c) The agency will conduct surveys at intervals deemed necessary by DMAS, but no less frequently than triennially.

(4) A mark-up allowance (150%) of the Estimated Acquisition Cost (EAC) for covered nonlegend drugs and oral contraceptives.

(5) The provider's usual and customary charge to the public, as identified by the claim charge.

(6) Payment for pharmacy services will be as described above; however, payments for legend drugs (except oral contraceptives) will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Payments will be reduced by the amount of the established copayment per prescription by noninstitutionalized clients with exceptions as provided in federal law and regulation.

(7) The Program recognizes the unit dose delivery system of dispensing drugs only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose add on fee and an allowance for the cost of unit dose packaging established by the state agency. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC based on the 60th percentile cost level identified by the state agency or HCFA's upper limits. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency.

(8) Historical determination of EAC. Determination of

EAC was the result of an analysis of FY'89 paid claims data of ingredient cost used to develop a matrix of cost using 0 to 10% reductions from AWP as well as discussions with pharmacy providers. As a result of this analysis, AWP minus 9.0% was determined to represent prices currently paid by providers effective October 1, 1990.

The same methodology used to determine AWP minus 9.0% was utilized to determine a dispensing fee of $4.40 per prescription as of October 1, 1990. A periodic review of dispensing fee using Employment Cost Index - wages and salaries, professional and technical workers will be done with changes made in dispensing fee when appropriate. As of October 1, 1990, the Estimated Acquisition Cost will be AWP minus 9.0% and dispensing fee will be $4.40.

g. All reasonable measures will be taken to ascertain the legal liability of third parties to pay for authorized care and services provided to eligible recipients including those measures specified under 42 USC 1396(a)(25).

h. The single state agency will take whatever measures are necessary to assure appropriate audit of records whenever reimbursement is based on costs of providing care and services, or on a fee-for-service plus cost of materials.

i. Payment for transportation services shall be according to the following table:

TYPE OF SERVICE	PAYMENT METHODOLOGY
Taxi services	Rate set by the single state agency
Wheelchair van	Rate set by the single state agency
Nonemergency ambulance	Rate set by the single state agency
Emergency ambulance	Rate set by the single state agency
Volunteer drivers	Rate set by the single state agency
Air ambulance	Rate set by the single state agency
Mass transit	Rate charged to the public
Transportation agreements	Rate set by the single state agency
Special Emergency transportation	Rate set by the single state agency

j. Payments for Medicare coinsurance and deductibles for noninstitutional services shall not exceed the allowed charges determined by Medicare in accordance with 42 CFR 447.304(b) less the portion paid by Medicare, other third party payors, and recipient copayment requirements of this Plan. See Supplement 2 of this methodology.

k. Payment for eyeglasses shall be the actual cost of the frames and lenses not to exceed limits set by the single state agency, plus a dispensing fee not to exceed limits set by the single state agency.

l. Expanded prenatal care services to include patient education, homemaker, and nutritional services shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

m. Targeted case management for high-risk pregnant women and infants up to age 1 shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

n. Reimbursement for all other nonenrolled institutional and noninstitutional providers.

(1) All other nonenrolled providers shall be reimbursed the lesser of the charges submitted, the DMAS cost to charge ratio, or the Medicare limits for the services provided.

(2) Outpatient hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the DMAS average reimbursable outpatient cost-to-charge ratio, updated annually, for enrolled outpatient hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Outpatient hospitals that are nonenrolled shall submit claims on DMAS invoices.

(3) Nonenrolled providers of noninstitutional services shall be paid on the same basis as enrolled in-state providers of noninstitutional services. Nonenrolled providers of physician, dental, podiatry, optometry, and clinical psychology services, etc., shall be reimbursed the lesser of the charges submitted, or the DMAS rates for the services.

(4) All nonenrolled noninstitutional providers shall be reviewed every two years for the number of Medicaid recipients they have served. Those providers who have had no claims submitted in the past twelve months shall be declared inactive.

(5) Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

o. Refund of overpayments.

(1) Providers reimbursed on the basis of a fee plus

cost of materials.

(a) When DMAS determines an overpayment has been made to a provider, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

(b) If the provider cannot refund the total amount of the overpayment within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

(c) In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

(d) Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (ii) the issue date factfinding conference, if the provider does not file an appeal, or (iii) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

(2) Providers reimbursed on the basis of reasonable costs.

(a) When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

(b) If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

(c) If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the

full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

(d) In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

(e) Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal factfinding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

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Title of Regulation: **State Plan for Medical Assistance Relating to Community Mental Health/Mental Retardation Services.**
VR 460-03-3.1100. Amount, Duration and Scope of Services.
VR 460-03-3.1102. Case Management Services.
VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality Care.
VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates—Other Types of Care.
VR 460-04-8.1500. Community Mental Health and Mental Retardation Services: Amount, Duration and Scope of Services.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until May 8, 1992.
(See Calendar of Events section for additional information)

Summary:

The purpose of this proposal is to obtain federal financial participation for some current programs and services, previously funded with 100% state funds, and to meet future demand for treatment services.

The 1990 Appropriations Act (Item 466) directed the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and DMAS to provide Medicaid coverage for community mental health and mental retardation services in Virginia. The purpose of this expansion of the Medicaid program is to obtain federal financial participation for some current programs and services as well as to meet future demand for treatment services. At a time of increasing fiscal constraints on state dollars, federal funding through Title XIX is the only mechanism available for addressing significant unmet service needs and continuing the Phase I Community Services initiative. In addition, this action enables the Commonwealth to make effective use of federal funds.

On October 1, 1990, Medicaid began coverage of mental health, mental retardation rehabilitation services under an emergency regulation. During subsequent months, the DMAS and DMHMRSAS received feedback and resolved implementation problems associated with the emergency regulation, as identified by the Community Services Boards (CSBs). Some of the regulation's provisions presented implementation problems which could only be resolved by substantive change to the regulation itself. Thus a second emergency regulation was implemented effective July 1, 1991.

The second emergency regulation differed from the initial regulation by including provisions proposed by

the CSBs to simplify regulatory requirements imposed on the Boards, and to increase the services for which Medicaid reimbursement can be made. This proposed regulation reflects the content of the second emergency regulation.

The scope and coverage of this proposed regulation include Medicaid options for mental health and mental retardation services. The service definitions, provider requirements and qualification, and utilization review requirements included in the Plan change were developed by a task force of DMAS, DMHMRSAS, and local Community Services Board representatives.

Covered mental health services include targeted case management and rehabilitation services (e.g., emergency services, partial hospitalization/day treatment for adults, psychosocial rehabilitation for adults, therapeutic day treatment for children and adolescents).

For patients to be eligible to receive community mental health services, they must meet the standard Medicaid eligibility criteria. In addition, other service-specific criteria include the following: mental health targeted case management services will be limited to adults with serious mental illness and children with serious emotional disturbances or who are at risk for serious emotional disturbance, as determined by diagnosis, level of disability, and duration of illness; eligibility for mental health rehabilitation services will be determined by specific utilization criteria.

Covered mental retardation services include targeted case management and rehabilitation services such as day health and rehabilitation services.

Targeted case management services will be directed to those Medicaid eligibles who are mentally retarded. All of the mental retardation services will be provided based on a plan of care, developed by the case manager, which is to be approved and reviewed by DMHMRSAS staff every six months. Eligibility for mental retardation services will be determined by specific utilization criteria.

The 1988-90 Appropriations Act specifically dictated controls upon the providers who would be eligible to provide these services. These new covered services will be limited to providers who meet the specified qualifications. Programs must:

- *Be in accordance with the DMHMRSAS Comprehensive State Plan, 1990-96*
- *Be licensed under regulations promulgated by DMHMRSAS*
- *Guarantee client access to emergency services on a 24-hour basis*
- *Demonstrate willingness and ability to serve all in need, regardless of ability to pay, or eligibility for Medicaid*
- *Have the necessary administrative and financial management capabilities*
- *Have the capacity to document individual case records to meet state and federal requirements.*

VR 460-03-3.1100. Amount, Duration and Scope of Services.

General.

The provision of the following 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.

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

A. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under 15 days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed 14 days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection F of this section.)

B. Medicaid does not pay the medicare (Title XVIII) coinsurance for hospital care after 21 days regardless of the length-of-stay covered by the other insurance. (See exception to subsection F of this section.)

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

D. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional 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.

E. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Hospital claims with admission dates on Friday or Saturday 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 admissions will be denied.

F. Coverage of inpatient hospitalization will be limited to a total of 21 days for all admissions within a fixed period, which would begin with the first day inpatient hospital services are furnished to an eligible recipient and end 60 days from the day of the first admission. There may be multiple admissions during this 60-day period; however, when total days exceed 21, all subsequent claims will be reviewed. Claims which exceed 21 days within 60 days with a different diagnosis and medical justification will be paid. Any claim which has the same or similar diagnosis will be denied.

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 acute care 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. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

G. Reimbursement will not be provided for inpatient hospitalization for any selected elective surgical procedures that require a second surgical opinion unless a properly executed second surgical opinion form has been obtained from the physician and submitted with the hospital invoice for payment, or is a justified emergency or exemption. The requirements for second surgical opinion do not apply to recipients in the retroactive eligibility period.

H. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the mandatory outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions. The requirements for mandatory outpatient surgery do not apply to recipients in the retroactive eligibility period.

I. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. 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. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

J. The department may exempt portions or all of the utilization review documentation requirements of subsections A, D, E, F as it pertains to recipients under age 21, G, or H in writing for specific hospitals from time to time as part of their ongoing hospital utilization review peformance evaluation. These exemptions are based on utilization review performance and review edit criteria which determine an individual hospital's review status as specified in the hospital provider manual. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterlization, hysterectomy or abortion procedures were performed, shall be subject to medical documentation requirements.

K. Hospitals qualifying for an exemption of all documentation requirements except as described in subsection J above shall be granted "delegated review status" and shall, while the exemption remains in effect, not be required to submit medical documentation to support pended claims on a prepayment hospital utilzation review basis to the extent allowed by federal or state law or regulation. The following audit conditions apply to delegated review status for hospitals:

1. The department shall conduct periodic on-site post-payment audits of qualifying hospitals using a statistically valid sampling of paid claims for the purpose of reviewing the medical necessity of inpatient stays.

2. The hospital shall make all medical records of which medical reviews will be necessary available upon request, and shall provide an appropriate place for the department's auditors to conduct such review.

3. The qualifying hospital will immediately refund to the department in accordance with § 32.1-325.1 A and B of the Code of Virginia the full amount of any initial overpayment identified during such audit.

4. The hospital may appeal adverse medical necessity and overpayment decisions pursuant to the current administrative process for appeals of post-payment review decisions.

5. The department may, at its option, depending on the utilization review performance determined by an

audit based on criteria set forth in the hospital provider manual, remove a hospital from delegated review status and reapply certain or all prepayment utilization review documentation requirements.

§ 2. Outpatient hospital and rural health clinic services.

2a. Outpatient hospital services.

1. Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

a. Are furnished to outpatients;

b. Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist; and

c. Are furnished by an institution that:

(1) Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and

(2) Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare.

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

3. Reimbursement will not be provided for outpatient hospital services for any selected elective surgical procedures that require a second surgical opinion unless a properly executed second surgical opinion form has been obtained from the physician and submitted with the invoice for payment, or is a justified emergency or exemption.

2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

The same service limitations apply to rural health clinics as to all other services.

2c. 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).

The same service limitations apply to FQHCs as to all other services.

§ 3. Other laboratory and x-ray services.

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

§ 4. Skilled nursing facility services, EPSDT and family planning.

4a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

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

4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. 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 acute care facilities, and the accompanying attendant physician care, 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.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4c. Family planning services and supplies for individuals of child-bearing age.

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

§ 5. 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. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension (subject to the approval of the Psychiatric Review Board) of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. These limitations also apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology.

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 were carried to term.

G. Physician visits to inpatient hospital patients are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses and is further restricted to medically necessary 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 acute care 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 determined to be medically unjustified will be adjusted.

H. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine are covered.

I. Reimbursement will not be provided for physician services for those selected elective surgical procedures requiring a second surgical opinion unless a properly executed second surgical opinion form has been submitted with the invoice for payment, or is a justified emergency or exemption. The requirements for second surgical opinion do not apply to recipients in a retroactive eligibility period.

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.

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. 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. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

§ 6. 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. Optometric services.

1. Diagnostic examination and optometric treatment procedures and services by ophthamologists, 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.

Not provided.

D. Other practitioners' services.

1. Clinical psychologists' services.

a. These limitations apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

b. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology are covered.

§ 7. Home health services.

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

B. Nursing services provided by a home health agency.

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

2. Patients may receive up to 32 visits by a licensed nurse within a 60-day period without authorization. A patient may receive a maximum of 64 nursing visits annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services.

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

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

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

3. For home health aide services, patients may receive up to 32 visits within a 60-day period without authorization from DMAS. A recipient may receive a maximum of 64 visits annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services.

D. Medical supplies, equipment, and appliances suitable for use in the home.

1. All medically necessary supplies, equipment, and appliances are covered for patients of the home health agency. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.

2. Medical supplies, equipment, and appliances for all others are limited to home renal dialysis equipment and supplies, respiratory equipment and oxygen, and ostomy supplies, as authorized by the agency.

3. Supplies, equipment, or appliances that are not covered include, but are not limited to, the following:

a. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners.

b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office.

c. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales).

d. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface; mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience (i.e., electric wheelchair plus a manual chair); cleansing wipes.

e. Prosthesis, except for artificial arms, legs, and their supportive devices which must be preauthorized by the DMAS central office (effective July 1, 1989).

f. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, over-the-counter drugs; dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; support stockings; and nonlegend drugs.

g. Orthotics, including braces, splints, and supports.

h. Home or vehicle modifications.

i. Items not suitable for or used primarily in the home setting (i.e., car seats, equipment to be used while at school, etc.).

j. Equipment that the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.).

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

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

2. Patients may receive up to 24 visits for each rehabilitative therapy service ordered within a 60-day period without authorization. Patients may receive up to 48 visits for each rehabilitative service ordered annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services.

§ 8. Private duty nursing services.

Not provided.

§ 9. Clinic services.

A. 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.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;

2. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. Except in the case of nurse-midwife services, as specified in 42 dentist.

§ 10. Dental services.

A. Dental services are limited to recipients under 21 years of age in fulfillment of the treatment requirements under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

B. Initial, periodic, and emergency examinations; required radiography necessary to develop a treatment plan; patient education; dental prophylaxis; fluoride treatments; dental sealants; routine amalgam and composite restorations; crown recementation; pulpotomies; emergency endodontics for temporary relief of pain; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure are dental services covered without preauthorization by the state agency.

C. All covered dental services not referenced above require preauthorization by the state agency. The following services are also covered through preauthorization: medically necessary full banded orthodontics, for handicapping malocclusions, minor tooth guidance or repositioning appliances, complete and partial dentures, surgical preparation (alveoloplasty) for prosthetics, single permanent crowns, and bridges. The following service is not covered: routine bases under restorations.

D. The state agency may place appropriate limits on a service based on medical necessity, for utilization control, or both. Examples of service limitations are: examinations, prophylaxis, fluoride treatment (once/six months); space maintenance appliances; bitewing x-ray – two films (once/12 months); routine amalgam and composite restorations (once/three years); dentures (once per 5 years); extractions, orthodontics, tooth guidance appliances, permanent crowns, and bridges, endodontics, patient education and sealants (once).

E. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare), are covered for all recipients, and also require preauthorization by the state agency.

§ 11. Physical therapy and related services.

Physical therapy and related services shall be defined as physical therapy, occupational therapy, and speech-language pathology services. These services shall be prescribed by a physician and be part of a written plan of care. Any one of these services may be offered as the sole service and shall not be contingent upon the provision of another service. All practitioners and providers of services shall be required to meet state and federal licensing and/or certification requirements.

11a. Physical Therapy.

A. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective July 1, 1988, the Program will not provide direct reimbursement to enrolled providers for physical therapy service rendered to patients residing in long term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing homes' operating cost.

C. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11b. Occupational therapy.

A. Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for occupational therapy services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist; see Page 1, General and Page 12, Physical Therapy and Related Services.)

A. These services are provided by or under the supervision of a speech pathologist or an audiologist only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for speech-language pathology services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who meets the qualifications in number 1. The program shall meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11d. Authorization for services.

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, or home health agencies shall include authorization for up to 24 visits by each ordered rehabilitative service within a 60-day period. A recipient may receive a maximum of 48 visits annually without authorization. The provider shall maintain documentation to justify the need for services.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized. This request must be signed and dated by a physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS.

11e. Documentation requirements.

A. Documentation of physical therapy, occupational therapy, and speech-language pathology services provided by a hospital-based outpatient setting, home health agency, a school division, or a rehabilitation agency shall, at a minimum:

1. Describe the clinical signs and symptoms of the patient's condition;

2. Include an accurate and complete chronological picture of the patient's clinical course and treatments;

3. Document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

4. Include a copy of the physician's orders and plan of care;

5. Include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

6. Describe changes in each patient's condition and response to the rehabilitative treatment plan;

7. (Except for school divisions) describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination; and

8. In school divisions, include an individualized education program (IEP) which describes the anticipated improvements in functional level in each school year and the time frames necessary to meet these goals.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

11f. Service limitations. The following general conditions shall apply to reimbursable physical therapy, occupational therapy, and speech-language pathology:

A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.

B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

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

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Physical therapy, occupational therapy and speech-language services are to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

§ 13. Other diagnostic, screening, preventive, and

rehabilitative services, i.e., other than those provided elsewhere in this plan.

13a. Diagnostic services.

Not provided.

13b. Screening services.

Not provided.

13c. Preventive services.

Not provided.

13d. Rehabilitative services.

A. Intensive physical rehabilitation:

1. Medicaid covers intensive inpatient rehabilitation services as defined in subdivision A 4 in facilities certified as rehabilitation hospitals or rehabilitation units in acute care hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient physical rehabilitation services as defined in subdivision A 4 in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).

3. These facilities are excluded from the 21-day limit otherwise applicable to inpatient hospital services. Cost reimbursement principles are defined in Attachment 4.19-A.

4. An intensive rehabilitation program provides intensive skilled rehabilitation nursing, physical therapy, occupational therapy, and, if needed, speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation. The nursing staff must support the other disciplines in carrying out the activities of daily living, utilizing correctly the training received in therapy and furnishing other needed nursing services. The day-to-day activities must be carried out under the continuing direct supervision of a physician with special training or experience in the field of rehabilitation.

5. Nothing in this regulation is intended to preclude DMAS from negotiating individual contracts with in-state intensive physical rehabilitation facilities for those individuals with special intensive rehabilitation needs.

B. Community mental health services.

Definitions. The following words and terms, when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise:

"Code" means the Code of Virginia.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DMHMRSAS" means Department of Mental Health, Mental Retardation and Substance Abuse Services consistent with Chapter 1(§ 37.1-39 et seq.) of Title 37.1 of the Code of Virginia.

1. Mental health services. The following services, with their definitions, shall be covered:

a. Intensive in-home services for children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders-III-R (DSM-III-R). These services provide crisis treatment; individual and family counseling; life (e.g., counseling to assist parents to understand and practice proper child nutrition, child health care, personal hygiene, and financial management, etc.), parenting (e.g., counseling to assist parents to understand and practice proper nurturing and discipline, and behavior management, etc.), and communication skills (e.g., counseling to assist parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks.

b. Therapeutic day treatment for children and adolescents shall be provided in sessions of two or more hours per day, to groups of seriously emotionally disturbed children and adolescents or children at risk of serious emotional disturbance in order to provide therapeutic interventions. Day treatment programs, limited annually to 260 days, provide evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control and appropriate peer relations, etc.), and individual, group and family counseling.

c. Day treatment/partial hospitalization services for adults shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 260 days, include the major diagnostic,

medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment.

d. Psychosocial rehabilitation for adults shall be provided in sessions of two or more consecutive hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 312 days, include assessment, medication education, psychoeducation, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support, and education within a supportive and normalizing program structure and environment.

e. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute mental dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities, limited annually to 180 hours, shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual or the family unit or both, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include, but are not limited to, office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

2. Mental retardation services. Day health and rehabilitation services shall be covered and the following definitions shall apply:

a. Day health and rehabilitation services (limited to 500 units per year) shall provide individualized activities, supports, training, supervision, and transportation based on a written plan of care to eligible persons for two or more hours per day scheduled multiple times per week. These services are intended to improve the recipient's condition or to maintain an optimal level of functioning, as well as to ameliorate the recipient's disabilities or deficits by reducing the degree of impairment or dependency. Therapeutic consultation to service providers, family, and friends of the client around implementation of the plan of care may be included as part of the services provided by the day health and rehabilitation program. The provider must be licensed by DMHMRSAS as a Day Support Program. Specific components of day health and rehabilitation services include the following as needed:

(1) Self-care and hygiene skills;

(2) Eating and toilet training skills;

(3) Task learning skills;

(4) Community resource utilization skills (e.g., training in time, telephone, basic computations with money, warning sign recognition, and personal identifications, etc.);

(5) Environmental and behavior skills (e.g., training in punctuality, self-discipline, care of personal belongings and respect for property and in wearing proper clothing for the weather, etc.);

(6) Medication management;

(7) Travel and related training to and from the training sites and service and support activities;

(8) Skills related to the above areas, as appropriate that will enhance or retain the recipient's functioning.

b. There shall be two levels of day health and rehabilitation services: Level I and Level II.

(1) Level I services shall be provided to individuals who meet the basic program eligibility requirements.

(2) Level II services may be provided to individuals who meet the basic program eligibility requirements and for whom one or more of the following indicators are present.

(a) The individual requires physical assistance to meet basic personal care needs (toilet training, feeding, medical conditions that require special attention).

(b) The individual has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals.

(c) The individual requires extensive personal care or constant supervision to reduce or eliminate behaviors which preclude full participation in programming. A formal, written behavioral program is required to address behaviors such as, but not limited to, severe depression, self injury, aggression, or self-stimulation.

§ 14. Services for individuals age 65 or older in institutions for mental diseases.

14a. Inpatient hospital services.

Provided, no limitations.

14b. Skilled nursing facility services.

Provided, no limitations.

14c. Intermediate care facility.

Provided, no limitations.

§ 15. Intermediate care services and intermediate care services for institutions for mental disease and mental retardation.

15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with § 1902 (a)(31)(A) of the Act, to be in need of such care.

Provided, no limitations.

15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided, no limitations.

§ 16. Inpatient psychiatric facility services for individuals under 22 years of age.

Not provided.

§ 17. Nurse-midwife services.

Covered services for the nurse midwife are defined as those services allowed under the licensure requirements of the state statute and as specified in the Code of Federal Regulations, i.e., maternity cycle.

§ 18. Hospice care (in accordance with § 1905 (o) of the Act).

A. Covered hospice services shall be defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in the Code of Federal Regulations, Title 42, Part 418.

B. Categories of care.

As described for Medicare and applicable to Medicaid, hospice services shall entail the following four categories of daily care:

1. Routine home care is at-home care that is not continuous.

2. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered or licensed practical nurse must provide care for more than half of the period of the care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of 8 hours of care per day must be provided to qualify as continuous home care.

3. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the recipient. Respite care is limited to not more than 5 consecutive days.

4. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting.

C. Covered services.

1. As required under Medicare and applicable to Medicaid, the hospice itself must provide all or substantially all of the "core" services applicable for the terminal illness which are nursing care, physician services, social work, and counseling (bereavement, dietary, and spiritual).

2. Other services applicable for the terminal illness that must be available but are not considered "core" services are drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language pathology services.

3. These other services may be arranged, such as by contractual agreement, or provided directly by the hospice.

4. To be covered, a certification that the individual is terminally ill must have been completed by the physician and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no coverage will be provided.

5. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

a. Nursing care. Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved

school of professional nursing and who is licensed as a registered nurse.

b. Medical social services. Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

c. Physician services. Physician services must be performed by a professional who is licensed to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

d. Counseling services. Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

e. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

f. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

g. Drugs and biologicals. Only drugs used which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

h. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

i. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

D. Eligible groups.

To be eligible for hospice coverage under Medicare or Medicaid, the recipient must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the attending physician and the hospice medical director must certify the life expectancy. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

1. For the first 90-day period of hospice coverage, the hospice must obtain, within two calendar days after the period begins, a written certification statement signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. For the initial 90-day period, if the hospice cannot obtain written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

2. For any subsequent 90-day or 30-day period or a subsequent extension period during the individual's lifetime, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s). The hospice must maintain the certification statements.

§ 19. Case management services for high-risk pregnant women and children up to age 1, as defined in Supplement 2 to Attachment 3.1-A in accordance with § 1915(g)(1) of the Act.

Provided, with limitations. See Supplement 2 for detail.

§ 20. Extended services to pregnant women.

20a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

The same limitations on all covered services apply to this group as to all other recipient groups.

20b. Services for any other medical conditions that may complicate pregnancy.

The same limitations on all covered services apply to this group as to all other recipient groups.

§ 21. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of Health and Human Services.

21a. Transportation.

Nonemergency transportation is administered by local health department jurisdictions in accordance with reimbursement procedures established by the Program.

21b. Services of Christian Science nurses.

Not provided.

21c. Care and services provided in Christian Science sanitoria.

Provided, no limitations.

21d. Skilled nursing facility services for patients under 21 years of age.

Provided, no limitations.

21e. Emergency hospital services.

Provided, no limitations.

21f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Not provided.

Emergency Services for Aliens (17.e)

No payment shall be made for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law unless such services are necessary for the treatment of an emergency medical condition of the alien.

Emergency services are defined as:

Emergency treatment of accidental injury or medical condition (including emergency labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical/surgical attention could reasonably be expected to result in:

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

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Medicaid eligibility and reimbursement is conditional upon review of necessary documentation supporting the need for emergency services. Services and inpatient lengths of stay cannot exceed the limits established for other Medicaid recipients.

Claims for conditions which do not meet emergency critieria for treatment in an emergency room or for acute care hospital admissions for intensity of service or severity of illness will be denied reimbursement by the Department of Medical Assistance Services.

VR 460-03-3.1102. Case Management Services.

§ 1. High risk pregnant women and children.

A. Target group.

To reimburse case management services for high-risk Medicaid eligible pregnant women and children up to age two.

B. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of § 1915(g)(1) of the Act is invoked to provide services less than statewide.

C. Comparability of services.

☐ Services are provided in accordance with § 1902(a)(10)(B) of the Act.

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

D. Definition of services.

The case management services will provide maternal and child health coordination to minimize fragmentation of care, reduce barriers, and link clients with appropriate services to ensure comprehensive, continuous health care. The Maternity Care Coordinator will provide:

1. Assessment. Determining clients' service needs,

which include psychosocial, nutrition, medical, and educational factors.

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

3. Coordination and referral. Assisting the client in arranging for appropriate services and ensuring continuity of care.

4. Follow-up and monitoring. Assessing ongoing progress and ensuring services are delivered.

5. Education and counseling. Guiding the client and developing a supportive relationship that promotes the service plan.

E. Qualifications of providers.

Any duly enrolled provider which the department determines is qualified who has signed an agreement with Department of Medical Assistance Services to deliver Maternity Care Coordination services. Qualified service providers will provide case management regardless of their capacity to provide any other services under the Plan. A Maternity Care Coordinator is the Registered Nurse or Social Worker employed by a qualified service provider who provides care coordination services to eligible clients. The RN must be licensed in Virginia and should have a minimum of one year of experience in community health nursing and experience in working with pregnant women. The Social Worker (MSW, BSW) must have a minimum of one year of experience in health and human services, and have experience in working with pregnant women and their families. The Maternity Care Coordinator assists clients in accessing the health care and social service system in order that outcomes which contribute to physical and emotional health and wellness can be obtained.

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

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

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

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

§ 2. Seriously mentally ill adults and emotionally disturbed children.

A. Target Group.

The Medicaid eligible individual shall meet the DMHMRSAS definition for "serious mental illness," or "serious emotional disturbance in children and adolescents."

1. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including a minimum of one face-to-face contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

2. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to 30 days immediately preceding discharge. Case management for institutionalized individuals may be billed for no more than two predischarge periods in 12 months.

B. Areas of state in which services will be provided:

☒ *Entire state.*

☐ *Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:*

C. Comparability of services.

☐ *Services are provided in accordance with section 1902(a)(10)(B) of the Act.*

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

D. Definition of services; mental health services.

Case management services assist individual children and adults, in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include:

1. Assessment and planning services, to include developing an Individual Service Plan (does not include performing medical and psychiatric assessment but does include referral for such assessment);

2. Linking the individual to services and supports specified in the individualized service plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills and use vocational, civic, and recreational services;

6. Making collateral contacts with the individuals' significant others to promote implementation of the service plan and community adjustment;

7. Follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of providers.

1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and individuals with serious/chronic mental illness to the Community Services Boards only to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental health case management, the provider of the services must meet certain criteria. These criteria shall be:

a. The provider must guarantee that clients have access to emergency services on a 24-hour basis;

b. The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

c. The provider must have the administrative and financial management capacity to meet state and federal requirements;

d. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

f. The provider must be certified as a mental health case management agency by the DMHMRSAS.

3. Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers. The case manager must possess a combination of mental health work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The incumbent must have at entry level the following knowledge, skills and abilities. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

(1) The nature of serious mental illness in adults and serious emotional disturbance in children and adolescents;

(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

(3) Different types of assessments, including functional assessment, and their uses in service planning;

(4) Consumers' rights;

(5) Local community resources and service delivery systems, including support services (e.g. housing, financial, social welfare, dental, educational, transportation, communication, recreational, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g. churches, clubs, self-help groups);

(6) Types of mental health programs and services;

(7) Effective oral, written and interpersonal communication; principles and techniques;

(8) General principles of record documentation; and

(9) The service planning process and major components of a service plan.

b. Skills in:

(1) Interviewing;

(2) Observing, recording and reporting on an individual's functioning;

(3) Identifying and documenting a consumer's needs for resources, services and other supports;

(4) Using information from assessments, evaluations, observation and interviews to develop service plans;

(5) Identifying services within the community and established service system to meet the individual's needs;

(6) Formulating, writing and implementing individualized service plans to promote goal attainment for seriously mentally ill and emotionally disturbed persons;

(7) Negotiating with consumers and service providers;

(8) Coordinating the provision of services by diverse public; and private providers;

(9) Identifying community resources and organizations and coordinating resources and activities; and

(10) Using assessment tools (e.g. level of function scale, life profile scale).

c. Abilities to:

(1) Demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of mentally-ill people, respecting consumers' and families' privacy, believing consumers are valuable members of society);

(2) Be persistent and remain objective;

(3) Work as a team member, maintaining effective inter- and intra-agency working relationships;

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

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

(6) Establish and maintain ongoing supportive relationships.

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

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

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

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

§ 3. Youth at risk of serious emotional disturbance.

A. Target Group.

Medicaid eligible individuals who meet the DMHMRSAS definition of youth at risk of serious emotional disturbance.

1. An active client shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including a minimum of one face-to-face contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

2. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to thirty days immediately preceding discharge. Case management for institutionalized individuals may be billed for no more than two predischarge periods in 12 months.

B. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of services.

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

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

D. Definition of services; mental health services.

Case management services assist youth at risk of serious emotional disturbance in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include:

1. Assessment and planning services, to include developing an Individual Service Plan;

2. Linking the individual directly to services and supports specified in the treatment/services plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;

6. Making collateral contacts which are nontherapy contacts with an individual's significant others to promote treatment or community adjustment;

7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of providers.

1. To qualify as a provider of case management services to youth at risk of serious emotional disturbance, the provider of the services must meet certain criteria. These criteria shall be:

a. The provider must guarantee that clients have access to emergency services on a 24-hour basis;

b. The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

c. The provider must have the administrative and financial management capacity to meet state and federal requirements;

d. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

f. The provider must be certified as a mental health case management agency by the DMHMRSAS.

2. Providers may bill Medicaid for mental health case management to youth at risk of serious emotional disturbance only when the services are provided by qualified mental health case managers. The case manager must possess a combination of mental health work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The incumbent must have at entry level the following knowledge, skills and abilities. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

(1) The nature of serious mental illness in adults and serious emotional disturbance in children and adolescents;

(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

(3) Different types of assessments, including functional assessment, and their uses in service planning;

(4) Consumer's rights;

(5) Local community resources and service delivery systems, including support services (e.g. housing, financial, social welfare, dental, educational, transportation, communication, recreational, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g. churches, clubs, self-help groups);

(6) Types of mental health programs and services;

(7) Effective oral, written and interpersonal communication principles and techniques;

(8) General principles of record documentation; and

(9) The service planning process and major components of a service plan.

b. Skills in:

(1) Interviewing;

(2) Observing, recording and reporting on an individual's functioning;

(3) Identifying and documenting a consumer's needs for resources, services and other supports;

(4) Using information from assessments, evaluations, observation and interviews to develop service plans;

(5) Identifying services within the community and established service system to meet the individual's needs;

(6) Formulating, writing and implementing individualized service plans to promote goal attainment for seriously mentally ill and emotionally

disturbed persons;

(7) Negotiating with consumers and service providers;

(8) Coordinating the provision of services by diverse public and private providers;

(9) Identifying community resources and organizations and coordinating resources and activities; and

(10) Using assessment tools (e.g. level of function scale, life profile scale).

c. Abilities to:

(1) Demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of mentally-ill people, respecting consumers' and families' privacy, believing consumers are valuable members of society);

(2) Be persistent and remain objective;

(3) Work as a team member, maintaining effective inter- and intra- agency working relationships;

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

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

(6) Establish and maintain ongoing supportive relationships.

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

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

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

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

§ 4. Individuals with mental retardation.

A. Target group.

Medicaid eligible individuals who are mentally retarded as defined in state law.

1. An active client for mental retardation case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including a minimum of one face-to-face contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

2. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to thirty days immediately preceding discharge. Case management for institutionalized individuals be billed for no more than two predischarge periods in twelve months.

B. Areas of state in which services will be provided:

☒ *Entire state.*

☐ *Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:*

C. Comparability of services.

☐ *Services are provided in accordance with section 1902(a)(10)(B) of the Act.*

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

D. Definition of services.

Mental retardation services to be provided include:

1. Assessment and planning services, to include developing a Consumer Service Plan (does not include performing medical and psychiatric assessment but does include referral for such assessment);

2. Linking the individual to services and supports specified in the consumer service plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic and

recreational services;

6. Making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment;

7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of providers.

1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and serious/chronic mental illness to the Community Services Boards only to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental retardation case management, the provider of the services must meet certain criteria. These criteria shall be:

a. The provider must guarantee that clients have access to emergency services on a 24-hour basis;

b. The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

c. The provider must have the administrative and financial management capacity to meet state and federal requirements;

d. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

f. The provider must be certified as a mental retardation case management agency by the DMHMRSAS.

3. Providers may bill for Medicaid mental retardation case management only when the services are provided by qualified mental retardation case managers. The case manager must possess a combination of mental retardation work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The incumbent must have at entry level the following knowledge, skills and abilities. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

(1) The definition, causes and program philosophy of mental retardation;

(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

(3) Different types of assessments and their uses in program planning;

(4) Consumers' rights;

(5) Local service delivery systems, including support services;

(6) Types of mental retardation programs and services;

(7) Effective oral, written and interpersonal communication principles and techniques;

(8) General principles of record documentation; and

(9) The service planning process and the major components of a service plan.

b. Skills in:

(1) Interviewing;

(2) Negotiating with consumers and service providers;

(3) Observing, recording and reporting behaviors;

(4) Identifying and documenting a consumer's needs for resources, services and other assistance;

(5) Identifying services within the established service system to meet the consumer's needs;

(6) Coordinating the provision of services by diverse public and private providers;

(7) Analyzing and planning for the service needs of mentally retarded persons;

(8) Formulating, writing and implementing individualized consumer service plans to promote goal attainment for individuals with mental

retardation; and

(9) Using assessment tools.

c. Abilities to:

(1) Demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of mentally retarded people, respecting consumers' and families' privacy, believing consumers can grow);

(2) Be persistent and remain objective;

(3) Work as team member, maintaining effective inter- and intra-agency working relationships;

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

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

(6) Establish and maintain ongoing supportive relationships.

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

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

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

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

§ 5. Individuals with mental retardation and related conditions who are participants in the home and community-based care waivers for persons with mental retardation and related conditions.

A. Target group.

Medicaid eligible individuals with mental retardation and related conditions, or a child under six years of age who is at developmental risk, who have been determined to be eligible for home and community based care waiver services for persons with mental retardation and related conditions. An active client for waiver case management shall mean an individual who receives a minimum of one face-to-face contact every two months and monthly on-going case management interactions. There shall be no maximum service limits for case management services. Case management services must be preauthorized by DMAS after review and recommendation by the care coordinator employed by DMHMRSAS and verification of waiver eligibility.

B. Areas of state in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of § 1915(g)(1) of the Act is invoked to provide services less than statewide.

C. Comparability of services.

☐ Services are provided in accordance with § 1902(a)(10)(B) of the Act.

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

D. Definition of services.

Mental retardation case management services to be provided include:

1. Assessment and planning services to include developing a Consumer Service Plan (does not include performing medical and psychiatric assessment but does include referral for such assessment);

2. Linking the individual to services and supports specified in the consumer service plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic and recreational services;

6. Making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment;

7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered: and

8. Education and counseling which guide the client and develop a supportive relationship that promotes the service plan.

E. Qualifications of providers.

1. Services are not comparable in amount, duration,

and scope. Authority of § 1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and serious/chronic mental illness to the community services boards only to enable them to provide services to seriously/chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental retardation case management, the provider of the services must meet certain criteria. These criteria shall be:

a. The provider must guarantee that clients have access to emergency services on a 24-hour basis;

b. The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individuals' ability to pay or eligibility for Medicaid reimbursement;

c. The provider must have the administrative and financial management capacity to meet state and federal requirements;

d. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

f. The provider must be certified as a mental retardation case management agency by the DMHMRSAS.

3. Providers may bill for Medicaid mental retardation case management only when the services are provided by qualified mental retardation case managers. The case manager must possess a combination of mental retardation work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities at the entry level. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

(1) The definition, causes and program philosophy of mental retardation,

(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination,

(3) Different types of assessments and their uses in program planning,

(4) Consumers' rights,

(5) Local service delivery systems, including support services,

(6) Types of mental retardation programs and services.

(7) Effective oral, written and interpersonal communication principles and techniques,

(8) General principles of record documentation, and

(9) The service planning process and the major components of a service plan.

b. Skills in:

(1) Interviewing,

(2) Negotiating with consumers and service providers,

(3) Observing, recording and reporting behaviors,

(4) Identifying and documenting a consumer's needs for resources, services and other assistance,

(5) Identifying services within the established service system to meet the consumer's needs,

(6) Coordinating the provision of services by diverse public and private providers,

(7) Analyzing and planning for the service needs of mentally retarded persons,

(8) Formulating, writing and implementing individualized consumer service plans to promote goal attainment for individuals with mental retardation, and

(9) Using assessment tools.

c. Abilities to:

(1) Demonstrate a positive regard for consumers and their families (e.g., treating consumers as individuals, allowing risk taking, avoiding stereotypes of mentally retarded people, respecting consumers' and families' privacy, believing consumers can grow),

(2) Be persistent and remain objective,

(3) Work as team member, maintaining effective interagency and intraagency working relationships,

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

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

(6) Establish and maintain ongoing supportive relationships.

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

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

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

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

VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality of Care.

The following is a description of the standards and the methods that will be used to assure that the medical and remedial care and services are of high quality:

§ 1. Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX.

§ 2. Utilization control.

A. Hospitals.

1. The Commonwealth of Virginia is required by state law to take affirmative action on all hospital stays that approach 15 days. It is a requirement that the hospitals submit to the Department of Medical Assistance Services complete information on all hospital stays where there is a need to exceed 15 days. The various documents which are submitted are reviewed by professional program staff, including a physician who determines if additional hospitalization is indicated. This review not only serves as a mechanism for approving additional days, but allows physicians on the Department of Medical Assistance Services' staff to evaluate patient documents and give the Program an insight into the quality of care by individual patient. In addition, hospital representatives of the Medical Assistance Program visit hospitals, review the minutes of the Utilization Review Committee, discuss patient care, and discharge planning.

2. In each case for which payment for inpatient hospital services, or inpatient mental hospital services is made under the State Plan:

a. A physician must certify at the time of admission, or if later, the time the individual applies for medical assistance under the State Plan that the individual requires inpatient hospital or mental hospital care.

b. The physician, or physician assistant under the supervision of a physician, must recertify, at least every 60 days, that patients continue to require inpatient hospital or mental hospital care.

c. Such services were furnished under a plan established and periodically reviewed and evaluated by a physician for inpatient hospital or mental hospital services.

B. Long-stay acute care hospitals (nonmental hospitals).

1. Services for adults in long-stay acute care hospitals. The population to be served includes individuals requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, comprehensive rehabilitative therapy services and individuals with communicable diseases requiring universal or respiratory precautions.

a. Long-stay acute care hospital stays shall be preauthorized by the submission of a completed comprehensive assessment instrument, a physician certification of the need for long-stay acute care hospital placement, and any additional information that justifies the need for intensive services. Physician certification must accompany the request. Periods of care not authorized by DMAS shall not be approved for payment.

b. These individuals must have long-term health conditions requiring close medical supervision, the need for 24-hour licensed nursing care, and the need for specialized services or equipment needs.

c. At a minimum, these individuals must require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is the designated unit must be on the nursing unit 24 hours a day on which the resident resides), and coordinated multidisciplinary team approach to meet needs that must include daily therapeutic leisure activities.

d. In addition, the individual must meet at least one of the following requirements:

(1) Must require two out of three of the following rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, five days per week, for a minimum of one hour each day; individual must demonstrate progress in overall rehabilitative

plan of care on a monthly basis; or

(2) Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by a licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy; or

(3) The individual must require at least one of the following special services:

(a) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(b) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only);

(c) Dialysis treatment that is provided on-unit (i.e. peritoneal dialysis);

(d) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(e) Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e. grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body); or

(f) Ongoing management of multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e. suctioning every hour; stabilization of feeding; stabilization of elimination, etc.).

e. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the individuals' medical records as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

f. When the individual no longer meets long-stay acute care hospital criteria or requires services that the facility is unable to provide, then the individual must be discharged.

2. Services to pediatric/adolescent patients in long-stay acute care hospitals. The population to be served shall include children requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, daily dependence on device-based respiratory or nutritional support (tracheostomy, gastrostomy, etc.), comprehensive rehabilitative therapy services, and those children having communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.) and with terminal illnesses.

a. Long-stay acute care hospital stays shall be preauthorized by the submission of a completed comprehensive assessment instrument, a physician certification of the need for long-stay acute care, and any additional information that justifies the need for intensive services. Periods of care not authorized by DMAS shall not be approved for payment.

b. The child must have ongoing health conditions requiring close medical supervision, the need for 24-hour licensed nursing supervision, and the need for specialized services or equipment. The recipient must be age 21 or under.

c. The child must minimally require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is that nursing unit must be on the unit 24 hours a day on which the child is residing), and a coordinated multidisciplinary team approach to meet needs.

d. In addition, the child must meet one of the following requirements:

(1) Must require two out of three of the following physical rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, fivedays per week, for a minimum of 45 minutes per day; child must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

(2) Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy, etc; or

(3) Must require at least one of the following special services:

(a) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(b) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only or isolation for normal childhood diseases such as measles, chicken pox, strep throat, etc.);

(c) Dialysis treatment that is provided within the facility (i.e. peritoneal dialysis);

(d) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(e) Extensive wound care requiring debridement, irrigation, packing, etc. more than two times a day (i.e. grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body);

(f) Ostomy care requiring services by a licensed nurse;

(g) Services required for terminal care.

e. In addition, the long-stay acute care hospital must provide for the educational and habilitative needs of the child. These services must be age appropriate, must meet state educational requirements, and must be appropriate to the child's cognitive level. Services must also be individualized to meet the child's specific needs and must be provided in an organized manner that encourages the child's participation. Services may include, but are not limited to, school, active treatment for mental retardation, habilitative therapies, social skills, and leisure activities. Therapeutic leisure activities must be provided daily.

f. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

g. When the resident no longer meets long-stay hospital criteria or requires services that the facility is unable to provide, the resident must be discharged.

C. Nursing facilities.

1. Long-term care of residents in nursing facilities will be provided in accordance with federal law using practices and procedures that are based on the resident's medical and social needs and requirements.

2. Nursing facilities must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. Each resident must be reviewed at least quarterly, and a complete assessment conducted at least annually.

3. The Department of Medical Assistance Services shall conduct at least annually a validation survey of the assessments completed by nursing facilities to determine that services provided to the residents are medically necessary and that needed services are provided. The survey will be composed of a sample of Medicaid residents and will include review of both current and closed medical records.

4. Nursing facilities must submit to the Department of Medical Assistance Services resident assessment information at least every six months for utilization review. If an assessment completed by the nursing facility does not reflect accurately a resident's capability to perform activities of daily living and significant impairments in functional capacity, then reimbursement to nursing facilities may be adjusted during the next quarter's reimbursement review. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties.

5. In order for reimbursement to be made to the nursing facility for a recipient's care, the recipient must meet nursing facility criteria as described in Supplement 1 to Attachment 3.1-C, Part 1 (Nursing Facility Criteria).

In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in Supplement 1 to Attachment 3.1-C, Part 2 (Adult Specialized Care Criteria) or Part 3 (Pediatric/Adolescent Specialized Care Criteria). Reimbursement for specialized care must be preauthorized by the Department of Medical Assistance Services. In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis.

In each case for which payment for nursing facility services is made under the State Plan, a physician must recommend at the time of admission or, if later, the time at which the individual applies for medical assistance under the State Plan that the individual requires nursing facility care.

6. For nursing facilities, a physician must approve a recommendation that an individual be admitted to a facility. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 90 days thereafter. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

7. When the resident no longer meets nursing facility criteria or requires services that the nursing facility is unable to provide, then the resident must be discharged.

D. Facilities for the Mentally Retarded (FMR) and Institutions for Mental Disease (IMD).

1. With respect to each Medicaid-eligible resident in an FMR or IMD in Virginia, a written plan of care must be developed prior to admission to or authorization of benefits in such facility, and a regular program of independent professional review (including a medical evaluation) shall be completed periodically for such services. The purpose of the review is to determine: the adequacy of the services available to meet his current health needs and promote his maximum physical well being; the necessity and desirability of his continued placement in the facility; and the feasibility of meeting his health care needs through alternative institutional or noninstitutional services. Long-term care of residents in such facilities will be provided in accordance with federal law that is based on the resident's medical and social needs and requirements.

2. With respect to each intermediate care FMR or IMD, periodic on-site inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), shall be conducted. The review shall include, with respect to each recipient, a determination of the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, the necessity and desirability of continued placement in the facility, and the feasibility of meeting his health care needs through alternative institutional or noninstitutional services. Full reports shall be made to the state agency by the review team of the findings of each inspection, together with any recommendations.

3. In order for reimbursement to be made to a facility for the mentally retarded, the resident must meet criteria for placement in such facility as described in Supplement 1, Part 4, to Attachment 3.1-C and the facility must provide active treatment for mental retardation.

4. In each case for which payment for nursing facility services for the mentally retarded or institution for mental disease services is made under the State Plan:

a. A physician must certify for each applicant or recipient that inpatient care is needed in a facility for the mentally retarded or an institution for mental disease. The certification must be made at the time of admission or, if an individual applies for assistance while in the facility, before the Medicaid agency authorizes payment; and

b. A physician, or physician assistant or nurse practitioner acting within the scope of the practice as defined by state law and under the supervision of a physician, must recertify for each applicant at least every 365 days that services are needed in a facility for the mentally retarded or institution for mental disease.

5. When a resident no longer meets criteria for facilities for the mentally retarded or an institution for mental disease or no longer requires active treatment in a facility for the mentally retarded, then the resident must be discharged.

E. Home health services.

1. Home health services which meet the standards prescribed for participation under Title XVIII will be supplied.

2. Home health services shall be provided by a licensed home health agency on a part-time or intermittent basis to a homebound recipient in his place of residence. The place of residence shall not include a hospital or nursing facility. Home health services must be prescribed by a physician and be part of a written plan of care utilizing the Home Health Certification and Plan of Treatment forms which the physician shall review at least every 62 days.

3. Except in limited circumstances described in subdivision 4 below, to be eligible for home health services, the patient must be essentially homebound. The patient does not have to be bedridden. Essentially homebound shall mean:

a. The patient is unable to leave home without the assistance of others or the use of special equipment;

b. The patient has a mental or emotional problem which is manifested in part by refusal to leave the home environment or is of such a nature that it would not be considered safe for him to leave home unattended;

c. The patient is ordered by the physician to restrict activity due to a weakened condition following surgery or heart disease of such severity that stress and physical activity must be avoided;

d. The patient has an active communicable disease and the physician quarantines the patient.

4. Under the following conditions, Medicaid will reimburse for home health services when a patient is not essentially homebound. When home health services are provided because of one of the following reasons, an explanation must be included on the Home Health Certification and Plan of Treatment forms:

a. When the combined cost of transportation and medical treatment exceeds the cost of a home health services visit;

b. When the patient cannot be depended upon to go to a physician or clinic for required treatment, and, as a result, the patient would in all probability have to be admitted to a hospital or nursing facility because of complications arising from the lack of treatment;

c. When the visits are for a type of instruction to the patient which can better be accomplished in the home setting;

d. When the duration of the treatment is such that rendering it outside the home is not practical.

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

a. Nursing services,

b. Home health aide services,

c. Physical therapy services,

d. Occupational therapy services,

e. Speech-language pathology services, or

f. Medical supplies, equipment, and appliances suitable for use in the home.

6. General conditions. The following general conditions apply to reimbursable home health services.

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

b. Services shall be furnished under a written plan of care and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of care and must be related to the patient's condition. The written plan of care shall appear on the Home Health Certification and Plan of Treatment forms.

c. A physician recertification shall be required at intervals of at least once every 62 days, must be signed and dated by the physician who reviews the plan of care, and should be obtained when the plan of care is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long home health services will be needed. Recertifications must appear on the Home Health Certification and Plan of Treatment forms.

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

e. The physician orders for durable medical equipment and supplies shall include the specific item identification including all modifications, the number of supplies needed monthly, and an estimate of how long the recipient will require the use of the equipment or supplies. All durable medical equipment or supplies requested must be directly related to the physician's plan of care and to the patient's condition.

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

(1) The home health services are required because the individual is confined to his or her home (except when receiving outpatient services);

(2) The patient needs licensed nursing care, home health aide services, physical or occupational therapy, speech-language pathology services, or durable medical equipment and/or supplies;

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

(4) These services were furnished while the individual was under the care of a physician.

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

(1) Diagnosis and prognosis,

(2) Functional limitations,

(3) Orders for nursing or other therapeutic services,

(4) Orders for medical supplies and equipment, when applicable

(5) Orders for home health aide services, when applicable,

(6) Orders for medications and treatments, when applicable,

(7) Orders for special dietary or nutritional needs, when applicable, and

(8) Orders for medical tests, when applicable,

including laboratory tests and x-rays

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

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

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

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

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

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

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

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

d. Durable medical equipment and supplies. Durable medical equipment, supplies, or appliances must be ordered by the physician, be related to the needs of the patient, and included on the plan of care. Treatment supplies used for treatment during the visit are included in the visit rate. Treatment supplies left in the home to maintain treatment after the visits shall be charged separately.

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

F. Optometrists' services are limited to examinations (refractions) after preauthorization by the state agency except for eyeglasses as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

G. In the broad category of Special Services which includes nonemergency transportation, all such services for recipients will require preauthorization by a local health department.

H. Standards in other specialized high quality programs such as the program of Crippled Children's Services will be incorporated as appropriate.

I. Provisions will be made for obtaining recommended medical care and services regardless of geographic boundaries.

* * *

PART I.
INTENSIVE PHYSICAL REHABILITATIVE SERVICES.

§ 1.1. A patient qualifies for intensive inpatient or outpatient rehabilitation if:

A. Adequate treatment of his medical condition requires an intensive rehabilitation program consisting of a multi-disciplinary coordinated team approach to improve his ability to function as independently as possible; and

B. It has been established that the rehabilitation program cannot be safely and adequately carried out in a less intense setting.

§ 1.2. In addition to the initial disability requirement, participants shall meet the following criteria:

A. Require at least two of the listed therapies in addition to rehabilitative nursing:

1. Occupational Therapy

2. Physical Therapy

3. Cognitive Rehabilitation

4. Speech-Language Therapy

B. Medical condition stable and compatible with an active rehabilitation program.

PART II.
INPATIENT ADMISSION AUTHORIZATION.

§ 2.1. Within 72 hours of a patient's admission to an intensive rehabilitation program, or within 72 hours of notification to the facility of the patient's Medicaid eligibility, the facility shall notify the Department of Medical Assistance Services in writing of the patient's admission. This notification shall include a description of the admitting diagnoses, plan of treatment, expected progress and a physician's certification that the patient meets the admission criteria. The Department of Medical Assistance Services will make a determination as to the appropriateness of the admission for Medicaid payment and notify the facility of its decision. If payment is approved, the Department will establish and notify the facility of an approved length of stay. Additional lengths of stay shall be reques ted in writing and approved by the Department. Admissions or lengths of stay not authorized by the Department of Medical Assistance Services will not be approved for payment.

PART III.
DOCUMENTATION REQUIREMENTS.

§ 3.1. Documentation of rehabilitation services shall, at a minimum:

A. Describe the clinical signs and symptoms of the patient necessitating admission to the rehabilitation program;

B. Describe any prior treatment and attempts to rehabilitate the patient;

C. Document an accurate and complete chronological picture of the patient's clinical course and progress in treatment;

D. Document that a multi-disciplinary coordinated treatment plan specifically designed for the patient has been developed;

E. Document in detail all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response to treatment, and identify who provided such treatment;

F. Document each change in each of the patient's conditions;

G. Describe responses to and the outcome of treatment; and

H. Describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

§ 3.2. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no reimbursement will be provided.

PART IV.
INPATIENT REHABILITATION EVALUATION.

§ 4.1. For a patient with a potential for physical rehabilitation for which an outpatient assessment cannot be adequately performed, an intensive evaluation of no more than seven calendar days will be allowed. A comprehensive assessment will be made of the patient's medical condition, functional limitations, prognosis, possible need for corrective surgery, attitude toward rehabilitation, and the existence of any social problems affecting

rehabilitation. After these assessments have been made, the physician, in consultation with the rehabilitation team, shall determine and justify the level of care required to achieve the stated goals.

§ 4.2. If during a previous hospital stay an individual completed a rehabilitation program for essentially the same condition for which inpatient hospital care is now being considered, reimbursement for the evaluation will not be covered unless there is a justifiable intervening circumstance which necessitates a re-evaluation.

§ 4.3. Admissions for evaluation and/or training for solely vocational or educational purposes or for developmental or behavioral assessments are not covered services.

PART V.
CONTINUING EVALUATION.

§ 5.1. Team conferences shall be held as needed but at least every two weeks to assess and document the patient's progress or problems impeding progress. The team shall periodically assess the validity of the rehabilitation goals established at the time of the initial evaluation, and make appropriate adjustments in the rehabilitation goals and the prescribed treatment program. A review by the various team members of each others' notes does not constitute a team conference. A summary of the conferences, noting the team members present, shall be recorded in the clinical record and reflect the reassessments of the various contributors.

§ 5.2. Rehabilitation care is to be terminated, regardless of the approved length of stay, when further progress toward the established rehabilitation goal is unlikely or further rehabilitation can be achieved in a less intensive setting.

§ 5.3. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no reimbursment shall be provided.

PART VI.
THERAPEUTIC FURLOUGH DAYS.

§ 6.1. Properly documented medical reasons for furlough may be included as part of an overall rehabilitation program. Unoccupied beds (or days) resulting from an overnight therapeutic furlough will not be reimbursed by the Department of Medical Assistance Services.

PART VII.
DISCHARGE PLANNING.

§ 7.1. Discharge planning shall be an integral part of the overall treatment plan which is developed at the time of admission to the program. The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination. The patient, unless unable to do so, or the responsible party shall participate in the discharge planning. Notations concerning changes in the discharge plan shall be entered into the record at least every two weeks, as a part of the team conference.

PART VIII.
REHABILITATION SERVICES TO PATIENTS.

§ 8.1. Rehabilitation services are medically prescribed treatment for improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. The rules pertaining to them are:

A. Rehabilitative nursing.

Rehabilitative nursing requires education, training, or experience that provides special knowledge and clinical skills to diagnose nursing needs and treat individuals who have health problems characterized by alteration in cognitive and functional ability.

Rehabilitative nursing are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan approved by a physician after any needed consultation with a registered nurse who is experienced in rehabilitation;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a registered nurse or licensed professional nurse, nursing assistant, or rehabilitation technician under the direct supervision of a registered nurse who is experienced in rehabilitation;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The service shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative nursing services which can only be provided in an intensive rehabilitation setting.

B. Physical therapy.

Physical therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a qualified physical therapist licensed by the Board of Medicine;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

C. Occupational therapy.

Occupational therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Certification Board under the direct supervision of a qualified occupational therapist as defined above;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

D. Speech-Language therapy.

Speech-Language therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

E. Cognitive rehabilitation.

Cognitive rehabilitation services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a clinical psychologist experienced in working with the neurologically impaired and licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be rendered after a neuropsychological evaluation administered by a clinical psychologist or physician experienced in the administration of neuropsychological assessments and licensed by the Board of Medicine and in accordance with a plan of care based on the findings of the neuropsychological evaluation;

3. Cognitive rehabilitation therapy services may be provided by occupational therapists, speech-language pathologists, and psychologists who have experience in working with the neurologically impaired when provided under a plan recommended and coordinated by a physician or clinical psychologist licensed by the Board of Medicine;

4. The cognitive rehabilitation services shall be an integrated part of the total patient care plan and shall relate to information processing deficits which are a consequence of and related to a neurologic event;

5. The services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning, memory, discrimination and behavior; and

6. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis.

F. Psychology.

Psychology services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified psychologist as required by state law;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

G. Social work.

Social work services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified social worker as required by state law;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

H. Recreational therapy.

Recreational therapy are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services are performed as an integrated part of a comprehensive rehabilitation plan of care by a recreation therapist certified with the National Council for Therapeutic Recreation at the professional level;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

I. Prosthetic/orthotic services.

1. Prosthetic services furnished to a patient include prosthetic devices that replace all or part of an external body member, and services necessary to

design the device, including measuring, fitting, and instructing the patient in its use;

2. Orthotic device services furnished to a patient include orthotic devices that support or align extremities to prevent or correct deformities, or to improve functioning, and services necessary to design the device, including measuring, fitting and instructing the patient in its use; and

3. Maxillofacial prosthetic and related dental services are those services that are specifically related to the improvement of oral function not to include routine oral and dental care.

4. The services shall be directly and specifically related to an active written treatment plan approved by a physician after consultation with a prosthetist, orthotist, or a licensed, board eligible prosthodontist, certified in Maxillofacial prosthetics.

5. The services shall be provided with the expectation, based on the assessment made by physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance.

6. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical and dental practice; this includes the requirement that the amount, frequency, and duration of the services be reasonable.

J. Durable medical equipment.

1. Durable medical equipment furnished the patient receiving approved covered rehabilitation services is covered when the equipment is necessary to carry out an approved plan of rehabilitation. A rehabilitation hospital or a rehabilitation unit of a hospital enrolled with Medicaid under a separate provider agreement for rehabilitative services may supply the durable medical equipment. The provision of the equipment is to be billed as an outpatient service. Medically necessary medical supplies, equipment and appliances shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase. Payment shall not be made for additional equipment or supplies unless the extended provision of services has been authorized by DMAS. All durable medical equipment is subject to justification of need. Durable medical equipment normally supplied by the hospital for inpatient care is not covered by this provision.

2. Supplies, equipment, or appliances that are not covered for recipients of intensive physical rehabilitative services include, but are not limited to, the following:

a. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners;

b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office;

c. Furniture or appliance not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales);

d. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface; mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience, for example, an electric wheelchair plus a manual chair; cleansing wipes);

e. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, over-the-counter drugs; dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; support stockings; and non-legend drugs);

f. Home or vehicle modifications;

g. Items not suitable for or used primarily in the home setting (i.e., but not limited to, car seats, equipment to be used while at school);

h. Equipment that the primary function is vocationally or educationally related (i.e., but not limited to, computers, environmental control devices, speech devices) environmental control devices, speech devices).

PART IX.
HOSPICE SERVICES.

§ 9.1. Admission criteria.

To be eligible for hospice coverage under Medicare or Medicaid, the and elect to receive hospice services rather

than active treatment for the illness. Both the attending physician (if the individual has an attending physician) and the hospice medical director must certify the life expectancy.

§ 9.2. Utilization review.

Authorization for hospice services requires an initial preauthorization by DMAS and physician certification of life expectancy. Utilization review will be conducted to determine if services were provided by the appropriate provider and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patients' medical records as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

§ 9.3. Hospice services are a medically directed, interdisciplinary program of palliative services for terminally ill people and their families, emphasizing pain and symptom control. The rules pertaining to them are:

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

2. Medical social services. Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

3. Physician services. Physician services must be performed by a professional who is licensed to practice, who is acting within the scope of his license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

4. Counseling services. Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him to adjust to the individual's approaching death. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

5. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

6. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

7. Drugs and biologicals. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

8. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

9. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

PART X.
COMMUNITY MENTAL HEALTH SERVICES.

§ 10.1. Utilization review general requirements.

A. On-site utilization reviews shall be conducted, at a minimum annually at each enrolled provider, by the state Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). During each on-site review, an appropriate sample of the provider's total Medicaid population will be selected for review. An expanded review shall be conducted if an appropriate number of exceptions or problems are identified.

B. The DMHMRSAS review shall include the following items:

1. Medical or clinical necessity of the delivered

service;

2. The admission to service and level of care was appropriate;

3. The services were provided by appropriately qualified individuals as defined in the Amount, Duration, and Scope of Services found in Attachment 3.1 A and B, Supplement 1 § 13d Rehabilitative Services; and

4. Delivered services as documented are consistent with recipients' Individual Service Plans, invoices submitted, and specified service limitations.

§ 10.2. Mental health services utilization criteria.

Utilization reviews shall include determinations that providers meet all the requirements of Virginia state regulations found at VR 460-03-3.1100.

A. Intensive in-home services for children and adolescents.

1. At admission, an appropriate assessment is made and documented that service needs can best be met through intervention provided in the client's residence; service must be recommended in the Individual Service Plan (ISP).

2. Services must be delivered primarily in the family's residence. Some services may be delivered while accompanying family members to community agencies or in other locations.

3. Services shall be used when out-of-home placement is a risk and when services that are far more intensive than outpatient clinic care are required to stabilize the family situation, and when the client's residence as the setting for services is more likely to be successful than a clinic.

4. Services are not appropriate for a family in which a child has run away or a family for which the goal is to keep the family together only until an out-of-home placement can be arranged.

5. Services shall also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful.

6. At least one parent or responsible adult with whom the child is living must be willing to participate in in-home services, with the goal of keeping the child with the family.

7. The provider of intensive in-home services for children and adolescents must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

8. The billing unit for intensive in-home service is one hour. Although the pattern of service delivery may vary, in-home service is an intensive service provided to individuals for whom there is a plan of care in effect which demonstrates the need for a minimum of five hours a week of intensive in-home service, and includes a plan for service provision of a minimum of five hours of service delivery per client/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the client and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Intensive in-home services below the five-hour a week minimum may be covered. However, variations in this pattern must be consistent with the individual service plan. Service plans must incorporate a discharge plan which identifies transition from intensive in-home to less intensive or nonhome based services.

9. The intensity of service dictates that caseload sizes should be six or fewer cases at any given time. If on review caseloads exceed this limit, the provider will be required to submit a corrective action plan designed to reduce caseload size to the required limit unless the provider can demonstrate that enough of the cases in the caseload are moving toward discharge so that the caseload standard will be met within three months by attrition. Failure to maintain required caseload sizes in two or more review periods may result in termination of the provider agreement unless the provider demonstrates the ability to attain and maintain the required caseload size.

10. Emergency assistance shall be available 24 hours per day, seven days a week.

B. Therapeutic day treatment for children and adolescents.

1. Therapeutic day treatment is appropriate for children and adolescents who meet the DMHMRSAS definitions of "serious emotional disturbance" or "at risk of developing serious emotional disturbance" and who also meet one of the following:

a. Children and adolescents who require year-round treatment in order to sustain behavioral or emotional gains.

b. Children and adolescents whose behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:

(1) This programming during the school day; or

(2) This programming to supplement the school day or school year.

c. Children and adolescents who would otherwise be

placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.

d. Children and adolescents who have deficits in social skills, peer relations, dealing with authority; are hyperactive; have poor impulse control; are extremely depressed or marginally connected with reality.

e. Children in preschool enrichment and early intervention programs when the children's emotional/behavioral problems are so severe that they cannot function in these programs without additional services.

2. The provider of therapeutic day treatment for child and adolescent services must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

3. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP.

4. The program must operate a minimum of two hours per day and may offer flexible program hours (i.e. before or after school or during the summer). One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service are defined as a minimum of three but less than five hours in a given day; and three units of service equals five or more hours of service. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be billable. These restrictions apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled activities.

5. Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.

6. Services shall be provided following a diagnostic assessment when authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker or certified psychiatric nurse and in accordance with an ISP.

C. Day treatment/partial hospitalization services shall be provided to adults with serious mental illness following diagnostic assessment when authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or certified psychiatric nurse. The service may be initiated without an Individual Service Plan (ISP) modification or goal in a crisis situation. When this occurs, an ISP must be completed within 10 working days of service initiation.

1. The provider of day treatment/partial hospitalization shall be licensed by DMHMRSAS.

2. The program must operate a minimum of two continuous hours in a 24-hour period. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

3. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state or when other less intensive services may achieve stabilization. Admission and services longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, licensed clinical psycholo gist, licensed professional counselor, licensed clinical social worker, or certified psychiatric nurse.

D. Psychosocial rehabilitation services shall be provided to those individuals who have mental illness or mental retardation, and who have experienced long-term or repeated psychiatric hospitalization, or who lack daily living skills and interpersonal skills, or whose support system is limited or nonexistent, or who are unable to function in the community without intensive intervention or when long-term care is needed to maintain the individual in the community.

1. The provider of psychosocial rehabilitation must be licensed by DMHMRSAS.

2. The program must operate a minimum of two continuous hours in a 24-hour period. One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimbursement unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

3. Time allocated for field trips may be used to

calculate time and units if the goal is to provide training in an integrated setting, and to increase the client's understanding or ability to access community resources.

E. Admission to crisis intervention services is indicated following a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress. Crisis intervention may be the initial contact with a client.

1. The provider of crisis intervention services must be licensed as an Outpatient Program by DMHMRSAS.

2. Client-related activities provided in association with a face-to-face contact are reimbursable.

3. An Individual Service Plan (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

4. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP must be developed or revised to reflect the short-term counseling goals by the fourth face-to-face contact.

5. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

6. Crisis intervention services may be provided to eligible individuals outside of the clinic and billed, provided the provision of out-of-clinic services is clinically/programmatically appropriate. Crisis intervention may involve the family or significant others.

F. Case management.

1. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or activity or communication with the client or families, service providers, significant others and others including a minimum of one face-to-face client contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

2. The Medicaid eligible individual shall meet the DMHMRSAS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

3. There shall be no maximum service limits for case management services.

4. The ISP must document the need for case management, and the case manager must review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

§ 10.3. Mental retardation utilization criteria.

Utilization reviews shall include determinations that providers meet all the requirements of Virginia state regulations found at VR 460-03-3.1100.

A. Appropriate use of day health and rehabilitation services requires the following conditions must be met:

1. The service is provided by a program with an operational focus on skills development, social learning and interaction, support, and supervision.

2. The individual shall be assessed and deficits must be found in two or more of the following areas to qualify for services:

a. Managing personal care needs,

b. Understanding verbal commands and communicating needs and wants,

c. Earning wages without intensive, frequent and ongoing supervision or support,

d. Learning new skills without planned and consistent or specialized training and applying skills learned in a training situation to other environments,

e. Exhibiting behavior appropriate to time, place and situation that is not threatening or harmful to the health or safety of self or others without direct supervision,

f. Making decisions which require informed consent,

g. Caring for other needs without the assistance or personnel trained to teach functional skills,

h. Functioning in community and integrated environments without structured, intensive and frequent assistance, supervision or support.

3. Services for the individual must be preauthorized every six months by DMHMRSAS.

4. Each individual must have a written plan of care developed by the provider, with a review of the plan of care at least every 90 days with modification as appropriate. A 10-day grace period is allowable.

5. The provider must update the plan of care annually.

6. The individual's record must contain adequate documentation concerning progress or lack thereof in meeting plan of care goals.

7. The program must operate a minimum of two continuous hours in a 24-hour period. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be at least four but less than seven hours on a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

8. The provider must be licensed by DMHMRSAS.

B. Appropriate use of case management services for mentally retarded persons requires the following conditions to be met:

1. The individual must require case management as documented on the consumer service plan of care which is developed based on appropriate assessment and supporting data. Authorization for case management services must be obtained from DMHMRSAS Care Coordination Unit every six months.

2. An active client shall be defined as an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and other entities including a minimum of one face-to-face contact within a 90-day period.

3. The plan of care shall address the individual's needs in all life areas with consideration of the individual's age, primary disability, level of functioning and other relevant factors.

a. The plan of care shall be reviewed by the case manager every three months to ensure the identified needs are met and the required services are provided. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be given up to the last day of the fourth month following the month of the prior review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of the actual review.

b. The need for case management services shall be assessed and justified through the development of an annual consumer service plan. Continued service justification shall be documented at the six-month review.

4. The individual's record must contain adequate documentation concerning progress or lack thereof in meeting the consumer service plan goals.

PART XI.
GENERAL OUTPATIENT PHYSICAL REHABILITATION SERVICES.

§ 11.1. Scope.

A. Medicaid covers general outpatient physical rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals and by rehabilitation agencies which have a provider agreement with the Department of Medical Assistance Services (DMAS).

B. Outpatient rehabilitative services shall be prescribed by a physician and be part of a written plan of care.

§ 11.2. Covered outpatient rehabilitative services.

Covered outpatient rehabilitative services shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service.

§ 11.3. Eligibility criteria for outpatient rehabilitative services.

To be eligible for general outpatient rehabilitative services, the patient must require at least one of the following services: physical therapy, occupational therapy, speech-language pathology services, and respiratory therapy. All rehabilitative services must be prescribed by a physician.

§ 11.4. Criteria for the provision of outpatient rehabilitative services.

All practitioners and providers of services shall be required to meet state and federal licensing and/or certification requirements.

A. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

B. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

C. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440 110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who meets the qualifications in Subdivision B1 above. The program must meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

§ 11.5. Authorization for services.

A. General physical rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals and by rehabilitation agencies shall include authorization for up to 24 visits by each ordered rehabilitative service within a 60-day period. A recipient may receive a maximum of 48 visits annually without authorization. The provider shall maintain documentation to justify the need for services. A visit shall be defined as the duration of time that a rehabilitative therapist is with a client to provide services prescribed by the physician. Visits shall not be defined in measurements or increments of time.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized by using the Rehabilitation Treatment Authorization form (DMAS-125). This request must be signed and dated by a physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS. Periods of care beyond those allowed which have

not been authorized by DMAS shall not be approved for payment.

§ 11.6. Documentation requirements.

A. Documentation of general outpatient rehabilitative services provided by a hospital-based outpatient setting or a rehabilitation agency shall, at a minimum:

1. describe the clinical signs and symptoms of the patient's condition;

2. include an accurate and complete chronological picture of the patient's clinical course and treatments;

3. document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

4. include a copy of the physician's orders and plan of care;

5. include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

6. describe changes in each patient's condition and response to the rehabilitative treatment plan; and

7. describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

§ 11.7. Service limitations.

The following general conditions shall apply to reimbursable physical rehabilitative services:

A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.

B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

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

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Rehabilitation care is to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided.

VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates–Other Types of Care.

The policy and the method to be used in establishing payment rates for each type of care or service (other than inpatient hospitalization, skilled nursing and intermediate care facilities) listed in § 1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs:

a. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

b. Participation in the program will be limited to providers of services who accept, as payment in full, the state's payment plus any copayment required under the State Plan.

c. Payment for care or service will not exceed the amounts indicated to be reimbursed in accord with the policy and methods described in this Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.304(a). The state agency has continuing access to data identifying the maximum charges allowed: such data will be made available to the Secretary, HHS, upon request.

d. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The

professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

Item 398 D of the 1987 Appropriation Act, as amended, effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

The services that are cost reimbursed are:

(1) Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals

(2) Home health care services

(3) Outpatient hospital services excluding laboratory

(4) Rural health clinic services provided by rural health clinics or other federally qualified health centers defined as eligible to receive grants under the Public Health Services Act §§ 329, 330, and 340.

(5) Rehabilitation agencies

(6) Comprehensive outpatient rehabilitation facilities

(7) Rehabilitation hospital outpatient services.

e. Fee-for-service providers. (1) Payment for the following services shall be the lowest of: State agency fee schedule, actual charge (charge to the general public), or Medicare (Title XVIII) allowances:

(a) Physicians' services (Supplement 1 has obstetric/pediatric fees.)

(b) Dentists' services

(c) Mental health services including:

Community mental health services

Services of a licensed clinical psychologist

Mental health services provided by a physician

(d) Podiatry

(e) Nurse-midwife services

(f) Durable medical equipment

(g) Local health services

(h) Laboratory services (Other than inpatient hospital)

(i) Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)

(j) X-Ray services

(k) Optometry services

(l) Medical supplies and equipment.

(2) Hospice services payments must be no lower than the amounts using the same methodology used under part A of Title XVIII, and adjusted to disregard offsets attributable to Medicare coinsurance amounts.

f. Payment for pharmacy services shall be the lowest of items (1) through (5) (except that items (1) and (2) will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.331 (c) if the brand cost is greater than the HCFA upper limit of VMAC cost) subject to the conditions, where applicable, set forth in items (6) and (7) below:

(1) The upper limit established by the Health Care Financing Administration (HCFA) for multiple source drugs pursuant to 42 CFR §§ 447.331 and 447.332, as determined by the HCFA Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

(2) The Virginia Maximum Allowable Cost (VMAC) established by the agency plus a dispensing fee, if a legend drug, for multiple source drugs listed on the VVF.

(3) The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percent discount established by the methodology set out in (a) through (c) below. (Pursuant to OBRA 90 § 4401, from January 1, 1991, through December 31, 1994, no changes in reimbursement limits or dispensing fees shall be made which reduce such limits or fees for covered outpatient drugs).

(a) Percent discount shall be determined by a statewide survey of providers' acquisition cost.

(b) The survey shall reflect statistical analysis of actual provider purchase invoices.

(c) The agency will conduct surveys at intervals deemed necessary by DMAS, but no less frequently than triennially.

(4) A mark-up allowance (150%) of the Estimated Acquisition Cost (EAC) for covered nonlegend drugs and oral contraceptives.

(5) The provider's usual and customary charge to the public, as identified by the claim charge.

(6) Payment for pharmacy services will be as described above; however, payments for legend drugs (except oral contraceptives) will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Payments will be reduced by the amount of the established copayment per prescription by noninstitutionalized clients with exceptions as provided in federal law and regulation.

(7) The Program recognizes the unit dose delivery system of dispensing drugs only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose add on fee and an allowance for the cost of unit dose packaging established by the state agency. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC based on the 60th percentile cost level identified by the state agency or HCFA's upper limits. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency.

(8) Historical determination of EAC. Determination of EAC was the result of an analysis of FY'89 paid claims data of ingredient cost used to develop a matrix of cost using 0 to 10% reductions from AWP as well as discussions with pharmacy providers. As a result of this analysis, AWP minus 9.0% was determined to represent prices currently paid by providers effective October 1, 1990.

The same methodology used to determine AWP minus 9.0% was utilized to determine a dispensing fee of $4.40 per prescription as of October 1, 1990. A periodic review of dispensing fee using Employment Cost Index - wages and salaries, professional and technical workers will be done with changes made in dispensing fee when appropriate. As of October 1, 1990, the Estimated Acquisition Cost will be AWP minus 9.0% and dispensing fee will be $4.40.

g. All reasonable measures will be taken to ascertain the legal liability of third parties to pay for authorized care and services provided to eligible recipients including those measures specified under 42 USC 1396(a)(25).

h. The single state agency will take whatever measures are necessary to assure appropriate audit of records whenever reimbursement is based on costs of providing care and services, or on a fee-for-service plus cost of materials.

i. Payment for transportation services shall be according to the following table:

TYPE OF SERVICE	PAYMENT METHODOLOGY
Taxi services	Rate set by the single state agency
Wheelchair van	Rate set by the single state agency
Nonemergency ambulance	Rate set by the single state agency
Emergency ambulance	Rate set by the single state agency
Volunteer drivers	Rate set by the single state agency
Air ambulance	Rate set by the single state agency
Mass transit	Rate charged to the public
Transportation agreements	Rate set by the single state agency
Special Emergency transportation	Rate set by the single state agency

j. Payments for Medicare coinsurance and deductibles for noninstitutional services shall not exceed the allowed charges determined by Medicare in accordance with 42 CFR 447.304(b) less the portion paid by Medicare, other third party payors, and recipient copayment requirements of this Plan. See Supplement 2 for this methodology.

k. Payment for eyeglasses shall be the actual cost of the frames and lenses not to exceed limits set by the single

state agency, plus a dispensing fee not to exceed limits set by the single state agency.

l. Expanded prenatal care services to include patient education, homemaker, and nutritional services shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

m. Targeted case management for high-risk pregnant women and infants up to age ~~1~~ *2 and for community mental health and mental retardation services* shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

n. Reimbursement for all other nonenrolled institutional and noninstitutional providers.

(1) All other nonenrolled providers shall be reimbursed the lesser of the charges submitted, the DMAS cost to charge ratio, or the Medicare limits for the services provided.

(2) Outpatient hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the DMAS average reimbursable outpatient cost-to-charge ratio, updated annually, for enrolled outpatient hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Outpatient hospitals that are nonenrolled shall submit claims on DMAS invoices.

(3) Nonenrolled providers of noninstitutional services shall be paid on the same basis as enrolled in-state providers of noninstitutional services. Nonenrolled providers of physician, dental, podiatry, optometry, and clinical psychology services, etc., shall be reimbursed the lesser of the charges submitted, or the DMAS rates for the services.

(4) All nonenrolled noninstitutional providers shall be reviewed every two years for the number of Medicaid recipients they have served. Those providers who have had no claims submitted in the past twelve months shall be declared inactive.

(5) Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

o. Refund of overpayments.

(1) Providers reimbursed on the basis of a fee plus cost of materials.

(a) When DMAS determines an overpayment has been made to a provider, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

(b) If the provider cannot refund the total amount of the overpayment within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

(c) In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

(d) Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be

final on (i) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (ii) the issue date factfinding conference, if the provider does not file an appeal, or (iii) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

(2) Providers reimbursed on the basis of reasonable costs.

(a) When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

(b) If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

(c) If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

(d) In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

(e) Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal factfinding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

VR 460-04-8.1500. Community Mental Health and Mental Retardation Services: Amount, Duration, and Scope of Services.

§ 1. Definitions.

The following words and terms, when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise:

"Board" or "BMAS" means the Board of Medical Assistance Services.

"Code" means the Code of Virginia.

"Consumer service plan" means that document addressing the needs of the client of mental retardation case management services, in all life areas. Factors to be considered when this plan is developed are, but not limited to, the client's age, primary disability, level of functioning and other relevant factors.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services consistent with Chapter 1 (§ 37.1-39 et seq.) of Title 37 of the Code of Virginia.

"Developmental disability" means a severe, chronic disability that (i) is attributable to a mental or physical impairment (attributable to mental retardation, cerebral palsy, epilepsy, autism, or neurological impairment or related conditions) or combination of mental and physical impairments; (ii) is manifested before that person attains the age of 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major areas: self-care, language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency; and (v) results in the person's need for special care, treatment or services that are individually planned and coordinated and that are of lifelong or extended duration.

"HCFA" means the Health Care Financing Administration as that unit of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.

"Individual Service Plan" or "ISP" means that which is defined in DMHMRSAS licensing regulations VR 470-02-09.

"Medical or clinical necessity" means an item or service that must be consistent with the diagnosis or treatment of the individual's condition. It must be in accordance with the community standards of medical or clinical practice.

"Mental retardation" means the diagnostic classification of substantial subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behavior.

"Preauthorization" means the approval by the care coordinator of the plan of care which specifies recipient and provider. Preauthorization is required before reimbursement can be made.

"Qualified case managers for mental health case management services" means individuals possessing a combination of mental health work experience or relevant education which indicates that the individual possesses the knowledge, skills, and abilities, as established by DMHMRSAS, necessary to perform case management services.

"Qualified case managers for mental retardation case management services" means individuals possessing a combination of mental retardation work experience and relevant education which indicates that the individual possesses the knowledge, skills, and abilities, as established by DMHMRSAS, necessary to perform case management services.

"Significant others" means persons related to or interested in the individual's health, well-being, and care. Significant others may be, but are not limited, to a spouse, friend, relative, guardian, priest, minister, rabbi, physician, neighbor.

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

§ 2. Mental health services.

The following services shall be covered: intensive in-home services, therapeutic day treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, and crisis intervention. These covered services are further defined below:

A. Intensive in-home services for children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders-III-R (DSM-III-R). These services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks. General program requirements shall be as follows:

1. The provider of intensive in-home services must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

2. An appropriate assessment is made and documented that service needs can best be met

through intensive in-home services; service must be recommended on an Individual Service Plan (ISP).

3. Intensive in-home services shall be used when out-of-home placement is a risk, when services that are far more intensive than outpatient clinic care are required to stabilize the family situation, and when the client's residence as the setting for services is more likely to be successful than a clinic.

4. Intensive in-home services shall also be used to facilitate the return from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful.

5. At least one parent or responsible adult with whom the child is living must be willing to participate in in-home services.

6. Since case management services are an integral and inseparable part of this service, case management services will not be reimbursed separately for periods of time when intensive in-home services are being reimbursed.

B. Therapeutic day treatment for children and adolescents shall be provided in sessions of two or more hours per day, to groups of seriously emotionally disturbed children and adolescents or children at risk of serious emotional disturbance in order to provide therapeutic interventions. Day treatment programs, limited annually to 260 days, provide evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills, and individual, group and family counseling. General program requirements shall be as follows:

1. The provider of therapeutic day treatment for child and adolescent services must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

2. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP.

3. The program must operate a minimum of two hours per day and may offer flexible program hours (i.e., before or after school or during the summer). One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service are defined as a minimum of three but less than five hours in a given day, and three units of service equals five or more hours of service. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be billable. These restrictions apply only to transportation to and from the program site. Other program related transportation may be included in the program day as indicated by scheduled activities.

4. When day treatment occurs during the school day, time solely for academic instruction (i.e., when no treatment activity is going on) cannot be included in the billing unit.

C. Day treatment/partial hospitalization services for adults shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 260 days, include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment. General program requirements shall be as follows:

1. The provider of day treatment/partial hospitalization shall be licensed by DMHMRSAS.

2. The program must operate a minimum of two continuous hours in a 24-hour period. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimburseable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program related transportation may be included in the program day as indicated by scheduled program activities.

3. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state or when other less intensive services may achieve stabilization. Admission and services longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or certified psychiatric nurse.

D. Psychosocial rehabilitation for adults shall be provided in sessions of two or more consecutive hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 312 days, include assessment, medication education, psychoeducation, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support, or education within a supportive and normalizing program structure and environment.

1. The provider of psychosocial rehabilitation must be

licensed by DMHMRSAS.

2. The program must operate a minimum of two continuous hours in a 24-hour period. A unit of service is defined as a minimum of two but less than four hours on a given day. Two units of service are defined as at least four but less than seven hours in a given day. Three units are defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimbursement unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

3. Time allocated for field trips may be used to calculate time and units of service if the goal is to provide training in an integrated setting, and to increase the client's understanding or ability to access community resources.

E. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute mental dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities, limited annually to 180 hours, shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual or the family unit, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include, but are not limited to, office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization. General program requirements are as follows:

1. The provider of crisis intervention services must be licensed by DMHMRSAS.

2. Client-related activities provided in association with a face-to-face contact shall be reimbursable.

3. An Individual Service Plan (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

4. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP must be developed or revised to reflect the short-term counseling goals by the fourth scheduled face-to-face contact.

5. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

6. Crisis intervention services may be provided to eligible individuals outside of the clinic and billed provided the provision of out-of-clinic services is clinically/programmatically appropriate. Crisis intervention may involve the family or significant others.

§ 3. Mental retardation services.

Day health and rehabilitation services shall be covered and the following definitions shall apply:

A. Day health and rehabilitation services (limited to 500 units per year) shall provide individualized activities, supports, training, supervision, and transportation based on a written plan of care to eligible persons for two or more hours per day scheduled multiple times per week. These services are intended to improve the recipient's condition or to maintain an optimal level of functioning, as well as to ameliorate the recipient's disabilities or deficits by reducing the degree of impairment or dependency. Therapeutic consultation to service providers, family, and friends of the client around implementation of the plan of care may be included as part of the services provided by the day health and rehabilitation program. The provider must be licensed by DMHMRSAS as a Day Support Program. Specific components of day health and rehabilitation services include the following as needed:

1. Self-care and hygiene skills: training in personal appearance and cleanliness, clothing selection/use, personal dental hygiene;

2. Eating skills: training in sitting at table, using utensils, and eating in a reasonable manner; using restaurants;

3. Toilet training skills: training in all steps of toilet process, practice of skills in a variety of public/private environments;

4. Task learning skills: training in eye/hand coordination tasks with varying levels of assistance by supervisors, developing alternative training strategies, providing training and reinforcement in appropriate community settings where such tasks occur;

5. Community resource utilization skills: training in time, telephone, basic computations, money, warning sign recognition, and personal identification such as personal address and telephone number; use of community services, resources and cultural opportunities;

6. Environmental skills: training in punctuality, self-discipline, care of personal belongings, respect for property, remaining on task and adequate attendance; training at actual sites where the skills will be performed;

7. Behavior skills: training in appropriate interaction with supervisors and other trainees, self control of disruptive behaviors, attention to program rules and coping skills, developing/enhancing social skills in relating to the general population, peer groups;

8. Medication management: awareness of importance of prescribed medications, identification of medications, the role of proper dosage and schedules, providing assistance in medication administration, and signs of adverse effects;

9. Travel and related training to and from the training sites and service and support activities;

10. Skills related to the above areas, as appropriate that will enhance or retain the recipient's functioning: training in appropriate manners, language, home care, clothing care, physical awareness and community awareness; opportunities to practice skills in community settings among the general population.

11. Transportation time to and from the program site may be included as part of the reimburseable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions apply only to transportation to and from the program site. Other program related transportation may be included in the program day as indicated by scheduled program activities.

B. There shall be two levels of Day Health and Rehabilitation services: Level I and Level II.

1. Level I services shall be provided to individuals who meet the basic program eligibility requirements.

2. Level II services may be provided to individuals who meet the basic program eligibility requirements and for whom one or more of the following indicators are present.

a. The individual requires physical assistance to meet basic personal care needs (toilet training, feeding, medical conditions that require special attention).

b. The individual has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals.

c. The individual requires extensive personal care and/or constant supervision to reduce or eliminate behaviors which preclude full participation in programming. A formal, written behavioral program is required to address behaviors such as, but not limited to, severe depression, self injury, aggression, or self-stimulation.

§ 4. Provider qualification requirements.

To qualify as a provider of services through DMAS for rehabilitative mental health or mental retardation services, the provider of the services must meet certain criteria. These criteria shall be:

1. The provider must guarantee that clients have access to emergency services on a 24-hour basis;

2. The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

3. The provider must have the administrative and financial management capacity to meet state and federal requirements;

4. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

5. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

6. In addition to those requirements stated above, a provider must meet the following requirements specific to each disability area:

a. Mental health.

(1) Intensive in-home: licensure by DMHMRSAS as an outpatient program.

(2) Therapeutic day treatment for children/adolescents: licensure by DMHMRSAS as a day support program.

(3) Day treatment/partial hospitalization: licensure by DMHMRSAS as a day support program.

(4) Psychosocial rehabilitation: licensure by DMHMRSAS as a day support program.

(5) Crisis intervention: licensure by DMHMRSAS as an Outpatient Program

(6) Case Management: certified by DMHMRSAS

b. Mental retardation.

(1) Day Health and Rehabilitation Services: licensure by DMHMRSAS as a day support program

(2) Case Management: Certified by DMHMRSAS

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

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

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

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

* * * * * * * * *

Title of Regulation: **VR 460-03-4.1921. Pediatric and Obstetric Services Maximum Payments.**

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public Hearing Date: Written comments may be submitted until May 8, 1992.
(See Calendar of Events section for additional information)

Summary:

The purpose of this proposal is to promulgate permanent regulations in conformance to OBRA '89 § 6402 and to new American Medical Association procedure codes. This regulatory action makes no fee changes but merely changes the coding convention used by DMAS.

Attachment 4.19 B of the Plan contains reimbursement methodologies for all covered services except for inpatient hospital and long-term care, which are covered in other Plan attachments. This amendment modifies Supplement 1 to Attachment 4.19 B, providing obstetric and pediatric payment rates, in conformance with the OBRA 89 requirement.

DMAS uses the American Medical Association's (AMA) Physicians' Current Procedural Terminology coding system for bills for physicians' services. Effective January 1, 1992, the AMA changed its coding system from one of identifying specific office visits to a system of evaluation and management codes. In order to conform its Plan to the 1989 requirements of OBRA § 6402 and to accommodate the recent AMA changes, DMAS must modify the procedure codes and concomitant descriptions contained in Supplement 1 to Attachment 4.19 B.

VR 460-03-4.1921. Pediatric and Obstetric Services Maximum Payments.

~~CPT-4 Code~~ ~~Description~~ ~~Payment~~

~~PEDIATRIC SERVICES~~

~~1. Office Medical Services. Physician services performed in an office and nonemergency services performed in other settings (e.g., emergency departments of hospitals).~~

~~NEW PATIENT~~

~~90000~~	~~Office medical service, new patient, brief service~~	~~$ 24.00~~
~~90010~~	~~limited service~~	~~28.00~~
~~90015~~	~~intermediate service~~	~~33.00~~
~~90017~~	~~extended service~~	~~40.00~~
~~90020~~	~~comprehensive service~~	~~50.00~~

~~ESTABLISHED PATIENT~~

~~90030~~	~~Office medical service, established patient, minimal service~~	~~$ 10.00~~
~~90040~~	~~brief service~~	~~19.00~~
~~90050~~	~~limited service~~	~~24.00~~
~~90060~~	~~intermediate service~~	~~28.00~~
~~90070~~	~~extended service~~	~~35.00~~
~~90080~~	~~comprehensive service~~	~~45.00~~

~~2. Emergency Department Services. For emergency care.~~

~~NEW PATIENT~~

~~90500~~	~~Emergency department service, new patient, minimal service~~	~~$ 18.00~~
~~90505~~	~~brief service~~	~~34.00~~
~~90510~~	~~limited service~~	~~44.00~~
~~90515~~	~~intermediate service~~	~~55.00~~
~~90517~~	~~extended service~~	~~78.00~~
~~90520~~	~~comprehensive service~~	~~102.00~~

~~ESTABLISHED PATIENT~~

~~90530~~	~~Emergency department services, established patient, minimal service~~	~~15.00~~
~~90540~~	~~brief service~~	~~25.00~~
~~90550~~	~~limited service~~	~~35.00~~
~~90560~~	~~intermediate service~~	~~40.00~~
~~90570~~	~~extended service~~	~~51.00~~
~~90580~~	~~comprehensive service~~	~~69.00~~

~~3. Immunization Injections.~~

~~90701~~	~~Immunization, active, diptheria and tetanus toxoids and pertussis vaccine (DTP)~~	~~$ 17.91~~
~~90702~~	~~diphtheria and tetanus toxoids (DT)~~	~~3.99~~
~~90704~~	~~mumps virus vaccine, live~~	~~16.35~~
~~90705~~	~~measles virus vaccine, live, attenuated~~	~~14.68~~
~~90706~~	~~rubella virus vaccine, live~~	~~15.19~~
~~90707~~	~~measles, mumps and rubella virus vaccine, live~~	~~29.97~~
~~90708~~	~~measles and rubella virus vaccine, live~~	~~21.23~~

90709	rubella and mumps virus vaccine, live	22.76
90712	poliovirus vaccine, live, oral (any type(s))	11.72
90737	Hemophilus influenza B	18.45

Note: appropriate office visit may be billed in addition to the above immunization injections

4. Preventive Medicine.

NEW PATIENT

90751	Initial history and examination related to the healthy individual, including anticipatory guidance; adolescent (age 12 through 17 years)	$ 35.00
90752	late childhood (age 5 through 11 years)	39.00
90753	early childhood (age 1 through 4 years)	39.00
90754	infant (age under 1 year)	30.00
90755	Infant care to one year of age with a maximum of 12 office visits during regular office hours, including tuberculin skin testing and immunization of DTP and oral polio	29.00
90757	Newborn care, in other than hospital setting, including physical examination of baby and conference(s) with parent(s)	33.00

ESTABLISHED PATIENT

90761	Interval history and examination, related to the healthy individual, including anticipatory guidance, periodic type of examination, adolescent (age 12 through 17 years)	$ 31.00
90762	late childhood (age 5 though 11 years)	36.00
90763	early childhood (age 1 through 4 years)	36.00
90764	infant (age under 1 year)	35.00
90774	Administration and medical interpretation of developmental tests	18.00
90778	Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant	10.00

OBSTETRICAL SERVICES

1. Maternity Care and Delivery.

INCISION

59020	Fetal oxytocin stress test	$ 60.00
59025	Fetal nonstress test	50.00
59030	Fetal scalp blood sampling,	66.00
	repeat	22.25
59050	Initiation and/or supervision of internal fetal monitoring during labor by consultant	50.00

REPAIR

59300	Episiotomy or vaginal repair only, by other than attending physician	250.00

DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400	Total ob. care (all-inclusive, "global" care) includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps or breech delivery) and postpartum care	$1200.00
59410	Vaginal delivery only (with or without episiotomy, forceps or breech delivery) including in-hospital postpartum care (separate procedure)	864.00
59412	External cephalic version, with or without tocolysis	250.00
59420	Antepartum care only (separate procedure)	300.00
59430	Postpartum care only (separate procedure)	93.00

CESAREAN SECTION

59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1441.00
59515	Cesarean delivery only including postpartum care	1134.00
59525	Subtotal or total hysterectomy after cesarean delivery	383.00

ABORTION

59812	Treatment of spontaneous abortion, any trimester, completed surgically	450.00
59820	Treatment of missed, abortion completed surgically, first trimester	442.00
59830	Treatment of septic abortion completed surgically	229.15

2. Diagnostic Ultrasound.

PELVIS

76805	Echography, pregnant uterus, B-scan and/or real time with image documentation complete	$ 98.00
76815	limited (fetal growth rate, heart beat, anomalies, placental location)	70.00
76816	follow-up or repeat	45.00
76818	Fetal biophysical profile	75.00
76825	Echocardiography, fetal heart in utero	92.50
76855	Echography, pelvic area (Doppler)	145.00

PEDIATRIC SERVICES

CPT-4 Code	*Description*	*Payment*

1. Evaluation and Management Services - Physician services performed in a physician's office or in an outpatient facility

	NEW PATIENT	
99201	*Problem focused history, examination, and straigtforward medical decision making*	*$24.00*
99202	*Expanded problem focused history, examination, straightforward medical decision making*	*28.00*
99203	*Detailed history, examination and straightforward medical decision making of moderate complexity*	*33.00*
99204	*Comprehensive history, examination, and medical decision making of moderate complexity*	*46.75*
99205	*Comprehensive history, examination and medical decision of high complexity*	*50.00*
	ESTABLISHED PATIENT	
99211	*Minimal presenting problems*	*$10.00*
99212	*Problem focused history, or examination, and straightforward medical decision making*	*19.00*
99213	*Expanded problem focused history or examination, and medical decision of low complexity*	*26.50*
99214	*Detailed history, or examination, and medical decision making of moderate complexity*	*35.00*
99215	*Comprehensive history, or examination and medical decision of high complexity*	*45.00*
	2. Emergency Department Services for emergency care	
	NEW OR ESTABLISHED PATIENT	
99281	*Problem focused history, examination and straightforward medical decision making*	*$26.60*
99282	*Expanded problem focused history examination and medical decision making of low complexity*	*46.60*
99283	*Expanded problem focused history, examination, and medical making decision of low to moderate complexity*	*49.60*
99284	*Detailed history, examination, and medical decision making of moderate complexity*	*57.30*
99285	*Comprehensive history Comprehensive examination Medical decision making of high complexity*	*81.40*

	*3. Immunization Injections**	
90701	*Immunization, active; diptheria and tetanus toxoids and pertussis vaccine (DTP)*	*$ drug cost*
90702	*Diptheria and tetanus toxoids (DT)*	*$ drug cost*
90704	*Mumps virus vaccine, live*	*$ drug cost*
90705	*Measles virus vaccine, live, attenuated*	*$ drug cost*
90706	*Rubella virus vaccine, live*	*$ drug cost*
90707	*Measles, mumps and rubella virus vaccine, live*	*$ drug cost*
90708	*Measles and rubella virus vaccine, live*	*$ drug cost*
90709	*Rubella and mumps virus vaccine, live*	*$ drug cost*
90712	*Poliovirus vaccine, live, oral (any type(s))*	*$ drug cost*
90737	*Hemophilus influenza B*	*$ drug cost*

** (Note: Appropriate office visit may be billed in addition to the above immunization injections. Payment for immunizations shall not exceed the Medicaid fee on file for the drug at time of service.)*

4. Preventive Medicine

	NEW PATIENT	
99381	*Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; infant (age under 1 year)*	*$35.00*
99382	*Early childhood (age 1 through 4 years)*	*39.00*
99383	*Late childhood (age 5 through 11 years)*	*39.00*
99384	*Adolescent (age 12 through 17 years)*	*35.00*
	ESTABLISHED PATIENT	
99391	*Periodic evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; infant (age under 1 year)*	*$35.00*
99392	*Early childhood (age 1 through 4 years*	*36.00*
99393	*Late childhood*	*36.00*

(age 5 through 11 years)

99394 Adolescent (age 12 through 17 years) 31.00

OBSTETRICAL SERVICES

1. Maternity Care and Delivery

INCISION

59020 Fetal oxytocin street test $60.00

59025 Fetal non-stress test 50.00

59030 Fetal scalp blood sampling 66.00

59050 Initiation and/or supervision of internal fetal monitoring during labor by consultant 50.00

REPAIR

59300 Episiotomy or vaginal repair, by other than attending physician $250.00

DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400 Total ob. care (all-inclusive, "global" care) includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps or breech delivery) and postpartum care $1,200.00

59410 Vaginal delivery only (with or without episiotomy, forceps or breech delivery) including in-hospital postpartum care (separate procedure) 864.00

OBSTETRICAL SERVICES

59412 External cephalic version, with or without tocolysis $250.00

59420 Antepartum care only (separate procedure) 300.00

59430 Postpartum care only (separate procedure) 36.00

CESAREAN SECTION

59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care $1,441.00

59515 Cesarean delivery only including postpartum care 1,134.00

59525 Subtotal or total hysterectomy after cesarean delivery 383.00

ABORTION

59812 Treatment of spontaneous abortion, any trimester, completed surgically $475.00

59820 Treatment of missed abortion, completed surgically; first trimester 442.00

59830 Treatment of septic abortion completed surgically 229.15

2. Diagnostic Ultrasound

PELVIS

76805 Echography, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation) $90.00

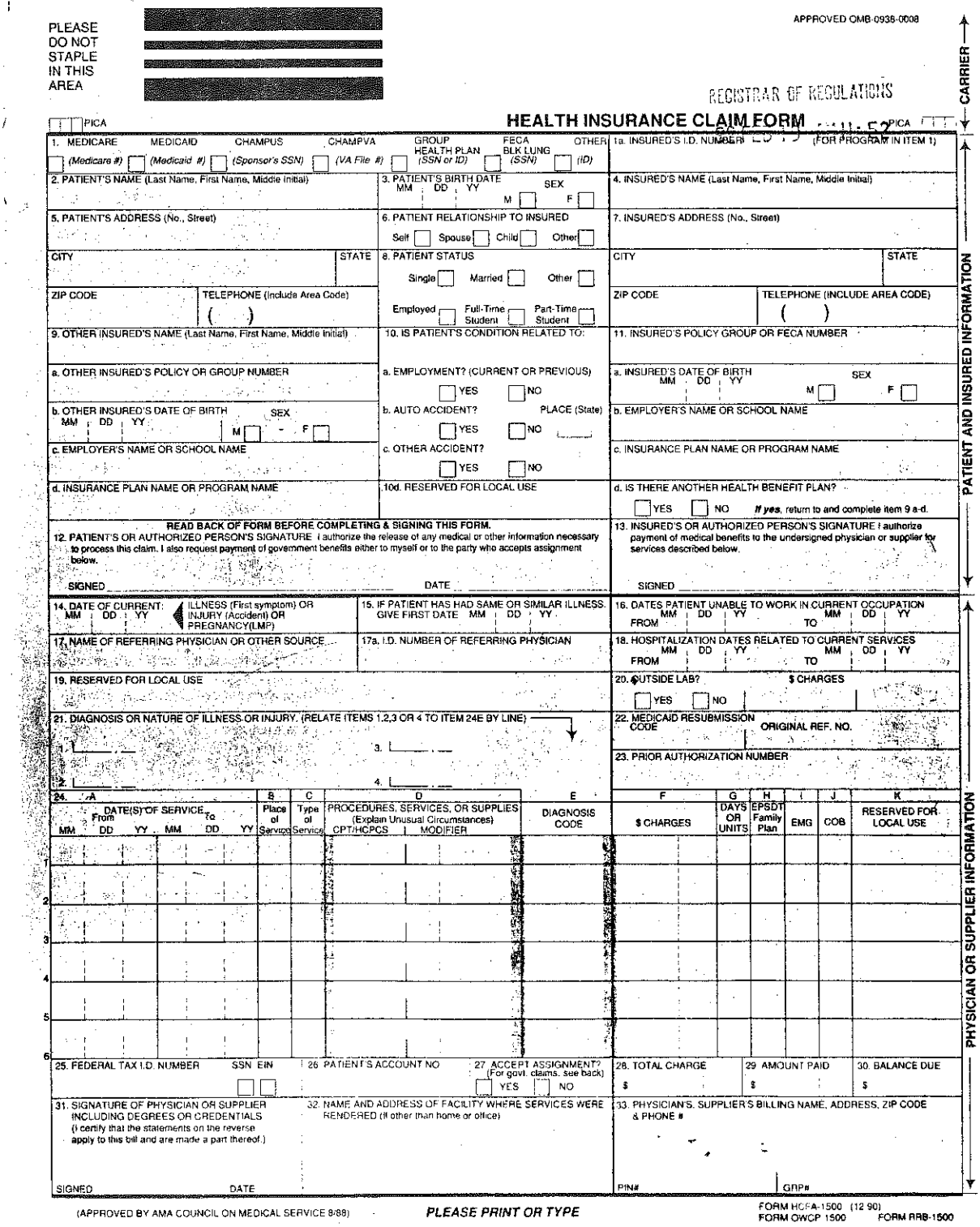
76810 Complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester 180.00

76815 Limited (gestation age,) heart beat, placental location, fetal position, or emergency in the delivery room) 60.00

76816 Follow-up or repeat 45.00

76818 Fetal biophysical profile 75.00

76825 Echocardiography, fetal, real time with image documentation (2D) with or without M-mode recording 90.00



PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

REGISTRAR OF REGULATIONS

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12 90)
FORM OWCP 1500 FORM RRB-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records:

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance or copayment or similar cost sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing statements made by me on this claim are true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503

DEPARTMENT OF STATE POLICE

REGISTRAR'S NOTICE: Due to its length, the full text of the proposed regulation filed by the Department of State Police is not being published; however, the proposed amendment to subdivision 13 of § 21 is being published. In accordance with § 9-6.14:22 of the Code of Virginia, the summary is being published in lieu of the full text. The full text of the regulation is available for public inspection at the office of the Registrar of Regulations and at the Department of State Police.

Title of Regulation: **VR 545-01-07. Motor Vehicle Safety Inspection Rules and Regulations.**

Statutory Authority: §§ 46.2-1002, 46.2-1163 and 46.2-1165 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until May 8, 1992.
(See Calendar of Events section for additional information)

Summary:

The proposed amendment to § 21, paragraph 13, adds subparagraph 13a excepting colored or tinted ventvisors that do not extend more than two inches from the forward door post into the driver's viewing area from the regulation prohibiting wind silencers, breezes, or other ventilation adaptors not made of clear transparent material.

VR 545-01-07. Motor Vehicle Safety Inspection Rules and Regulations.

13. Front side windows have cloudiness above three inches from the bottom of the glass, or other defects that affect the driver's vision or one or more cracks which permit one part of the glass to be moved in relation to another part. Wind silencers, breezes or other ventilator adaptors are not made of clear transparent material.

a. EXCEPTION: Colored or tinted ventvisors that do not exceed more than two inches from the forward door post into the driver's viewing area are permitted.

DEPARTMENT OF THE TREASURY (STATE TREASURER)

Title of Regulation: **VR 640-04-1. Regulations Governing Escheats.**

Statutory Authority: § 55-200.1 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until May 8, 1992.
(See Calendar of Events section for additional information)

Summary:

The proposed regulations address the annual reporting requirements for local government treasurers and escheators and outline the escheator's responsibilities for the disclosures to be made at escheat auctions, the collection and remittance of sale proceeds, and the notifications to be made to defaulting purchasers. In addition, the regulations stipulate the required bonding for escheators, specify the commission basis for escheators and auctioneers as well as the reimbursable expenses of auctioneers, and outline department charges for requests for information under the Freedom of Information Act.

VR 640-04-1. Regulations Governing Escheats.

§ 1. Definitions.

The following words and terms, when used in these regulations, shall have the following meaning unless the context clearly indicates otherwise:

"Agency" means the Department of the Treasury.

"Escheator" means any individual who has been appointed and qualified, and who continues in service in accordance with §§ 55-168 through 55-170 of the Code of Virginia.

§ 2. General.

These regulations are promulgated pursuant to the authority set forth in § 55-200.1 of the Code of Virginia which requires the State Treasurer to adopt any necessary rules and regulations in accordance with the Administrative Process Act to carry out the provisions of the Escheat Generally Statutes, Chapter 10 (§ 55-168 et seq.) of Title 55 of the Code of Virginia.

§ 3. Effective date.

These regulations shall be effective on and after July 1, 1992.

§ 4. Annual reporting requirement for local government treasurers.

An Annual Escheat Report shall be remitted by each local government treasurer, director of finance, or other designated local government official to the appointed escheator for that locality and to the agency by May 31 of each year for the calendar year just ended. This report is required even if there are no real property parcels to be reported. The report shall be prepared on the appropriate form, or in an approved format, and shall be submitted on either hard copy or an acceptable diskette in a file layout and format approved by the agency. The report shall be certified as to its accuracy by the

Commissioner of Revenue or designated local official prior to the May 31 submission date.

§ 5. Annual reporting requirements for escheators.

Escheators shall be required to file a report with the agency by May 1 of each year, for the calendar year just ended, summarizing escheat activity for that period. The required report shall include, but not be limited to, (i) information about any litigation occurring during the period and the status of such litigation, (ii) the status of any collection proceedings, (iii) the status of any real estate parcels removed from the escheat process subsequent to an inquest, (iv) the status of any other real estate parcels under the escheator's control, and (v) any other information which should be brought to the agency's attention that the escheator deems to be relevant to the escheat process. The escheator shall provide, upon written request from the agency, any additional data relating to this report within 30 days of such request.

§ 6. Required bond for escheators.

Each escheator shall give a "Personal Recognizance Bond" before the circuit court of the county or the city for which the escheator is appointed in the amount of $3,000 within 60 days of confirmation of the appointment and provide the agency with a copy of the bond. This bond shall remain in force as long as the escheator shall continue in office until removed or until a successor is duly appointed and qualified.

§ 7. Escheator's responsibility for collection of sale proceeds and remittance to State Treasurer.

The escheator shall be responsible for the collection of all moneys during the escheat process. Any and all moneys collected during the escheat process shall be deposited into the bank account of the escheator no later than the next banking day following the collection date. A check for the full amount collected shall be drawn on this account and made payable to the Treasurer of Virginia no later than 10 banking days following the deposit date. The escheator shall submit the check and complete columns 5, 6, 7 and 8 of the Annual Escheat Report Form received from the local treasurer or submit other supporting documentation for funds collected other than sale proceeds.

The escheator shall be responsible for the collection of any checks relative to the escheat process returned by the bank to the escheator's bank account for insufficient funds or any other reason which makes a check uncollectible. The escheator shall institute procedures for collection of these moneys immediately upon notification from the bank that a check has been returned uncollected. The procedures shall include, but not be limited to, a written notice to the maker of the returned check advising the maker that payment, with certified funds or cash, be made within five business days of the correspondence date. In regard to a sale transaction, the notice shall state that failure to comply may result in (i) the forfeiture of any deposit and the resale of escheated property pursuant to § 55-187 of the Code of Virginia, (ii) a suit to enforce specific performance of the sale agreement, (iii) resale of the property and suit for any damages resulting from nonperformance by the purchaser, (iv) any other remedy at law or in equity available to a seller against a defaulting purchaser or real estate.

§ 8. Defaulting purchasers.

If a sale of escheated property is rescinded pursuant to § 55-187, the escheator shall notify the purchaser in writing that (i) due to the purchaser's nonperformance, the property will be offered for sale at the next sale of escheated property for that locality, (ii) the purchaser may be held liable for any deficiency which arises from the subsequent sale at a lesser purchase price, (iii) cash or a certified check will be required from the purchaser from any future transaction involving the purchase of escheated property, and (iv) the purchaser has a right to have an administrative review of actions taken by the escheator or the agency. Before an escheator may bring a suit against a defaulting purchaser, express authority to do so in each case shall be obtained from the Office of the Attorney General of the Commonwealth of Virginia and approval of anticipated expenses of litigation shall be obtained from the agency.

§ 9. Required written disclosures to be made by the escheator at the escheat auction.

The escheator shall provide written information to any and all individuals who register as a bidder for an escheat sale that the grant for the escheated property will be issued in accordance with § 55-186.1 of the Code of Virginia and that this statutory form of grant contains no warranty of title. In addition, the written information shall instruct any and all bidders seeking a recovery of proceeds from a sale of escheated property that the recovery of proceeds of each sale from the Commonwealth, less the expenses of sale and the escheator's fee, may be obtained if the buyer, pursuant to § 55-200 of the Code of Virginia, submits satisfactory evidence to the State Treasurer within 120 days of the sale that the escheated property does not exist or was improperly escheated.

§ 10. Commission basis for the escheator and the auctioneer.

The commissions paid to the escheator and the auctioneer are determined based on the proceeds collected from the sales of escheated property. If a partial payment is collected and the purchaser fails to complete the sales transaction, the purchaser forfeits the partial payment to the State Treasurer and the commissions paid shall be based on the partial payment only. The commissions base does not include recording fees.

§ 11. Reimbursable expenses and required documents of

the auctioneer.

The auctioneer shall submit an expense report with supporting documentation of the State Treasurer within 30 days of the auction to ensure proper reimbursement of the auction expenses pursuant to § 55-186. Reimbursable expenses shall include: advertisements, postage, payroll, and any other expenses directly related to the auction, but in no case shall the expense reimbursement exceed 5.0% of the proceeds collected. Proceeds do not include recording fees.

§ 12. Fees charged for requests under the Freedom of Information Act.

Fees shall be computed on all requests for information under the Freedom of Information Act, Chapter 21 (§ 2.1-340 et seq.) of Title 2.1 of the Code of Virginia, related to the escheat process. The fee assessed shall be determined based on the actual time of the employee performing the duties necessary to comply with the request and other costs incurred. Other costs include copies, postage, and any other cost directly associated with providing the requested information.

If there is an amount due the agency and it is in excess of 30 days past due, current and future requests for information will be withheld until the outstanding amount is paid to the agency. Continued failure to pay fees when due may result in the agency requesting payment in advance.

ANNUAL ESCHEAT REPORT

LIST OF REAL PROPERTY PRESUMED ABANDONED

(CODE OF VIRGINIA SECTION 55-168 THROUGH 55-200.1)

PAGE ____ OF ____

LOCALITY	FED. ID#
TREASURER'S NAME AND ADDRESS	TREASURER'S SIGNATURE
	COMMISSIONER OF REVENUE'S SIGNATURE
ESCHEATOR'S NAME	REPORT YEAR 19____

TYPE OF REPORT (1)
____ NEGATIVE
____ POSITIVE
____ # OF PARCELS

COMMONWEALTH OF VIRGINIA
Department of the Treasury
Division of Unclaimed Property
P. O. Box 3-R
Richmond, Virginia 23207

MUST BE TYPED

TAX MAP NUMBER (2)	LAST KNOWN OWNER AND MAILING ADDRESS (3)	PROPERTY DESCRIPTION (4)	STATUS CODE (5)	SALE PRICE (6)	RECORDING FEE (7)	PURCHASER'S NAME AND ADDRESS (SPECIFY ENTITLEMENT IF NECESSARY SEE INSTRUCTIONS) (8)
TOTALS BROUGHT FORWARD FROM PREVIOUS PAGE				$	$	
				$	$	TOTALS CARRIED FORWARD TO NEXT PAGE

ESH-1 3/91 **SUBMIT YOUR REPORT BY MAY 31 OF REPORT YEAR**

INSTRUCTIONS FOR PREPARING ANNUAL ESCHEAT REPORT

The local treasurers must file this report by May 31 pursuant to Section 55-171 of the *Code of Virginia*. It is to be completed by the local treasurers following the criteria below:

1. The property owner died intestate without leaving any known heirs.
2. No person is known by the local treasurer, commissioner of revenue or appointed tax assessor to be entitled to the property.
3. Property which appears abandoned.

NOTE: Non-payment of taxes or special assessments (for a period of ten (10) years) do not necessarily mean the property is escheatable, but may be used to support the above criteria.

The commissioner of revenue or person assigned his duties must certify the properties listed on the annual report as well as the local treasurers.

* * * * * * * * * * REPORT FORMAT * * * * * * * * * *

(1) **TYPE OF REPORT** (To be completed by local treasurer): If there are no parcels to report, check the "negative" field. If there are parcels to report, check the positive field and indicate the number of parcels reported.

(2) **TAX MAP NUMBER** (To be completed by local treasurer): If tax map number is available, please list. If not, indicate "NOT AVAILABLE".

(3) **LAST KNOWN OWNER & MAILING ADDRESS** (To be completed by local treasurer): List the last known owner as indicated on the records of the locality. If there was no last known owner, indicate "UNKNOWN", "NOT AVAILABLE", or other description as applicable. If the mailing or street address is available please list. If not available indicate "ADDRESS NOT AVAILABLE".

(4) **PROPERTY DESCRIPTION** (To be completed by local treasurer): List the legal description as recorded on the locality's records (Example: Lot 2, Block A, XYZ Subdivision, 2.4 Acres).

By May 31, the local treasurer must forward this report to the Escheator of the locality and submit a copy to the Department of the Treasury, Division of Unclaimed Property.

(5) **STATUS CODE** (To be completed by Escheator): Use the following codes to indicate the status of a parcel through the entire escheat process:

A - Removed prior to inquest
B - Removed at inquest
C - Removed after inquest, but prior to sale
D - Removed at the time of sale
E - Defaulted purchaser, carry over to next sale (requires approval pursuant to Section 55-187)
F - Approved extension, carry over to next sale

(6) **SALE PRICE** (To be completed by Escheator): Indicate the highest bid at the auction. If different from amount collected attach an explanation to the report.

(7) **RECORDING FEE** (To be completed by Escheator): Indicate the dollar amount collected from purchaser. Amount of recording fee pursuant to Section 55-186 should be verified prior to sale.

(8) **PURCHASER'S NAME & ADDRESS...** (To be completed by Escheator): Indicate the purchaser's name as it should be recorded on the grant. Please indicate entitlement if appropriate. Use the list below as a guide.

JT - Joint tenants
JTROS - Joint tenants with rights of survivorship
TIC - Tenants in common
TEROS - Husband and wife, as tenants by the entireties with the right of survivorship
SSEE - Sole separate equitable estate
OTH - Specify under the purchasers name and address for those not listed above

* *

The escheator will update the report with any changes occurring prior to the sale and forward an updated copy to the Division of Unclaimed Property with supporting documentation whenever changes occur. Once the properties are sold, the escheator will complete the report and forward the original to the Division of Unclaimed Property.

REMEMBER!!! All receipts from the escheat sale, including the recording fee, must be submitted to the Division of Unclaimed Property within ten (10) days of the sale. The final report must be received by the Division within 30 days of the sale.

Reports must be submitted on this form or in the same format.

If you have any questions or need further assistance, please contact the Division of Unclaimed Property, Escheat Officer at (804) 225-2393 or 1-800-468-1088..

For information concerning Final Regulations, see information page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates new text. Language which has been stricken indicates text to be deleted. [Bracketed language] indicates a substantial change from the proposed text of the regulations.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES (BOARD OF)

NOTICE: The following regulations do not comply with the format established by the Registrar of Regulations since the Board of Agriculture and Consumer Services is bound and preempted by the Federal Fair Packaging and Labeling Act of the United States and the rules and regulations adopted under the U.S. Food and Drug Administration Act and the Federal Trade Commission Act and preemptive labeling by U.S. Department of Agriculture and other federal agencies. The most up-to-date manual on this subject is the National Bureau of Standards Handbook 130 (NBS No. 130) Uniform Laws and Regulations, sections entitled Packaging and Labeling Regulation and Method of Sale of Commodities Regulation, published annually by the U.S. Department of Commerce, National Bureau of Standards, as adopted by the National Conference on Weights and Measures annually. The Department has adopted this manual in its latest form as the basis for regulations of "Commodities in Package Form" for the Commonwealth.

Title of Regulation: **VR 115-04-04. Rules and Regulations for the Enforcement of the Virginia Weights and Measures Law.**

Statutory Authority: §§ 3.1-926 and 3.1-943 of the Code of Virginia.

Effective Date: April 8, 1992.

Summary:

The amendments include a new section for the purposes of (i) establishing standards for the method of sale for clams, mussels, oysters, and other mollusks, and (ii) establishing standards of fill by limiting the percentage of free liquid by weight in packaged clams, mussels, oysters, and other mollusks.

VR 115-04-04. Rules and Regulations for the Enforcement of the Virginia Weights and Measures Law.

PACKAGING AND LABELING REQUIREMENTS

§ 1. Application.

This regulation shall apply to packages and to commodities in package form, but shall not apply to:

A. Inner wrappings not intended to be individually sold to the customer,

B. Shipping containers or wrapping used solely for the transportation of any commodities in bulk or in quantity to manufacturers, packers, or processors, or to wholesale or retail distributors, but in no event shall this exclusion apply to packages of consumer or nonconsumer commodities, as defined herein,

C. Auxiliary containers or outer wrappings used to deliver packages of such commodities to retail customers if such containers or wrappings bear no printed matter pertaining to any particular commodity,

D. Containers used for retail tray pack displays when the container itself is not intended to be sold (e.g., the tray that is used to display individual envelopes of seasonings, gravies, etc., and the tray itself is not intended to be sold), or

E. Open carriers and transparent wrappers or carriers for containers when the wrappers or carriers do not bear any written, printed, or graphic matter obscuring the label information required by this regulation.

§ 2. Definitions.

2.1. *"Commodity in Package Form."* The term "commodity in package form" shall be construed to mean a commodity put up or packaged in any manner in advance of sale in units suitable for either wholesale or retail sale. An individual item or lot of any commodity not in package form as defined in this section, but on which there is marked a selling price based on an established price per unit of weight or of measure, shall be construed to be a commodity in package form. Where the term "package" is used in this regulation, it shall be construed to mean "commodity in package form" as herein defined.

2.2. *"Consumer Package: Package of Consumer Commodity."* A "consumer package" or "package of consumer commodity" shall be construed to mean a commodity in package form that is customarily produced or distributed for sale through retail sales agencies or instrumentalities for consumption by individuals or use by individuals for the purposes of personal care or in the performance of services ordinarily rendered in or about the household or in connection with personal possessions.

2.3. *"Nonconsumer Package: Package of Nonconsumer Commodity."* A "nonconsumer package" or "package of nonconsumer commodity" shall be construed to mean any commodity in package form other than a consumer package, and particularly a package intended solely for industrial or institutional use or for wholesale distribution.

2.4. *"Random Package."* The term "random package" shall be construed to mean a package that is one of a lot, shipment, or delivery of packages of the same consumer commodity with varying weights; that is, packages of the same consumer commodity with no fixed pattern of weight.

2.5. *"Label."* The term "label" shall be construed to mean any written, printed, or graphic matter affixed to, applied to, attached to, blown into, formed, molded into, embossed on, or appearing upon or adjacent to a consumer commodity or a package containing any consumer commodity, for the purposes of branding, identifying, or giving any information with respect to the commodity or to the contents of the package, except that an inspector's tag or other nonpromotional matter affixed to or appearing upon a consumer commodity shall not be deemed to be a label requiring the repetition of label information required by this regulation.

2.6. *"Person."* The term "person" shall be construed to mean both singular and plural, and shall include any individual, partnership, company, corporation, association, and society.

2.7. *"Principal Display Panel or Panels."* The term "principal display panel" or "panels" shall be construed to mean that part, or those parts, of a label that is, or are, so designed as to most likely be displayed, presented, shown, or examined under normal and customary conditions of display and purchase. Wherever a principal display panel appears more than once on a package, all requirements pertaining to the "principal display panel" shall pertain to all such "principal display panels."

2.8. *"Multi-Unit Package."* The term "multi-unit package" shall be construed to mean a package containing two or more individual packages of the same commodity, in the same quantity, with the individual packages intended to be sold as part of the multi-unit package but capable of being individually sold in full compliance with all requirements of this regulation.

§ 3. Declaration of Identity: Consumer Package.

3.1. Declaration of Identity: Consumer Package. A declaration of identity on a consumer package shall appear on the principal display panel, and shall positively identify the commodity in the package by its common or usual name, description, generic term, or the like.

3.1.1. Parallel Identity Declaration: Consumer Package. A declaration of the identity on a consumer package shall appear generally parallel to the base on which the package rests as it is designed to be displayed.

§ 4. Declaration of Identity: Nonconsumer Package.

A declaration of identity on a nonconsumer package shall appear on the outside of a package and shall positively identify the commodity in the package by its common or usual name, description, generic term, or the like.

§ 5. Declaration of Responsibility: Consumer and Nonconsumer Packages.

Any package kept, offered, or exposed for sale, or sold, at any place other than on the premises where packed shall specify conspicuously on the label of the package the name and address of the manufacturer, packer, or distributor. The name shall be the actual corporate name, or when not incorporated, the name under which the business is conducted. The address shall include street address, city, state, and zip code; however, the street address may be omitted if this is shown in a current city directory or telephone directory.

If a person manufactures, packs, or distributes a commodity at a place other than his principal place of business, the label may state the principal place of business in lieu of the actual place where the commodity was manufactured or packed or is to be distributed, unless such statement would be misleading. Where the commodity is not manufactured by the person whose name appears on the label, the name shall be qualified by a phrase that reveals the connection such person has with such commodity, such as "Manufactured for and packed by .....," "Distributed by .....," or any other wording of similar import that expresses the facts.

§ 6. Declaration of Quantity: Consumer Packages.

6.1. General[1] The metric and inch-pound systems of weights and measures are recognized as proper systems to be used in the declaration of quantity. Units of both systems may be presented in a dual declaration of quantity.

6.2. Largest Whole Unit. Where this regulation requires that the quantity declaration be in terms of the largest whole unit, the declaration shall, with respect to a particular package, be in terms of the largest whole unit of weight or measure, with any remainder expressed (following the requirements of Section 6.10 Fractions):

A. Inch-Pound Units.

1. In common or decimal fractions of such largest whole unit, or in

2. The next smaller whole unit, or units, with any further remainder in terms of common or decimal fractions of the smallest unit present in the quantity declaration.

B. Metric Units, in decimal fractions of such largest whole unit.

6.3. Net Quantity. A declaration of net quantity of the commodity in the package, exclusive of wrappers and any other material packed with such commodity (except as

noted in Section 10.3), shall appear on the principal display panel of a consumer package and, unless otherwise specified in this regulation (see subsections 6.7 through 6.8.3), shall be in terms of the largest whole unit.

6.3.1. Use of "Net Weight." The term "net weight" shall be used in conjunction with the declaration of quantity in units of weight. The term may either precede or follow the declaration of weight.

6.3.2. Lines of Print or Type. A declaration of quantity may appear on one or more lines of print or type.

6.4. Terms: Weight, Liquid Measure, Dry Measure, or Count. The declaration of the quantity of a particular commodity shall be expressed in terms of liquid measure if the commodity is liquid, or dry measure if the commodity is dry, or in terms of weight if the commodity is solid, semisolid, viscous, or a mixture of solid and liquid, or in terms of numerical count. However, if there exists a firmly established general consumer usage and trade custom with respect to the terms used in expressing a declaration of quantity of a particular commodity, such a declaration of quantity may be expressed in its traditional terms, if such traditional declaration gives accurate and adequate information as to the quantity of the commodity.

6.4.1. Combination Declaration.

A. A declaration of quantity in terms of weight shall be combined with appropriate declarations of the measure, count, and size of the individual units unless a declaration of weight alone is fully informative.

B. A declaration of quantity in terms of measure shall be combined with appropriate declarations of the weight, count, and size of the individual units unless a declaration of measure alone is fully informative.

C. A declaration of quantity in terms of count shall be combined with appropriate declarations of the weight, measure, and size of the individual units unless a declaration of count alone is fully informative.

6.5. Inch-Pound Units: Weight, Measure. A declaration of Quantity:

A. In units of weight, shall be in terms of the avoirdupois pound or ounce;

B. In units of liquid measure, shall be in terms of the United States gallon of 231 cubic inches or liquid-quart, liquid-pint, or fluid-ounce subdivisions of the gallon and shall express the volume at 68°F, except in the case of petroleum products or distilled spirits, for which the declaration shall express the volume at 60°F, and except also in the case of a commodity that is normally sold and consumed while frozen, for which the declaration shall express the volume at the frozen temperature, and except also in the case of a commodity that is normally sold in the refrigerated state, for which the declaration shall express the volume at 40°F, and except also in the case of malt beverages, for which the declaration shall express the volume at 39.1°F;

C. In units of linear measure, shall be in terms of the yard, foot, or inch;

D. In units of area measure, shall be in terms of the square yard, square foot, or square inch;

E. In units of volume measure, shall be in terms of the cubic yard, cubic food, or cubic inch;

F. In units of dry measure, shall be in terms of the United States bushel of 2150.42 cubic inches, or peck, dry-quart, and dry-pint subdivisions of the bushel.

6.5.1. Symbols and Abbreviations. Any of the following symbols and abbreviations, and none other, shall be employed in the quantity statement on a package of commodity:

avoirdupois	avdp	ounce	oz
cubic	cu	pint	pt
feet or foot	ft	pound	lb
fluid	fl	quart	qt
gallon	gal	square	sq
inch	in	weight	wt
liquid	liq	yard	yd

(There normally are no periods following, nor plural forms of, symbols. For example, "oz" is the symbol for both "ounce" and "ounces". Both upper and lower case letters are acceptable.)

6.5.2. Units of Two or More Meanings. When the term "ounce" is employed in a declaration of liquid quantity, the declaration shall identify the particular meaning of the term by the use of the term "fluid"; however, such distinction may be omitted when, by association of terms (for example, as in "20 fluid ounces, 1 pint 4 ounces"), the proper meaning is obvious. Whenever the declaration of quantity is in terms of the dry pint or dry quart, the declaration shall include the word "dry."

6.6. Metric Units: Weight, Measure. A declaration of quantity in:

A. Units of weight shall be in terms of the kilogram, gram, or milligram;

B. Units of liquid measure shall be in terms of the liter or milliliter, and shall express the volume at 20°C, except in the case of petroleum products or distilled spirits, for which the declaration shall express the volume at 15°C, and except also in the case of malt beverages or a commodity that is normally sold and consumed while frozen, for which the declaration shall express the volume at the frozen temperature, and except also in the case of

malt beverages or a commodity that is normally sold in the refrigerated state, for which the declaration shall express the volume at 4°C;

C. Units of linear measure shall be in terms of the meter, centimeter, or millimeter;

D. Units of area measure, shall be in terms of the square meter or square centimeter;

E. Units of volume other than liquid measure, shall be in terms of the liter and milliliter, except that the terms cubic meter and cubic centimeter will be used only when specifically designated as a method of sale.

6.6.1. Symbols. Any of the following symbols for metric units, and none other, may be employed in the quantity statement on a package of commodity:

kilogram	kg
gram	g
milligram	mg
liter	L or l
milliliter	mL or ml
meter	m
centimeter	cm
millimeter	mm
square meter	m/2
square centimeter	cm/2
cubic meter	m/3
cubic centimeter	cm/3

A. Symbols, except for liter, are not capitalized unless the unit is derived from a proper name. Periods should not be used after the symbol. Symbols are always written in the singular form–do not add "s" to express the plural when the symbol is used.

B. The "l" symbol for liter and "ml" symbol for milliliter are permitted; however, the "L" symbol and the "mL" symbol are preferred.

6.7. Prescribed Units, Inch-Pound System.

6.7.1. Less than 1 Foot, 1 Square Foot, 1 Pound, or 1 Pint. The declaration of quantity shall be expressed in terms of:

A. In the case of length measure of less than 1 foot, inches and fractions of inches;

B. In the case of area measure of less than 1 square foot, square inches and fractions of square inches;

C. In the case of weight of less than 1 pound, ounces and fractions of ounces;

D. In the case of liquid measure of less than 1 pint, fluid ounces and fractions of fluid ounces;

Provided, that the quantity declaration appearing on a random package may be expressed in terms of decimal fractions of the largest appropriate unit, the fraction being carried out to not more than three[2] decimal places.

6.7.2. Weight: Dual Quantity Declaration. On packages containing 1 pound or more but less than 4 pounds, the declaration shall be expressed in ounces and, in addition, shall be followed by a declaration in parentheses, expressed in terms of the largest whole unit: provided, that the quantity declaration appearing on a random package may be expressed in terms of pounds and decimal fractiions of the pound carried out to not more than three[2] decimal places.

6.7.3. Liquid Measure: Dual Quantity Declaration. On packages containing 1 pint or more, but less than 1 gallon, the declaration shall be expressed in fluid ounces and, in addition, shall be followed by a declaration in parentheses, expressed in terms of the largest whole unit.

6.7.4. Length Measure: Dual Quantity Declaration. On packages containing 1 foot or more, but less than 4 feet, the declaration shall be expressed in inches and, in addition, shall be followed by a declaration in parentheses, expressed in terms of the largest whole unit.

6.7.5. Area Measure: Dual Quantity Declaration. On packages containing 1 square foot or more but less than 4 square feet, the declaration shall be expressed in square inches and, in addition, shall be followed by a declaration in parentheses, expressed in terms of the largest whole unit.

6.7.6. Four Feet, 4 Square Feet, 4 Pounds, 1 Gallon, or More. In the case of:

A. Length measure of 4 feet or more

The declaration of quantity shall be expressed in terms of feet, followed in parentheses by a declaration of yards and common or decimal fractions of the yard, or in terms of feet followed in parentheses by a declaration of yards with any remainder in terms of feet and inches. In the case of

B. Area measure of 4 square feet or more;

C. Weight of 4 pounds or more;

D. Liquid measure of 1 gallon or more

The declaration of quantity shall be expressed in terms of the largest whole unit.

6.7.7. Bidimensional Commodities. For bidimensional commodities (including roll-type commodities) the quantity declaration shall be expressed:

A. If less than 1 square foot, in terms of linear inches

and fractions of linear inches;

B. If at least 1 square foot but less than 4 square feet, in terms of square inches followed in parentheses by a declaration of both the length and width, each being in terms of the largest whole unit; provided, that

1. No square inch declaration is required for a bidimensional commodity of 4 inches width or less,

2. A dimension of less than 2 feet may be stated in inches within the parenthetical declaration, and

3. Commodities consisting of usable individual units (except roll-type commodities with individual usable units created by perforations, for which see subsection 6.9. Count: Ply.) require a declaration of unit area but not a declaration of total area of all such units,

C. If 4 square feet or more, in terms of square feet followed in parentheses by a declaration of the length and width in terms of the largest whole unit; provided, that

1. No declaration in square feet is required for a bidimensional commodity with a width of 4 inches or less,

2. Bidimensional commodities, with a width of 4 inches or less, shall have the length expressed in inches followed by a statement in parentheses of the length in the largest whole unit. (Example: 2 inches by 360 inches (10 yards).)

3. A dimension of less than 2 feet may be stated in inches within the parenthetical declaration, and

D. No declaration in square units is required for commodities for which the length and width measurements are critical in terms of end use (such as tablecloths or bedsheets) if such commodities clearly present the length and width measurements on the label.

6.8. Prescribed Units, Metric System.

6.8.1. Less Than 1 Meter, 1 Square Meter, 1 Kilogram, or 1 Liter. The declaration of quantity shall be expressed in terms of:

A. In the case of length measure of less than 1 meter, centimeters, or millimeters;

B. In the case of area measure of less than 1 square meter, square centimeters and decimal fractions of square centimeters;

C. In the case of weight of less than 1 kilogram, grams and decimal fractions of a gram, but if less than 1 gram, then in milligrams;

D. In the case of liquid or dry measure of less than one liter, milliliters;

Provided, that the quantity declaration appearing on a random weight package may be expressed in terms of decimal fractions of the largest appropriate unit, the fraction being carried out to not more than three[2] decimal places.

6.8.2. One Meter, 1 Square Meter, 1 Kilogram, 1 Liter or More. In the case of:

A. Length measure of 1 meter or more; in meters and decimal fractions to not more than two places.

B. Area measure of 1 square meter or more; in square meters and decimal fractions to not more than two places.

C. Weight of 1 kilogram or more; in kilograms and decimal fractions to not more than two places.

D. Liquid or dry measure of 1 liter or more; in liters and decimal fractions to not more than two places.

6.8.3. Bidimensional Commodities. For bidimensional commodities (including roll-type commodities) the quantity declaration shall be expressed:

A. If less than 1 square meter in terms of length and width.

B. If 1 square meter or more, in terms of square measure followed in parentheses by a declaration of length and width: provided, that

1. Quantity declarations on bidimensional commodities with a width of 100 millimeters or less may be expressed in terms of width and length, only.

2. Commodities consisting of usable individual units (except roll-type commodities with individual usable units created by perforations, for which see subsection 6.9. Count: Ply.) require a declaration of unit area but not a declaration of total area of all such units.

3. No declaration in square units is required for commodities for which the length and width measurements are critical in terms of end use (such as tablecloths or bedsheets) if such commodities clearly present the length and width measurements on the label.

6.9. Count: Ply. If the commodity is in individually usable units of one or more components or plies, the quantity declaration shall, in addition to complying with other applicable quantity declaration requirements of this regulation, include the number of plies and total number of usable units.

Roll-type commodities, when perforated so as to identify individual usable units, shall not be deemed to be made up of usable units; however, such roll-type commodities shall be labeled in terms of:

A. Total area measurement,

B. Number of plies,

C. Count of usable units, and

D. Dimensions of a single usable unit.

6.10. Fractions.

A. Metric: A metric statement in a declaration of net quantity of contents of any consumer commodity may contain only decimal fractions.

B. Inch-Pound: An inch-pound statement of net quantity of contents of any consumer commodity may contain common or decimal fractions. A common fraction shall be in terms of halves, quarters, eights, sixteenths, or thirty-seconds, except that:

1. If there exists a firmly established general consumer usage and trade custom of employing different common fractions in the net quantity declaration of a particular commodity, they may be employed, and

2. If linear measurements are required in terms of yards or feet, common fractions may be in terms of thirds.

C. Common Fractions: A common fraction shall be reduced to its lowest term (Example: 2/4 becomes 1/2).

D. Decimal Fractions: A decimal fraction shall not be carried out to more than two places.

6.11. Supplementary Declarations.

6.11.1. Supplementary Quantity Declarations. The required quantity declaration may be supplemented by one or more declarations of weight, measure, or count, such declaration appearing other than on a principal display panel. Such supplemental statement of quantity of contents shall not include any term qualifying a unit of weight, measure, or count that tends to exaggerate the amount of commodity contained in the package (e.g., "giant" quart, "larger" liter, "full" gallon, "when packed," "minimum," or words of similar import).

6.11.2. Combined Metric and Inch-Pound Declarations. An equivalent statement of the net quantity of contents in terms of either the inch-pound or metric system is not regarded as a supplemental statement and such statement may also appear on the principal display panel; provided, that it conforms to both subsections 6.5 and 6.6.

6.11.3. Rounding. In all conversions for the purpose of showing an equivalent metric or inch-pound quantity to a rounded inch-pound or metric quantity, the number of significant digits retained should be such that accuracy is neither sacrificed nor exaggerated. As a general rule, converted values should be rounded down by dropping any digit beyond the first three. (Example: 196.4 grams becomes 196 grams or 1.759 feet becomes 1.75 feet.)

6.12. Qualification of Declaration Prohibited. In no case shall any declaration of quantity be qualified by the addition of the words "when packed," "minimum," or "not less than" or any words of similar import, nor shall any unit of weight, measure, or count be qualified by any term (such as "jumbo," "giant," "full," or the like) that tends to exaggerate the amount of commodity.

6.13. Character of Declaration: Average. The average quantity of contents in the packages of a particular lot, shipment, or delivery shall at least equal the declared quantity, and no unreasonable shortage in any package shall be permitted, even though overages in other packages in the same shipment, delivery, or lot compensate for such shortage.

§ 7. Declaration of Quantity: Nonconsumer Packages.

7.1. General. The metric and inch-pound systems of weights and measures are recognized as proper systems to be used in the declaration of quantity. Units of both systems might be combined in a dual declaration of quantity.[3]

7.2. Location. A nonconsumer package shall bear on the outside a declaration of the net quantity of contents. Such declaration shall be in terms of the largest whole unit (see subsection 6.2. Largest Whole Unit).

7.3. Terms: Weight, Liquid Measure, Dry Measure, or Count. The declaration of the quantity of a particular commodity shall be expressed in terms of liquid measure if the commodity is liquid, or in terms of dry measure if the commodity is dry, or in terms of weight if the commodity is solid, semisolid, viscous, or a mixture of solid and liquid, or in terms of numerical count. However, if there exists a firmly established general consumer usage and trade custom with respect to the terms used in expressing a declaration of quantity of a particular commodity, such declaration of quantity may be expressed in its traditional terms, if such traditional declaration gives accurate and adequate information as to the quantity of the commodity.

7.4. Inch-Pound Units: Weight, Measure. A declaration of quantity:

A. In units of weight, shall be in terms of the avoirdupois pound or ounce;

B. In units of liquid measure, shall be in terms of the United States gallon of 231 cubic inches or liquid-quart, liquid-pint, or fluid-ounce subdivisions of the gallon, and shall express the volume at 68°F except in the case of

petroleum products or distilled spirits, for which the declaration shall express the volume at 60°F, and except also in the case of a commodity that is normally sold and consumed while frozen, for which the declaration shall express the volume at the frozen temperature, and except also in the case of a commodity that is normally sold in the refrigerated state, for which the declaration shall express the volume at 40°F, and except also in the case of malt beverages, for which the declaration shall express the volume at 39.1°F;

C. In units of linear measure, shall be in terms of the yard, foot, or inch;

D. In units of area measure, shall be in terms of the square yard, square foot, or square inch;

E. In units of volume measure, shall be in terms of the cubic yard, cubic foot, or cubic inch;

F. In units of dry measure, shall be in terms of the United States bushel of 2150.42 cubic inches, or peck, dry-quart and dry-pint subdivisions of the bushel.

7.4.1. Symbols and Abbreviations. Any generally accepted symbol and abbreviation of a unit name may be employed in the quantity statement on a package of commodity. (For commonly accepted symbols and abbreviations, see subsection 6.5.1. Symbols and Abbreviations.)

7.5. Metric Units: Weight, Measure. A declaration of quantity:

A. In units of weight, shall be in terms of the kilogram, gram, or milligram;

B. In units of liquid measure, shall be in terms of the liter or milliliter, and shall express the volume at 20°C, except in the case of petroleum products or distilled spirits, for which the declaration shall express the volume at 15°C, and except also in the case of a commodity that is normally sold and consumed while frozen, for which the declaration shall express the volume at the frozen temperature, and except also in the case of malt beverages or a commodity that is normally sold in the refrigerated state, for which the declaration shall express the volume at 4°C;

C. In units of linear measure, shall be in terms of the meter, centimeter, or millimeter;

D. In units of area measure, shall be in terms of the square meter or square centimeter;

E. In units of volume other than liquid measure, shall be in terms of the liter and milliliter, except that the terms cubic meter and cubic centimeter will be used only when specifically designated as a method of sale.

7.5.1. Symbols. Only those symbols as detailed in subsection 6.6.1. Symbols, and none other, may be employed in the quantity statement on a package of commodity.

7.6. Character of Declaration: Average. The average quantity of contents in the packages of a particular lot, shipment, or delivery shall at least equal the declared quantity, and no unreasonable shortage in any package shall be permitted, even though overages in other packages in the same shipment, delivery, or lot compensate for such shortage.

§ 8. Prominence and Placement: Consumer Packages.

8.1. General. All information required to appear on a consumer package shall appear thereon in the English language and shall be prominent, definite, and plain, and shall be conspicuous as to size and style of letters and numbers and as to color of letters and numbers in contrast to color of background. Any required information that is either in hand lettering or hand script shall be entirely clear and equal to printing in legibility.

8.1.1. Location. The declaration or declarations of quantity of the contents of a package shall appear in the bottom 30% of the principal display panel or panels. For cylindrical containers, see also subsection 10.7 for additional requirements.

8.1.2. Style of Type or Lettering. The declaration or declarations of quantity shall be in such a style of type or lettering as to be boldly, clearly, and conspicuously presented with respect to other type, lettering, or graphic material on the package, except that a declaration of net quantity blown, formed, or molded on a glass or plastic surface is permissible when all label information is blown, formed, or molded on the surface.

8.1.3. Color Contrast. The declaration or declarations of quantity shall be in a color that contrasts conspicuously with its background, except that a declaration of net quantity blown, formed, or molded on a glass or plastic surface shall not be required to be presented in a contrasting color if no required label information is on the surface in a contrasting color.

8.1.4. Free Area. The area surrounding the quantity declaration shall be free of printed information:

A. Above and below, by a space equal to at least the height of the lettering in the declaration, and

B. To the left and right, by a space equal to twice the width of the letter "N" of the style and size of type used in the declaration.

8.1.5. Parallel Quantity Declaration. The quantity declaration shall be presented in such a manner as to be generally parallel to the declaration of identity and

to the base on which the package rests as it is designed to be displayed.

8.2. Calculation of Area of Principal Display Panel for Purposes of Type Size. The area of the principal display panel shall be:

A. In the case of a rectangular container, one entire side which properly can be considered to be the principal display panel, the product of the height times the width of that side;

B. In the case of a cylindrical or nearly cylindrical container, 40% of the product of the height of the container times the circumference; or

C. In the case of any other shaped container, 40% of the total surface of the container, unless such container presents an obvious principal display panel (e.g., the top of a triangular or circular package of cheese, or the top of a can of shoe polish), in which event the area shall consist of the entire such surface.

Determination of the principal display panel shall exclude tops, bottoms, flanges at tops and bottoms of cans, and shoulders and necks of bottles or jars.

8.2.1. Minimum Height of Numbers and Letters. The height of any letter or number in the required quantity declaration shall be not less than that shown in Table 1 with respect to the area of the panel, and the height of each number of a common fraction shall meet one-half the minimum height standards. In the case of the symbol for milliliter, the "m" shall meet the minimum height standard.

8.2.2. Numbers and Letters: Proportion. No number or letter shall be more than three times as high as it is wide.

TABLE 1.
MINIMUM HEIGHT OF NUMBERS AND LETTERS.

Area of Principal Display Panel	Minimum Height of Numbers and Letters	Minimum Height: Label Information Blown, Formed, or Molded on Surface of Container
5 square inches (in/2) and less	1/16 inch	1/8 inch
Greater than 5 in/2 and not greater than 25 in/2	1/8 inch	3/16 inch
Greater than 25 in/2 and not greater than 100 in/2	3/16 inch	1/4 inch
Greater than 100 in/2 and not greater than 400 in/2	1/4 inch	5/16 inch
Greater than 400 in/2	1/2 inch	9/16 inch

§ 9. Prominence and Placement: Nonconsumer Packages.

9.1. General. All information required to appear on a nonconsumer package shall be definitely and clearly stated thereon in the English language. Any required information that is either in hand lettering or hand script shall be entirely clear and equal to printing in legibility.

§ 10. Requirements: Specific Consumer Commodities, Nonconsumer Commodities, Packages, Containers.

10.1. Display Card Package. For an individual package affixed to a display card, or for a commodity and display card together comprising a package, the type size of the quantity declaration is governed by the dimensions of the display card.

10.2. Eggs. When cartons containing 12 eggs have been designed so as to permit division in half by the retail purchaser, the required quantity declaration shall be so positioned as to have its context destroyed when the carton is divided.

10.3. Aerosols and Similar Pressurized Containers. The declaration of quantity on an aerosol package, and on a similar pressurized package, shall disclose the net quantity of the commodity (including propellant), in terms of weight, that will be expelled when the instructions for use as shown on the container are followed.

10.4. Multi-Unit Packages[4]. Any package containing more than one individual "commodity in package form" (see subsection 2.1) of the same commodity shall bear on the outside of the package a declaration of:

A. The number of individual units,

B. The quantity of each individual unit, and

C. The total quantity of the contents of the multi-unit package; provided, that any such declaration of total quantity shall not be required to include the parenthetical quantity statement of a dual quantity representation. (example: soap bars, "6 Bars, Net Weight 75 grams each; Total Net Weight 450 grams)

10.5. Combination Packages. Any package containing individual units of dissimilar commodites (such as an antiquing or a housecleaning kit, for example) shall bear on the label of the package a quantity declaration for each unit. (Example: sponges and cleaner: "2 sponges, each 10 centimeters x 15 centimeters x 2 centimeters; 1 box cleaner, net weight 150 grams")

10.6. Variety Packages. Any package containing individual units of reasonably similar commodities (such as seasonal gift packages, variety packages of cereal) shall bear on the label of the package a declaration of the total quantity of commodity in the package. (Example: plastic

tableware: 4 spoons, 4 forks, 4 knives, 12 pieces total.)

10.7. Cylindrical Containers. In the case of cylindrical or nearly cylindrical containers, information required to appear on the principal display panel shall appear within that 40% of the circumference which is most likely to be displayed, presented, shown, or examined under customary conditions of display for retail sale.

10.8. Measurement of Container-Type Commodities, How Expressed.

10.8.1. General. Commodities designated and sold at retail to be used as containers for other materials or objects, such as bags, cups, boxes, and pans, shall be labeled with the declaration of net quantity as follows:

A. For bag-type commodities, in terms of count followed by linear dimensions of the bag (whether packaged in a perforated roll or otherwise).

When the unit bag is characterized by two dimensions because of the absence of a gusset, the width and length will be expressed:

1. Inch-pound units - in inches, except that a dimension of 2 feet or more will be expressed in feet with any remainder in terms of inches or common or decimal fractions of the foot. (Example: "25 BAGS, 17 inches X 20 inches" or "100 BAGS, 20 inches X 2 feet 6 inches" or "50 BAGS, 20 inches X 2-1/2 feet")

2. Metric units - in millimeters except a dimension of one meter or more will be expressed in meters with the remainder in terms of decimal fractions of the meter (Examples: "25 BAGS, 500 millimeters X 600 millimeters" or "50 BAGS, 750 millimeters X 1.2 meters")

When the unit bag is gusseted, the dimensions will be expressed as width, depth, and length.

3. Inch-pound units - expressed in feet with any remainder in terms of inches or the common or decimal fractions of the foot. (Examples: "25 BAGS, 17 inches X 4 inches X 20 inches" or "100 BAGS, 20 inches X 12 inches X 2-1/2 feet")

4. Metric units. In millimeters except a dimension of one meter or more will be expressed in meters with the remainder in terms of decimal fractions of the meter. (Exampled: "25 Bags, 430 millimeters X 100 millimeters X 500 millimeters" or "50 bags, 500 millimeters X 300 millimeters X 1.2 meters")

B. For other square, oblong, rectangular, or similarly shaped containers, in terms of count followed by length, width, and depth, except depth need not be listed when less than 50 millimeters or 2 inches. (Examples: "2 PANS, 8 inches X 8 inches" or "2 PANS, 203 millimeters X 203 millimeters")

C. For circular or other generally round-shaped containers, except cups, and the like, in terms of count followed by diameter and depth, except depth need not be listed when less than 50 millimeters or two inches. (Examples: "4 PANS, 8 inches diameter X 4 inches" or "4 PANS, 200 millimeters diameter X 100 millimeters")

D. Notwithstanding the above requirements, the net quantity statement for containers such as cups will be listed in terms of count and liquid capacity per unit. (Examples: "24 CUPS, 6 fluid ounces capacity" or "24 CUPS 250 milliliter capacity")

10.8.2. Capacity. When the functional use of the container is related by label references in standard terms of measure to the capability of holding a specific quantity of substance or class of substances such references shall be a part of the net quantity statement and shall specify capacity as follows:

A. Inch-Pound Units:

1. Liquid measure for containers which are intended to be used for liquids, semisolids, viscous materials, or mixtures of solids and liquids. The expressed capacity will be stated in terms of the largest whole unit (gallon, quart, pint, ounce, with any remainder in terms of the common or decimal fraction of that unit). (Examples: Freezer Box - "4 BOXES, 1 quart capacity, 5 inches X 4 inches X 3 inches")

2. Dry measure for containers which are intended to be used for solids. The expressed capacity will be stated in terms of the largest whole unit (bushel, peck), with a remainder in terms of the common or decimal fraction of that unit. (Example: Leaf Bags - "8 BAGS, 6 bushel capacity, 3 feet X 5 feet")

3. Where containers are used as liners for other more permanent containers, in the same terms as are normally used to express the capacity of the more permanent containers. (Example: Garbage Can Liners - "10 LINERS, 2 feet 6 inches X 3 feet 9 inches. FITS UP TO 30-GALLON CANS")

B. Metric Units: Volume measure for all containers and liners. (Examples: "4 BOXES, 1 liter capacity. 150 millimeters X 120 millimeters X 90 millimeters;" "8 BAGS, 200 liter capacity, 85 millimeters X 1.5 meters" or "10 LINERS, 750 millimeters X 1 meter, fits up to 120 LITER CANS")

10.8.3. Terms. For purposes of this section, the use of the terms "CAPACITY", "DIAMETER", and "FLUID" is optional.

10.9. Textile Products, Threads, and Yarns.

10.9.1. Wearing Apparel. Wearing apparel (including nontextile apparel and accessories such as leather goods and footwear) sold as single-unit items, or if

normally sold in pairs (such as hosiery, gloves, and shoes) sold as single-unit pairs, shall be exempt from the requirements for a net quantity statement by count, as reqiured by subsection 6.4 of this regulation.

10.9.2. Textiles. Bedsheets, blankets, pillowcases, comforters, quilts, bedspreads, mattress covers and pads, afghans, throws, dresser and other furniture scarfs, tablecloths and napkins, flags, curtains, drapes, dishtowels, dish cloths, towels, face cloths, utility cloths, bath mats, carpets and rugs, pot holders, fixture and appliance covers, nonrectangular diapers, slip covers, etc., shall be exempt from the requirements of subsections 6.7.7 and 6.8.3 of this regulation; provided, that:

A. The quantity statement for fitted sheets and mattress covers shall state, in centimeters or inches, the length and width of the mattress for which the item is designed, such as "twin," "double," "king," etc. (Example: "Double Sheet for 135 centimeter X 190 centimeter mattress.")

B. The quantity statement for flat sheets shall state the size designation of the mattress for which the sheet is designed, such as "twin," "double," "king," etc. The quantity statement also shall state, in centimeters or inches, the length and width of the mattress for which the sheet is designed, followed in parentheses by a statement, in centimeters or inches, of the length and width of the finished sheet. (Example: "Twin Flat Sheet for 100 centimeter X 190 centimeter mattress (170 centimeter X 240 centimeter finished size)")

C. The quantity statement for pillowcases shall state the size designation of the pillow for which the pillowcase is designed, such as "youth," "standard," and "queen," etc. The quantity statement also shall state, in centimeters or inches, the length and width of the pillow for which the pillowcase is designed, followed in parentheses by a statement, in centimeters or inches, of the length and width of the finished pillowcase. (Example: "Standard Pillowcase for 50 centimeter X 65 centimeter pillow (53 centimeter X 75 centimeter finished size)")

D. The quantity statement for blankets, comforters, quilts, bedspreads, mattress pads, afghans, and throws shall state, in centimeters or inches, the length and width of the finished item. The quantity statement also may state the length of any ornamentation and the size designation of the mattress for which the item is designed, such as "twin," "double," "king," etc.

E. The quantity statement for tablecloths and napkins shall state, in centimeters or inches, the length and width of the finished item. The quantity statement also may state parenthetically, in centimeters or inches, the length and width of the item before hemming and properly identified as such.

F. The quantity statement for curtains, drapes, flags, furniture scarfs, etc., shall state, in centimeters or inches, the length and width of the finished item. The quantity statement also may state parenthetically, in centimeters or inches, the length of any ornamentation.

G. The quantity statement for carpets and rugs shall state, in meters or feet, with any remainder in decimal fractions of the meter for metric sizes or common or decimal fractions of the foot or in inches for inch-pound sizes, the length and width of the item. The quantity statement also may state parenthetically, in centimeters or inches, the length of any ornamentation.

H. The quantity statement for woven dish towels, dish cloths, towels, face cloths, utility cloths, bath mats, etc., shall state, in centimeters or inches, the length and width of the item. The quantity statement for such items, when knitted, need not state the dimensions.

I. The quantity statement for textile products such as pot holders, fixture and appliance covers, nonrectangular diapers, slip covers, etc., shall be stated in terms of count and may include size designations and dimensions.

J. The quantity statement for other than rectangular textile products identified in subsections A through H shall state the geometric shape of the product and the dimensions which are customarily used in describing such geometric shape. (Example: "Oval Tablecloth 140 centimeters X 110 centimeters" representing the maximum length and width in this case)

K. The quantity statement for packages of remnants of textile products of assorted sizes, when sold by count, shall be accompanied by the term "irregular dimensions" and the minimum size of such remnants.

10.9.3. Textiles: Variations From Declared Dimensions.

A. For an item with no declared dimension less than 60 centimeters or 24 inches, a minus variation greater than 3% of a declared dimension and a plus variation greater than 6% of a declared dimension should be considered unreasonable.

B. For an item with a declared dimension less than 60 centimeters or 24 inches, a minus variation greater than 6% of that declared dimension and a plus variation greater than 12% of that declared dimension should be considered unreasonable.

10.9.4. Exemption: Variety Textile Packages. Variety packages of textiles that are required by reason of subsection 6.4.1 to provide a combination declaration stating the quantity of each inidividual unit, shall be exempt from the requirements in this regulation for:

A. Location (see subsection 8.1.1),

B. Free Area (see subsection 8.1.4), and

C. Minimum height of numbers and letters (see

subsection 8.2.1).

10.9.5. Sewing Threads, Handicrafts Threads, and Yarns. Sewing and handicraft threads shall be exempt from the requirements of subsections 6.7.2 and 6.8.2 A. of this regulation; provided, that:

A. The net quantity statement for inch-pound sizes of sewing and handicraft threads shall be expressed in terms of yards.

B. The net quantity statement for yarns shall be expressed in terms of weight.

C. Thread products may, in lieu of name and address, bear a trademark, symbol, brand, or other mark that positively identifies the manufacturer, packer, or distributor, provided that such marks, employed to identify the vendor, shall be filed with the director.

D. Each unit of industrial thread shall be marked to show its net length in terms of meters or yards or its net weight in terms of kilograms or grams or avoirdupois pounds or ounces, except that ready-wound bobbins that are not sold separately, shall not be required to be individually marked to show the number of bobbins contained therein and the net meters or yards of thread on each bobbin.

10.10. Packaged Seed. Packages of seed intended for planting shall be labeled in full accord with this regulation except as follows:

A. The quantity statement shall appear in the upper thirty percent of the principal display panel.

B. The quantity statements shall be in terms of the largest whole unit of the metric system for all weights up to seven grams, and in grams or in ounces for all other weights less than 225 grams or eight ounces; packaged seed weighing 225 grams or eight ounces or more shall not be subject to subsection 10.10.

C. The quantity statement for coated seed, encapsulated seed, pelletized seed, preplanters, seed tapes, etc., shall be in terms of count.

10.11. Bark Mulch: Variations From Declared Volume.[5] An individual package minus variation greater than 5% of the declared volume shall be considered unreasonable.

10.12. Polyethylene Products: Variations From Declared Thickness[6]. Any individual thickness measurement of polyethylene sheeting, film, or bag may be as much as 20 % below the labeled thickness, i.e., at least 80% of the labeled thickness [7]. The average thickness of a single package of polyethylene sheeting, film, or bags may be as much as 7% below the labeled thickness, i.e., at least 93% of the labeled thickness.

§ 11. Exemptions.

11.1. General. Whenever any consumer commodity or package of consumer commodity is exempted from the requirements for dual quantity declaration, the net quantity required to appear on the package shall be in terms of the largest whole unit (except see subsection 10.4(C)).

11.2. Random Packages. A random package bearing a label conspicuously declaring:

A. The net weight,

B. The price per kilogram or pound, and

C. The total price.

Shall be exempt from the type size, dual declaration, placement, and free area requirements of this regulation. In the case of a random package packed at one place for subsequent sale at another, neither the price per unit of weight nor the total selling price need appear on the package, provided the package label included both such prices at the time it is offered or exposed for sale at retail.

This exemption shall also apply to uniform weight packages of cheese and cheese products labeled in the same manner and by the same type of equipment as random packages exempted by this section.

11.3. Small Confections. Individually wrapped pieces of "penny candy" and other confectionery of less than 15 grams or one-half ounce net weight per individual piece shall be exempt from the labeling requirements of this regulations when the container in which such confectionery is shipped is in conformance with the labeling requirements of this regulation. Similarly, when such confectionery items are sold in bags or boxes, such items shall be exempt from the labeling requirements of this regulation, including the required declaration of net quantity of contents, when the declaration of the bag or box meets the requirements of this regulation.

11.4. Individual Servings. Individual-serving-size packages of foods containing less than 15 grams or 1/2 ounce or less than 15 milliliters or 1/2 fluid ounce for use in restaurants, institutions, and passenger carriers, and not intended for sale at retail, shall be exempt from the required declaration of net quantity of contents specified in this regulation.

11.5. Cuts, Plugs, and Twists of Tobacco and Cigars. When individual cuts, plugs, and twists of tobacco and individual cigars are shipped or delivered in containers that conform to the labeling requirements of this regulation, such individual cuts, plugs, and twists of tobacco and cigars shall be exempt from such labeling requirements.

11.6. Reusable (Returnable) Glass Containers. Nothing in this regulation shall be deemed to preclude the continued

use of reusable (returnable) glass containers; provided, that such glass containers ordered after the effective date of this regulation shall conform to all requirements of this regulation.

11.7. Cigarettes and Small Cigars. Cartons of cigarettes and small cigars, containing ten individual packages of twenty, labeled in accordance with the requirements of this regulation, shall be exempt from the requirements set forth in subsection 8.1.1 Location, subsection 8.2.1 Minimum Height of Numbers and Letters, and subsection 10.4 Multi-Unit Packages; provided, that such cartons bear a declaration of the net quantity of commodity in the package.

11.8. Packaged Commodities With Labeling Requirements Specified in Federal Law. Packages of meat and meat products, poultry products, tobacco and tobacco products, insecticides, fungicides, rodenticides, and alcoholic beverages shall be exempt from those portions of these regulations requiring dual declarations in customary units and specifying location and minimum type size of the net quantity declaration; provided, that quantity labeling requirements for such products are specified in federal law, so as to follow reasonably sound principles of providing consumer information.

11.9. Fluid Dairy Products, Ice Creams, and Similar Frozen Desserts:

A. When packaged in 1/2-liquid-pint and 1/2-gallon containers, are exempt from the requirements for stating net contents of 8 fluid ounces and 64 fluid ounces, which may be expressed as 1/2 pint and 1/2 gallon, respectively.

B. When packaged in 1-liquid-pint, 1-liquid-quart, and 1/2-gallon containers, are exempt from the dual net contents declaration requirements of subsection 6.7.3.

C. When measured by and packaged in measure containers as defined in "Measure Container Code of National Bureau of Standards Handbook 44," are exempt from the requirements of subsection 8.1.1 that the declaration of net contents be located within the bottom 30% of the principal display panel.

D. Milk and milk products when measured by and packaged in glass or plastic containers of 1/2-pint, 1-pint, 1-quart, 1/2-gallon, and 1-gallon capacities are exempt from the placement requirement of subsection 8.1.1 that the declaration of net contents be located within the bottom 30% of the principal display panel; provided, that other required label information is conspicuously displayed on the cap or outside closure, and the required net quantity of contents declaration is conspicuously blown, formed, or molded on, or permanently applied to that part of the glass or plastic container that is at or above the shoulder of the container.

11.10. Single Strength and Less Than Single Strength Fruit Juice Beverages, Imitations Thereof, and Drinking Water:

A. When packaged in glass, plastic, or fluid milk type paper containers of 8- and 64-fluid-ounce capacity, are exempt from the requirements of subsection 6.5 B, to the extent that net contents of 8 fluid ounces and 64 fluid ounces (or 2 quarts) may be expressed as 1/2 pint (or half pint) and 1/2 gallon (or half gallon), respectively.

B. When packaged in glass, plastic, or fluid milk type paper containers of 1-pint, 1-quart, and 1/2-gallon capacities, are exempt from the dual net contents declaration requirements of subsection 6.7.3.

C. When packaged in glass or plastic containers of 1/2-pint, 1-pint, 1-quart, 1/2-gallon, and 1-gallon capacities, are exempt from the placement requirements of subsection 8.1.1 that the declaration of net contents be located within the bottom 30% of the principal display panel; provided, that other label information is conspicuously displayed on the cap or outside closure and the required net quantity of contents declaration is conspicuously blown, formed, or molded into or permanently applied to that part of the glass or plastic container that is at or above the shoulder of the container.

11.11. Soft-Drink Bottles. Bottles of soft drinks shall be exempt from the placement requirements for the declaration of:

A. Identity, when such declaration appears on the bottle closure, and

B. Quantity, when such declaration is blown, formed, or molded on or above the shoulder of the container and when all other information required by this regulation appears only on the bottle closure.

11.12. Multi-Unit Soft-Drink Packages. Mult-unit packages of soft drinks are exempt from the requirement for a declaration of:

A. Responsibility, when such declaration appears on the individual units and is not obscured by the multi-unit packaging, or when the outside container bears a statement to the effect that such declaration will be found on the individual units inside, and

B. Identity, when such declaration appears on the individual units and is not obscured by the multi-unit packaging.

11.13. Butter. When packaged in 4-ounce, 8-ounce, and 1-pound packages with continuous label copy wrapping, butter is exempt from the requirements that the statement of identity (subsection 3.1.1) and the net quantity declaration (subsection 8.1.5) be generally parallel to the base of the package. When packaged in 8-ounce and 1-pound units, butter is exempt from the requirement for location (subsection 8.1.1) of net quantity declaration and, when packaged in 1-pound units, is exempt from the

requirement for dual quantity declaration (subsection 6.7.2).

11.14. Eggs. Cartons containing 12 eggs shall be exempt from the requirement for location (subsection 8.1.1) of net quantity declaration. When such cartons are designed to permit division in half, each half shall be exempt from the labeling requirements of this regulation if the undivided carton conforms to all such requirements.

11.15. Flour. Packages of wheat flour in conventional 2-, 5-, 10-, 25-, 50-, and 100-pound packages shall be exempt from the requirement in this regulation for location (subsection 8.1.1) of the net quantity declaration and, when packaged in units of 2 pounds, shall be exempt also from the requirement for a dual quantity declaration (subsection 6.7.2).

11.16. Small Packages. On a principal display panel of 5 square inches or less, the declaration of quantity need not appear in the bottom 30% of the principal display panel if that declaration satisfies the other requirements of this regulation.

11.17. Decorative Containers. The principal display panel of a cosmetic marketed in a "boudoir-type" container including decorative cosmetic containers of the "cartridge", "pill box", "compact", or "pencil" variety, and those with a capacity of 1/4 ounce or less, may be a tear-away tag or tape affixed to the decorative container, and bearing the mandatory label information as required by this regulation.

11.18. Combination Packages. Combination packages are exempt from the requirements in this regulation for:

A. Location (see subsection 8.1.1),

B. Free Area (see subsection 8.1.4), and

C. Minimum Height of Numbers and Letters (see subsection 8.2.1).

11.19. Margarine. Margarine in 1-pound rectangular packages, except for packages containing whipped or soft margarine or packages containing more than four sticks, shall be exempt from the requirement in this regulation for location (see subsection 8.1.1) of the net quantity declaration, and shall be exempt from the requirement for a dual quantity declaration (see subsection 6.7.2).

11.20. Corn Flour and Corn Meal. Corn flour and corn meal packaged in conventional 5-, 10-, 25-, 50-, and 100-pound bags shall be exempt from the requirement in this regulation for location (see subsection 8.1.1) of the net quantity declaration.

11.21. Prescription and Insulin-Containing Drugs. Prescription and insulin-containing drugs subject to the provisions of Section 503(b) (1) or 506 of the Federal Food, Drug, and Cosmetic Act shall be exempt from the provisions of this regulation.

11.22. Camera Film. Camera film packaged and labeled for retail sale is exempt from the net quantity statement requirements of this regulation that specify how measurement of commodities should be expressed; provided, that:

A. The net quantity of contents on packages of movie film and bulk still film is expressed in terms of the number of linear meters or feet of usable film contained therein.

B. The net quantity of contents on packages of movie film is expressed in terms of the running time of the exposed film for that portion of film which is of entertainment value.

"Entertainment value" is defined as that portion of a film that commences with the first frame of sound or picture, whichever comes first after the countdown sequence and ends with either:

1. the last frame of credits; or

2. the last frame of the phrase "The End", or

3. the end of sound whichever is last.

C. The net quantity of contents on packages of still film is expressed in terms of the number of exposures the contents will provide. The length and width measurements of the individual exposures, expressed in millimeters or inches, are authorized as an optional statement. (Example: "36 exposures, 36 millimeters X 24 millimeters" or "12 exposures, 2-1/4 inches X 2-1/4 inches")

11.23. Paints and Kindred Products:

A. Paints, varnishes, lacquers, thinners, removers, oils, resins, and solvents, when packed in 1-liquid-pint and 1-liquid-quart units shall be exempt from the dual quantity declaration requirements of subsection 6.7.3.

B. Tint base paint may be labeled on the principal display panel in terms of a quart or a gallon including the addition of colorant selected by the purchaser, provided that the system employed ensures that the purchaser always obtains a quart or a gallon; and further provided that in conjunction with the required quantity statement on the principal display panel, a statement indicating that the tint base paint is not to be sold without the addition of colorant is presented; and further provided that the contents of the container, before the addition of colorant, is stated in fluid ounces elsewhere on the label.

Wherever the above conditions cannot be met, containers of tint base paint must be labeled with a statement of the actual net contents prior to the addition of colorant in full accord with all the requirements of this regulation.

11.24. Automotive Cooling System Antifreeze. Antifreeze, when packed in 1-liquid-quart units, in metal or plastic containers, shall be exempt from the dual quantity declaration requirements of subsection 6.7.3.

11.25. Motor Oils. Motor oils, when packed in 1-liquid-quart units, shall be exempt from the dual quantity declaration requirements of subsection 6.7.3. Additionally, motor oil in 1-liquid-quart, 1-gallon, 1-1/4-gallon, 2-gallon, and 2-1/2-gallon units, bearing the principal display panel on the body of the container, is exempt from the requirements, of § 3, Declaration of Identity: Consumer Package, to the extent that the Society of Automotive Engineers (SAE) viscosity number is required to appear on the principal display panel, provided the SAE viscosity number appears on the can lid and is expressed in letters and numerals in type size of at least 6 millimeters or 1/4 inch.

11.26. Pillows, Cushions, Comforters, Mattress Pads, Sleeping Bags, and Similar Products. Those products, including pillows, cushions, comforters, mattress pads, and sleeping bags, that bear a permanent label as designated by the Association of Bedding and Furniture Law Officials or by the California Bureau of Home Furnishings shall be exempt from the requirements for location (subsection 8.1.1), size of letters or numbers (subsection 8.2.1 and 8.2.2), free area (subsection 8.1.4) and the declarations of identity and responsibility (subsections 3.1 and 5); provided, that declarations of identity, quantity, and responsibility are presented on a permanently attached label and satisfy the other requirements of this regulation, and further provided that the information on such permanently attached label be fully observable to the purchaser.

11.27. Commodities' Variable Weights and Sizes. Individual packaged commodities put up in variable weights and sizes for sale intact, and intended to be weighed and marked with the correct quantity statement prior to or at the point of retail sale, are exempt from the requirements of § 6 Declaration of Quantity: Consumer Packages, while moving in commerce and while held for sale prior to weighing and marking; provided, that the outside container bears a label declaration of the total net weight.

11.28. Packaged Commodities Sold By Count. When a packaged consumer commodity is properly measured in terms of count only, or in terms of count and some other appropriate unit, and the individual units are fully visible to the purchaser, such packages shall be labeled in full accord with this regulation except that those containing 6 or less items need not include a statement of count.

11.29. Fishing Lines and Reels. Packaged fishing lines and reels are exempt from the dual quantity declaration requirements of subsection 6.7.6 A; provided, that length of line or capacity of reel, as appropriate is presented in terms of meters or yards in full accord with all other requirements of this regulation.

§ 12. Variations To Be Allowed.

12.1. Packaging Variations.

12.1.1. Variations From Declared Net Quantity. Variations from the declared net weight, measure, or count shall be permitted when caused by unavoidable deviations in weighing, measuring, or counting the contents of individual packages that occur in good packaging practice, but such variations shall not be permitted to such extent that the average of the quantities in the packages of a particular commodity, or a lot of the commodity that is kept, offered, or exposed for sale, or sold, is below the quantity stated, and no unreasonable shortage in any package shall be permitted, even though overages in other packages in the same shipment, delivery, or lot compensate for such shortage. Variations above the declared quantity shall not be unreasonably large.

12.1.2. Variations Resulting From Exposure. Variations from the declared weight or measure shall be permitted when caused by ordinary and customary exposure to conditions that normally occur in good distribution practice and that unavoidably result in change of weight or measure, but only after the commodity is introduced into intrastate commerce; provided, that the phrase "introduced into intrastate commerce" as used in this paragraph shall be construed to define the time and the place at which the first sale and delivery of a package is made within the State, the delivery being either:

A. Directly to the purchaser or to his agent, or

B. To a common carrier for shipment to the purchaser, and this paragraph shall be construed as requiring that, so long as a shipment, delivery, or lot of packages of a particular commodity remains in the possession or under the control of the packager or the person who introduces the package into intrastate commerce, exposure variations shall not be permitted.

12.2. Magnitude of Permitted Variations. The magnitude of variations permitted under subsection 12, 12.1, 12.1.1, and 12.1.2 of this regulation shall be those expressly set forth in this regulation and those contained in the procedures and tables of National Bureau of Standards Handbook 133, Checking The Net Contents of Prepackaged Goods.

§ 13. Retail Sale Price Representations.

13.1. "Cents-Off" Representations. RESERVED

13.2. Introductory Offers. RESERVED

13.3. Economy Size.

A. The term "economy size" means any printed matter consisting of the words "economy size," "economy pack,"

"budget pack," "bargain size," "value size," or words of similar import placed upon any package containing any consumer commodity, or placed upon any label affixed adjacent to such commodity, stating or representing directly or by implication that a retail sale price advantage is accorded the purchaser thereof by reason of the size of that package or the quantity of its contents.

B. The packager or labeler of a consumer commodity may not have inprinted thereon an "economy" size representation unless:

1. At the same time the same brand of the commodity is offered in at least one other packaged size or labeled form.

2. Only one packaged or labeled form of that brand of commodity labeled with an "economy size" representation is offered.

3. The commodity labeled with an "economy size" representation is sold at a price per unit of weight, volume, measure, or count that is substantially reduced (i.e., at least 5%) from the actual price of all other packaged or labeled units of the same brand of that commodity offered simultaneously.

C. No "economy size" package shall be made available in any circumstances where it is known that it will be used as an instrumentality for deception, e.g., where the retailer charges a price which does not pass on to the consumer the substantial reduction in cost per unit initially granted.

D. The sponsor of an "economy size" package shall prepare and maintain invoices or other records showing compliance with paragraph B. of the subsection. The invoices or other records required by this section shall be open to inspection and shall be retained for one year.

METHODS OF SALE OF COMMODITIES REGULATION

§ 14.

Food Products[8]

14.1. Berries and Small Fruits.

Shall be offered and exposed for sale and sold by weight or by volume in open measure containers having capacities per subsection 1.1(a) or subsection 14.1(b) and when sold by volume, the containers shall be deemed not to be packages for labeling purposes.

(a) Inch-Pound Capacities - 1/2 dry pint, 1 dry pint, or 1 dry quart.

(b) Metric Capacities - 250 milliliters, 500 milliliters, or 1 liter.

14.2. Butter, Oleomargarine, and Margarine.[9]

Shall be offered and exposed for sale and sold by weight per subsection 14.2(a) or subsection 14.2(b).

(a) Inch-Pound-Weights - 1/4 pound, 1/2 pound, 1 pound, or a multiple of 1 pound.

(b) Metric Weights - 125 grams, 250 grams, 500 grams, or a multiple of 500 grams.

14.3. Flour, Cornmeal, and Hominy Grits.

Wheat flour, whole wheat flour, graham flour, self-rising wheat flour, phosphated wheat flour, bromated flour, corn flour, cornmeal, and hominy grits whether enriched or not, shall be packaged, kept, offered, or exposed for sale, or sold only in weights per subsection 14.3(a) or subsection 14.3(b); Provided, that inch-pound sizes less than 2 pounds or more than 100 pounds and that metric sizes less than 1 kilogram or more than 50 kilograms shall be permitted.

(a) Inch-Pound Weights - 2, 5, 10, 25, 50, or 100 pounds.

(b) Metric Weights - 1, 2.5, 5, 10, 25, or 50 kilograms. (Section 3.1-952 Weights and Measures Law).

14.4. Meat, Poultry, Fish, and Seafood[10].

Shall be sold by weight, except that shellfish may be sold by weight, measure, or count.

14.4.1. In Combination With Other Foods.

When meat, poultry, fish or seafood is combined with some other food element to form a distinctive food product, the quantity representation may be in terms of the total weight of the product or combination, and a quantity representation need not be made for each element. (Weights and Measures Law Section 3.1-950)

14.4.2. Stuffed Fish, Seafood, Poultry or Meat Products.

In the case of ready-to-cook stuffed fish, seafood, poultry, or meat products, the label must show the total net weight of the stuffed fish, seafood, poultry or meat products and the minimum net weight of the fish, seafood, poultry or meat in the product excluding the fish, seafood, meat, or poultry that may be part of the stuffing.

Excluding the poultry or meat that may be part of the stuffing. (Required by the United States Department of Agriculture).

14.4.3. Clams, Mussels, Oysters, and other Mollusks.

14.4.3.1. Whole clams, mussels, oysters, and other mollusks in the shell (fresh or frozen) shall be sold by

weight (including the weight of the shell, but not including the liquid or ice packed with them), dry measure (e.g., bushel), or count. In addition, size designations may be provided.

14.4.3.2. Whole clams, mussels, oysters, or other mollusks on the half shell (fresh, cooked, smoked, or frozen, with or without sauces or spices added) shall be sold by weight (excluding the weight of the shell) or by count. Size designations may also be provided.

14.4.3.3. Fresh clams, mussels, oysters, or other mollusks removed from the shell and placed in a container shall be sold by fluid volume, with free liquid not to exceed 15% by weight.

14.4.3.4. Processed clams, mussels, oysters, or other mollusks on the half shell (fresh or frozen) shall be sold by net weight excluding the weight of the shell. The term "processed" means removing the meat from the shell and chopping it or cutting it or commingling it with other solid foods.

14.4.3.5. Canned (heat-processed) clams, mussels, oysters, or other mollusks shall be sold by net weight, with free liquid not to exceed 41% by weight for canned oysters.

§ 14.5. Fluid Milk Products.

All fluid milk products, including but not limited to milk, lowfat milk, skim milk, cultured milks, and cream shall be packaged for retail sale only in volumes per subsection 14.5(a), or subsection 14.5(b); provided, that inch-pound sizes less than 1 gill and metric sizes less than 100 milliliters shall be permitted. (Section 3.1-951 - Weights and Measures Law).

(a) Inch-Pound Volumes - 1 gill, 1/2 liquid pint, 10 fluid ounces, 1 liquid pint, 1 liquid quart, 1/2 gallon, 1 gallon, 1-1/2 gallons, 2 gallons, 2-1/2 gallons, or multiples of 1 gallon.

(b) Metric Volumes - 125 milliliters, 250 milliliters, 500 milliliters, 1 liter, or multiples of 1 liter.

14.6. Other Milk Products.

Cottage cheese, cottage cheese products, and other milk products that are solid, semi-solid, viscous, or a mixture of solid and liquid, as defined in the Pasteurized Milk Ordinance of the United States Public Health Service, as amended in 1965, shall be sold in terms of weight; Provided, that cottage cheese, cottage cheese products, sour cream, and yogurt shall be packaged for retail sale only in weights per subsection 14.6(a) or subsection 14.6(b). And provided further, that, multipack or single serving inch-pound sizes of 6 ounces or less shall be sold only in whole ounces increments and that metric sizes of 200 grams or less shall be sold only in 25-gram increments.

(a) Inch-Pound Weights - 8, 12, 16, 24, 32, 64, 80, and 128 ounces avoirdupois. And provided further that an 18 ounce size of yogurt may be packed for retail sale.

(b) Metric Weights - 250, 375, 500, 750 grams; 1, 2, and 4 kilograms.

(Standard package sizes shall apply to low fat and dry curd cottage cheese products.)

14.6.1. Factory Packaged and Hand Packed Ice Cream and Similar Frozen Products.

Ice cream, ice milk, frozen yogurt, and similar products shall be kept, offered or exposed for sale, or sold in terms of fluid volume.

14.7. Pickles.

The declaration of net quantity of contents on pickles and pickles products, including relishes but excluding one or two whole pickles in a transparent wrapping which may be declared by count, shall be expressed in terms of liquid measure. Sales of pickles from bulk may be by count.

14.8. Pricing of Bulk Food Commodities.

Bulk food commodities or food commodities not in package form and sold be weight shall be priced in terms of whole units of weight and not in common or decimal fractions.

14.9. Ready-To-Eat Food.

The following may be sold by weight, measure, or count:

(a) Items sold for consumption on the premises;

(b) Items sold as one of three or more different elements, excluding condiments, comprising a ready-to-eat meal sold as a unit, for consumption elsewhere than on the premises where sold;

(c) Ready-to-eat chicken parts cooked on the premises but not packaged in advance of sale;

(d) Sandwiches and sandwich-like commodities when offered or exposed for sale on the premises where packed or produced and not intended for resale.

§ 15. Nonfood Products.

15.1. Coatings.

Asphalt paints, coatings, and plastic shall be sold in terms of liquid measure.

15.2. Fireplace and Stove Wood.

For the purpose of this regulation, this section shall apply to the sale of all wood, natural and processed, for use as fuel.

15.2.1. Definitions.

15.2.1.1. "Fireplace and Stove Wood." Any kindlings logs, boards, timbers or other wood, split or not split, advertised, offered for sale, or sold as fuel.

15.2.1.2. "Cord." The amount of wood which is contained in a space of 128 cubic feet, when the wood is ranked and well stowed. For the purpose of this regulation, "ranked and well stowed" shall be construed to mean that pieces of wood are placed in a line or row, with individual pieces touching and parallel to each other, and stacked in a compact manner.

15.2.1.3. "Representation." Any advertisement, offering, invoice, or the like that pertains to the sale of fireplace or stove wood.

15.2.2. "Identity." A representation may include a declaration of identity that indicates the species group (Example: 50% hickory, 50% miscellaneous softwood). Such a representation shall indicate, within 10% accuracy, the percentages of each group.

15.2.3. "Quantity." Wood, of any type, for use as fuel shall be advertised, offered for sale and sold only by measure, using the term "cord" and fractional parts of a cord, or the cubic meter; except that wood, natural or processed, offered for sale in packaged form shall display the quantity in terms of cubic feet, to include fractions of cubic feet or cubic meters, to include decimal fractions of cubic meters. A single log may be sold by weight or count. Packages of individual logs containing less than 4 cubic feet (1/32 cord) if sold by inch-pound volume, or less than one-tenth cubic meter if sold by metric volume may be sold by net weight plus count.

15.2.4. "Prohibition of Terms." The terms "face cord," "rack," "pile," "truckload," or terms of similar import shall not be used when advertising, offering for sale, or selling wood for use as fuel. An agreement after visual inspection, between buyer and seller in the sale of fireplace or stove wood by the "truckload" shall be permitted.

15.2.5. "Delivery Ticket or Sales Invoice." A delivery ticket or sales invoice shall be presented by the seller to the purchaser whenever any nonpackaged fireplace or stove wood is sold. The delivery ticket or sales invoice shall contain at least the following information:

(a) The name and address of the vendor;

(b) The name and address of the purchaser;

(c) The date delivered;

(d) The quantity delivered and the quantity upon which the price is based, if this differs from the delivered quantity;

(e) The price of the amount delivered.

15.3. Peat and Peat Moss.

Applies only with respect to organic matter of geological origin, excluding coal and lignite, originating principally from dead vegetative remains through the agency of water in the absence of air and occurring in a bog, swampland, or marsh, and containing an ash content not exceeding 25% on a dry-weight basis (dried in an oven at 105°C (221°F) until no further weight loss can be determined).

15.3.1. Declaration of Quantity.

The declaration of quantity of peat and peat moss shall be expressed in weight units or in cubic-measure units.

15.3.2. Units.

15.3.2.1. Weight.

Peat and peat moss sold in terms of weight shall be offered or exposed for sale only in pounds and/or kilograms.

15.3.2.2. Cubic Measure. Peat and peat moss sold in terms of cubic measure shall be offered and exposed for sale only in cubic feet and/or liters. If the commodity is labeled in terms of compressed cubic measurement, the quantity declaration shall represent the quantity in the compressed state and the quantity from which the final product was compressed (the latter declaration not exceeding the actual amount of material that can be recovered.)

15.4. Prefabricated Utility Buildings.

These buildings shall be offered for retail sale on the basis of usable inside space as follows:

(a) Length, measured from inside surface of wall panels at the base;

(b) Width, measured from inside surface of wall panels at the base;

(c) Height, measured from the base to the top of the shortest wall panel.

(Inside dimensions in inch-pound units shall be declared to the nearest inch; inside dimensions in metric units shall be declared to the nearest 0.01 meter.)

If total usable inside space is declared in a supplemental declaration, it shall be to the nearest cubic decimeter or cubic foot.

15.5. Roofing and Roofing Material.

Shall be sold either by the square or by the square foot only if sold in inch-pound units or by the square meter only if sold in metric units.

15.5.1. Definitions.

15.5.1.1. "Square Meter." The quantity of roofing or roofing material that, when applied according to the directions or instructions of the manufacturer, will cover one square meter exclusive of side laps or side joints.

15.5.1.2. "Square." The quantity of roofing or roofing material that, when applied according to directions or instructions of the manufacturer, will cover an area of 100 square feet exclusive of side laps or side joints; provided that, in the case of roofing or roofing material of corrugated design, the side lap or side joint shall be one full corrugation.

15.5.1.3. "Square Foot." The quantity of roofing and roofing material that, when applied according to the directions or instructions of the manufacturer, will cover 1 square foot (144 square inches) exclusive of side laps or side joints.

15.5.2. "Declaration of Quantity." When the declaration of quantity on a package of roofing or roofing material contains the term "square," it shall include, plainly and conspicuously, a numerical definition of the term "square;" for example, "One square covers 100 square feet of roof area."

15.5.2.1. "Common Fractions." The use of the common fraction one-third (1/3) is specifically authorized in the quantity statement of a package of roofing or roofing material when, and only when, used as the common fraction of the "square."

15.5.2.2. "Quantity Statement." The primary declaration if in inch-pound units shall only be in terms of squares or square feet and if in metric units shall only be in terms of square meters. There is no prohibition against the use of supplementary quantity declarations, such as shingle dimensions but in no case shall the weight of the material be stated or implied. However, the use of numerical description for rolls of felt roofing material may continue to be used.

15.6. Sealants.

Calking compounds, glazing compounds and putty shall be sold in terms of liquid measure except that rope calk shall be sold by weight.

15.7. Softwood Lumber.[11]

Applies to softwood boards, timbers, and dimension lumber that have been dressed on four sides, but shall not apply to rough lumber, to lumber that has been matched, patterned, or shiplapped, or to lumber remanufactured or joined so as to have changed the form or identity, such as individual, assembled, or packaged millwork items.

15.7.1. Definitions.

15.7.1.1. "Dressed (Surfaced) Lumber." Lumber that has been dressed (or surfaced) for the purpose of attaining smoothness of surface and uniformity of size.

15.7.1.2. "Boards." Lumber 1-1/4 inches or less in actual thickness and 1-1/2 or more inches in actual width. Lumber less than 1-1/2 inches in actual width may be classified as strips.

15.7.1.3. "Timbers." Lumber 1-1/2 or more inches in least actual dimension. Timber may be classified as beams, stringers, posts, caps, sills, girders, purlins, etc.

15.7.1.4. "Dimension Lumber." Lumber from 1-1/2 inches to, but not exceeding, 4-1/2 inches in actual thickness, and 1-1/2 or more inches in actual width. Dimension lumber may be classified as framing, joists, planks, rafters, studs, small timbers, etc.

15.7.1.5. "Rough Lumber." Lumber that has not been dressed but which has been sawed, edged, and trimmed at least to the extent of showing saw marks in the wood on the four longitudinal surfaces of each piece for its overall length.

15.7.1.6. "Matched Lumber." Lumber that has been worked with a tongue on one edge of each piece and a groove on the opposite edge to provide a close tongue-and-groove joint by fitting two pieces together; when end-matched, the tongue and groove are worked in the ends also.

15.7.1.7. "Patterned Lumber." Lumber that is shaped to a pattern or to a molded form, in addition to being dressed, matched, or shiplapped, or any combination of these workings.

15.7.1.8. "Shiplapped Lumber." Lumber that has been worked or rabbeted on both edges of each piece to provide a close-lapped joint by fitting two pieces together.

15.7.1.9. "Grade." The commercial designation assigned to lumber meeting specifications established by a nationally recognized grade rule writing organization.

15.7.1.10. "Species." The commercial name assigned

to a species of trees.

15.7.1.11. "Species Group." The commercial name assigned to two or more individual species having similar characteristics.

15.7.1.12. "Representation." Any advertisement, offering, invoice, or the like that pertains to the sale of lumber.

15.7.1.13. "Minimum Dressed Sizes (Width and Thickness)." The standardized width and thickness at which lumber is dressed when manufactured in accordance with the United States Department of Commerce Voluntary Product Standard 20-70, "American Softwood Lumber Standard," and regional grading rules conforming to VPS 20-70. (See Table 1.)

15.7.2. "Identity." Representations shall include a declaration of identity that specifies the grade or grades, species or species group, and whether the lumber is unseasoned (green) or dry.

15.7.3. "Quantity." Representations shall be in terms of the number of pieces, the minimum dressed width and thickness, the length of individual pieces, or the lineal footage, except that:

(a) The use of nominal dimensions shall be allowed when used in conjunction with the required minimum dressed sizes and actual length.

(b) With respect to all invoices, a table of minimum dressed sizes may appear on the reverse side of the invoice, so long as appropriate reference to the table is prominently and conspicuously shown on the face of the invoice.

TABLE 1.
SOFTWOOD LUMBER SIZES.

Minimum standard dressed sizes at the time of manufacture for both unseasoned (green) and dry lumber as published by the United States Department of Commerce in Product Standard 20-70.

Product Classification (Normal Size)	Minimum Dressed Sizes (See Note 2)	
Inches	Unseasoned Inches	Dry Inches
Dimension Lumber		
2 x 4	1-9/16 x 3-9/16	1-1/2 x 3-1/2
2 x 6	1-9/16 x 5-5/8	1-1/2 x 5-1/2
2 x 8	1-9/16 x 7-1/2	1-1/2 x 7-1/4
2 x 10	1-9/16 x 9-1/2	1-1/2 x 9-1/4
2 x 12 (See Note 1)	1-9/16 x 11-1/2	1-1/2 x 11-1/4
Board Lumber		
1 x 4	25/32 x 3-9/16	3/4 x 3-1/2
1 x 6	25/32 x 5-5/8	3/4 x 5-1/2
1 x 8	25/32 x 7-1/2	3/4 x 7-1/4
1 x 10	25/32 x 9-1/2	3/4 x 9-1/4
1 x 12	25/32 x 11-1/2	3/4 x 11-1/4

Note 1. The dry thicknesses of nominal 3" and 4" lumber are 2 1/2" and 3 1/2"; unseasoned thicknesses are 2 9/16" and 3 9/16". Widths for these thicknesses are the same as shown above.

Note 2. Product Standard 20-70 defines dry lumber as being 19% or less in moisture content and unseasoned lumber as being over 19% moisture content. The size of lumber changes approximately 1% for each 4% change in moisture content. Lumber stabilizes at approximately 15% moisture content under normal use conditions.

15.8. Polyethylene Products. Consumer products offered and exposed for sale at retail shall be sold in terms of:

15.8.1. Sheeting and Film.

(a) Length and width.

(b) Area in square feet or square meters.

(c) Thickness.

(d) Weight.

15.8.2. Food Wrap.

(a) Length and width.

(b) Area in square feet or square meters.

15.8.3. Lawn and Trash Bags.

(a) Count.

(b) Dimensions.

(c) Thickness.

15.8.4. Food and Sandwich Bags.

(a) Count.

(b) Dimensions.

Products not intended for the retail consumer shall be offered and exposed for sale in terms of:

15.8.5. Sheeting and Film.

(a) Length.

(b) Width.

(c) Thickness.

(d) Weight.

15.8.6. Bags.

(a) Count.

(b) Dimensions.

(c) Thickness.

(d) Weight.

15.8.7. Declaration of Weight.

The labeled statement of weight for polyethylene products under subsections 15.8.1, 15.8.5, and 15.8.6 shall be not less than the weight calculated by using the following formula:

W = T x A x 0.03613 x D, where

W = net weight in pounds

T = nominal thickness in inches

A = nominal length in inches times nominal width in inches

D = density in grams per cubic centimeter as determined by ASTM Standard D1505-68 "Standard Method of Test for Density of Plastics by the Density Gradient Technique" (or latest issue).
0.03613 is a factor for converting g/cm3 to lb/in3.

15.9. Insulation.

15.9.1. Packaged Loose-Fill Insulation Except Cellulose. Packaged loose-fill insulation, except cellulose, shall declare the net weight with no qualifying statement; each package must contain at least the stated weight. In addition, the following information shall be supplied on the package: minimum thickness, maximum net coverage area, number of bags per 1000 square feet, and minimum weight per square foot at R-values of 11, 19, and 22. This information shall also be supplied for any additional R-values listed.

15.9.2. Packaged Loose-Fill Cellulose Insulation. The principal display panel of packaged loose-fill cellulose insulation shall declare the net weight with no qualifying statement; each package must contain at least the stated weight. In addition, the following information shall be supplied on the package: minimum thickness, maximum net coverage area, number of bags per 100 square feet, and minimum weight per square foot at R-values of 13, 19, 24, 32, and 40. This information shall also be supplied for any additional R-values listed.

15.9.3. Batt and Blanket Insulation. The principal display panel of packaged batt or blanket insulation shall declare the square feet of insulation in the package, and the length and width of the batt or blanket. In addition, R-value and thickness shall be declared on the package.

15.9.4. Installed Insulation. Installed insulation must be accompanied by a contract or receipt. For all insulation except loose fill and aluminum foil, the receipt must show the coverage area, thickness, and R-value of the insulation installed. For loose-fill, the receipt must show those three items plus the number of bags used. For aluminum foil, the receipt must show the number and thickness of the air spaces, the direction of heat flow, and R-value. The receipt must be dated and signed by the installer.

EXAMPLE: This is to certify that the insulation has been installed in conformance with the requirements indicated by the manufacturer to provide a value of R-19 using 31.5 bags of insulation to cover a 1500 square foot area. Signed and dated.

15.10. Liquified Petroleum Gas Cylinder Tare Weights. Whenever stamped tare weights on cylinders are employed in the sale of liquified petroleum gas, the following shall apply:

15.10.1. Allowable Difference. The allowable difference between the actual tare weight and the stamped tare weight for a new or used cylinder shall be 1% of the actual tare weight. The tare weight shall include the weight of the cylinder (including paint), valve, and other permanent attachments. The weight of a protective cap shall not be included in tare or gross weights.

15.10.2. Average Requirement. The tare weights of cylinders at a single place of business found to be in error predominantly in a direction favorable to the seller and near the allowable difference limit shall be considered to be not in conformance with these requirements.

15.11. Bark Mulch. All bark mulch shall be sold, offered, or exposed for sale in terms of volume measure: in inch-pound units, in terms of the cubic yard or cubic foot; in metric units, in terms of the cubic meter or liter.

§ 16. GENERAL.

16.1. Presentation of Price. Whenever an advertised, posted, or labeled price per unit of weight, measure, or count for any commodity includes a fraction of a cent, all elements of the fraction shall be prominently displayed, and the numerals expressing the fraction shall be immediately adjacent to, of the same general design and style as, and at least one-half of the height and width of the numerals representing the whole cent. (Sec. 3.1-949 Weights and Measures Law)

16.2. Allowable Differences: Combination Quantity Declarations. Whenever the method of sale for a bulk or packaged commodity requires the use of a statement, that

includes count in addition to weight, measure, or size, the following shall apply to the particular commodity:

16.2.1. Beverageware: Pressed and Blown Tumblers and Stemware. The allowable difference between actual and declared capacity shall be:

(a) For Inch-Pound:

(1) Plus or minus 1/4 fluid ounce for items of 5 fluid ounce capacity or less;

(2) Plus or minus 5 % of the stated capacity for items over 5 fluid ounce capacity.

(b) For Metric:

(1) Plus or minus 10 milliliters for items of 200 milliliter capacity or less;

(2) Plus or minus 5% of the stated capacity for items over 200 milliliter capacity.

16.3. Machine Vended Commodities. All vending machines dispensing packaged commodities shall indicate:

(a) Product indentity.

(b) Net Quantity.

(c) Name, address, and telephone number of responsible party.

The requirements for product identity and net quantity can be met either by display of the package or by information posted on the outside of the machine.

16.4. Railroad Car Tare Weigths. Whenever stenciled tare weights on freight cars are employed in the sale of commodities or the assessment of freight charges, the following conditions and requirements shall apply:

16.4.1. Newly or Restenciled Tare Weights. All newly stenciled or restenciled tare weights shall be accurately represented to the nearest 100 pounds for inch-pound units and the nearest 50 kilograms for metric units and the representation shall include the date of weighing.

16.4.2. Allowable Differences. The allowable difference between actual tare weight and stenciled tare weight on freight cars in use shall be per subsection 16.4.2(a) or subsection 16.4.2(b).

(a) Inch-pound allowable difference:

(1) Plus or minus 300 pounds for cars 50,000 pounds or less;

(2) Plus or minus 400 pounds for cars over 50,000 pounds to and including 60,000 pounds;

(3) Plus or minus 500 pounds for cars over 60,000 pounds.

(b) Metric allowable difference:

(1) Plus or minus 150 kilograms for cars 25,000 kilograms or less;

(2) Plus or minus 200 kilograms for cars over 25,000 kilograms to and including 30,000 kilograms;

(3) Plus or minus 250 kilograms for cars over 30,000 kilograms.

16.4.3. Change of Stenciled Weights. Tare weight determinations for verification or change of stenciled weights shall only be made on properly prepared and adequately cleaned freight cars.

16.4.5. Responsibility For Reweighing and Restenciling. Tank cars, covered hopper cars, flat cars equipped with multideck racks, or special superstructure, mechanical refrigerator cars, and house-type cars equipped with special lading protective devices must be reweighed and restenciled only by owners or other authorized representatives:

(a) When car bears no light weight (empty weight) stenciling;

(b) When repairs or alterations result in a change of weight in excess of the permissible lightweight tolerance.

§ 17. Exemptions From Sealing or Marking and/or Annual Retesting of Weights and Measures Devices.

17.1. Weights and Measures Specifically Exempted. The weights and measures listed below shall be specifically exempted from the sealing and marking requirements of §§ 3.1-926 and 3.1-934, Title 3.1, Chapter 35 of the Code of Virginia.

17.1.1. Measure containers.

17.2. Annual Retesting Exemption. The weights and measures listed below shall be specifically exempted from the annual retesting requirements of §§ 3.1-926 and 3.1-928 of Title 3.1, Chapter 35 of the Code of Virginia, and shall be retested only as required:

17.2.1. Vehicle tanks used as measures.*

17.2.2. Farm milk tanks.*

17.2.3. Liquid measures.*

17.2.4. Glass graduates.*

17.2.5. Measures containers.*

17.2. 6. Linear measures.*

17.2. 7. Dry measures.*

* Whenever an item of this class is damaged, repaired, or modified in any way that affects the accuracy of measurement, it shall not thereafter be used for measurement until it has been officially inspected and reapproved.

§ 18. Weighing Tobacco in Auction Warehouses.

18.1. Sale By Net Weight - Value of Minimum Graduation. All tobacco received at tobacco auction warehouses for the purpose of sale must be weighed and sold on the basis of net weight, and shall be weighed on approved scales. The value of the minimum graduated interval on the main-weighbeam elements, on the tare-weighbeam elements, and on the reading face elements of scales in tobacco weighing service shall be not greater than one pound. The weighbeam or any other device or mechanism that is used to set the tare weight of the pushcart, dollies, baskets and/or sheets shall be completely enclosed.

18.2. Variation Permitted in Basket or Truck. In markets where baskets and trucks used in placing tobacco on the warehouse floor are represented as being of an average weight and uniform weight deductions are made to determine net weight, no basket or truck shall vary more than one-half pound either above or below the true average weight. If uniform weight deductions are made for the average weight of the basket and truck, the scale shall be balanced at the average weight of trucks and baskets used by back-balancing the scale. Each warehouse operation using baskets shall have (available at the warehouse at least 8 week prior to the opening date of each sales season) a reasonable number (but not less than 100) of baskets on which the average weight can be determined by the Weights and Measures Inspector.

18.3. Baskets Required To Be Marked. In markets where baskets are not represented as being of an average weight, or where baskets vary more than 1/2 pound from the average weight of baskets used, each such basket shall be plainly marked with its correct weight, and this weight shall be deducted from the gross weight at the time of weighing. In all such markets, scales shall be balanced at the average weight of the truck only by back-balancing the scale. No warehouse truck shall vary more than 1/2 pound either above or below the true average weight.

18.4. Scale Ticket Requirements. All baskets or other containers of tobacco weighed and placed on the warehouse floor for the purpose of sale shall be accompanined by a scale ticket on which there shall be plainly and conspicuously stated the name of the seller and the net weight of the tobacco. The date of weighing and the initials of the weighmasters must be shown on each floor sheet (Tobacco Sale Bill). The seller shall be given a copy of this floor sheet at the time the tobacco is weighed.

18.5. Weigh To The Nearest Whole Pound. All tobacco weighed for the purpose of sale, offering for sale, or sold, including "House" and/or "Speculators" tobacco, shall be weighed and recorded accurately to the nearest whole pound.

18.6. Reworked or Resale Tobacco. All "reworked" or "resale" tobacco must be reweighed before it is again offered or exposed for sale.

18.7. Weighmaster Name and Address To be Posted. In all tobacco warehouse offices, the full name and complete address (residence) of all weighmasters shall be posted. Each weighmaster shall personally initial the posted lists with the same initials he will use on floor sheets.

18.8. Record Retention. It shall be the duty of every tobacco auction market manager to retain a copy of all records, including sales coupons, weight tickets, accounts of sales, and other records covering each transaction, for a period of three years. This copy shall be available for, and open to, the confidential inspection of the Commissioner of Agriculture and Consumer Services, or his authorized agents at all times.

§ 19. Regulation Requiring Delivery Ticket.

19.1. Requirements For Delivery Tickets. All coal, coke, charcoal, agricultural limestone (whether burnt or unburnt), and fertilizer shall be sold by weight. Unless the product is delivered to the purchaser in package form, each delivery to an individual purchaser shall be accompanied by duplicate delivery tickets on which, in ink or other indelible substance, there shall be clearly stated:

(a) The name and address of the vendor,

(b) The name and address of the purchaser, and

(c) The net weight of the delivery and the gross and tare weight from which the net weight is computed, each expressed in pounds.

However, on any agricultural commodity, produce, sand, gravel, or any other commodity product or merchandise that is being sold in bulk form by weight, the gross and tare weights need not appear on the delivery ticket. The net weight may be expressed in pounds or kilograms. One of these tickets shall be retained by the vendor, and the other shall be delivered to the purchaser at the time of delivery of the product, or shall be surrendered on demand to the Commissioner of Agriculture and Consumer Services or his assistant, or an inspector, or sealer. If the official desires to retain the ticket as evidence, a substitute weight slip shall be given to the purchaser. However, if the purchaser carries away the purchase, the vendor shall be required only to give to the purchaser a delivery ticket at the time of sale stating the number of pounds of product delivered.

20. Exemption for Users of Vehicle Scales.

A vehicle scale shall not be used for weighing gross loads smaller than 50d (d = scale division).

Users of vehicle scales for other than livestock and grain shall be exempt from the minimum net load requirement (50 scale divisions) of U.R.3.7 of the Scale Code, National Bureau of Standards Handbook 44, 1989 Edition.

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FOOTNOTES

[1] Packages subject to the Federal Fair Packaging and Labeling Act must be labeled in inch-pound units of measure. Metric units may also be declared on the principal display panel and may even appear first.

[2] Packages entering interstate commerce are restricted by federal regulations to two decimal place quantity declarations. For example, see 9 CFR § 317.2(h)(5) for meat and meat products, 21 CFR § 101.105(j)(2) for non-meat and non-poultry foods, and 16 CFR § 500.9(b) for certain non-food consumer commodities.

[3] Note: Although nonconsumer packages under this regulation might bear only metric declarations, this regulation should not be construed to supersede any labeling requirement specified in federal law.

[4] Open multi-unit retail food packages under the authority of the Food and Drug Administration or U.S. Department of Agriculture that do not obscure the number of units or prevent examination of the labeling on each of the individual units are not required to declare the number of individual units or the total quantity of contents of the multi-unit package if the labeling of each individual unit complies with requirements so that it is capable of being sold individually. (See also Subsection 11.12)

[5] In addition, the average net contents of lots, shipments, or deliveries must equal or exceed the labeled net contents. See Section 12.1.

[6] ASTM Standard D-4397-84, "Specification for Polyethylene Sheeting for Construction, Industrial and Agricultural Applications", 1984.

[7] The average thickness of a single package of polyethylene sheeting, film, or bags may be as much as 7% below the labeled thickness, i.e., at least 93% of the labeled thickness.

[8] Packages subject to the Federal Fair Packaging and Labeling Act must be labeled in inch-pound units of measure. Metric units may also be declared on the principal display panel and may even appear first.

[9] Oleomargarine and margarine are not permitted in multiples of one pound, 500 grams, or multiples of 500 grams because Section 407(b)(2) of the Federal Food, Drug, and Cosmetic Act prohibits margarine and oleomargarine packaged in sizes greater than one pound.

[10] See § 14.9 for additional requirements for ready-to-eat food.

[11] Values in metric units for softwood lumber will not be added until a new standard is developed to cover metric softwood lumber.

DEPARTMENT OF AIR POLLUTION CONTROL (STATE BOARD)

Title of Regulation: **VR 120-01. Regulations for the Control and Abatement of Air Pollution - Documents Incorporated by Reference.**

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Effective Date: April 15, 1992.

Summary:

The regulation amendments concern provisions covering documents incorporated by reference. The amendments incorporate the latest edition of the American Conference of Governmental Industrial Hygienists Handbook and recently promulgated federal New Source Performance Standards (NSPS) and National Emission Standards for Hazardous Air Pollutants (NESHAPS), including any reference methods associated with the NSPS and NESHAPS. The amendments update Appendix M which lists all of the nonstatutory documents (those other than federal and state laws and regulations) and the primary federal regulations incorporated by reference. This list includes the name, reference number and edition for each document. The edition is being updated to reflect the latest available. Also included for each document is the name and address of the organization from which it may be obtained. The amendments also update Rule 5-5 which contains the list of promulgated federal NSPS and Rule 6-1 which contains the list of promulgated federal NESHAPS, including those NSPS and NESHAPS recently promulgated and incorporated by reference through this rulemaking.

NOTICE: As provided in § 9-6.14:22 of the Code of Virginia, this regulation is not being republished. The regulation was adopted as it was proposed in 7:26 VA.R. 4191-4207 September 23, 1991.

DEPARTMENT OF GENERAL SERVICES

Title of Regulation: **VR 330-02-05. Requirements for Approval to Perform Prenatal Serological Tests for Syphilis.**

Statutory Authority: § 32.1-60 of the Code of Virginia.

Effective Date: April 8, 1992.

Summary:

The "Requirements for Approval to Perform Prenatal

Serological Tests for Syphilis" is a regulation defining the procedure for a syphilis serology proficiency testing program used to evaluate a laboratory's ability to perform prenatal tests for syphilis as required by Virginia statutes. The present format has been changed to be more consistent with standard regulation format. An exemption for those laboratories already in an acceptable syphilis serology proficiency program is included. The number of unknown serum samples to be tested has been decreased from ten to five and the frequency of testing has been decreased from five times a year to four. The minimum acceptable score has been reduced to 80% to reflect federal requirements.

VR 330-02-05. Requirements for Approval to Perform Prenatal Serological Tests for Syphilis.

~~Title 32.1-60 of the Code of Virginia requires that prenatal serological tests for syphilis be made by the Department of General Services, Division of Consolidated Laboratory Services (DCLS) or by a laboratory approved for such purpose by the Division. To receive approval all laboratories must meet the provisions of these requirements.~~

~~The purpose of the Syphilis Serology Proficiency Testing Program is to evaluate each participating laboratories ability to perform a test procedure compared to the findings of reference laboratories. It is, therefore, essential for all laboratories enrolled in the program to participate in each evaluation set during the year. Successful participation is required in order to receive approval from the Department of General Services, Division of Consolidated Laboratory Services (DGS/DCLS) to continue performing prenatal test(s) for syphilis as required by Virginia state law.~~

§ 1. Definitions.

The following words and terms, when used in these regulations shall have the following meaning, unless the context clearly indicates otherwise.

[*"DGS" means Department of General Services.*

"DCLS" means Division of Consolidated Laboratory Services.]

"Reference laboratory" means a laboratory that will establish the accepted values of the proficiency test samples.

"Test" means any syphilis serological procedures accepted by the Centers for Disease Control.

"Unknown serum" means a serum sample to be tested by an acceptable syphilis serology test procedure to obtain a result which will be compared with results from reference laboratories.

§ 2. Requirements and procedures.

A. An authorized representative of [~~your~~ *the participating*] laboratory must complete the [~~enclosed questionnaire~~ *Request for Participation in Serologic Evaluation Study (DGS-22-142)*] and return it to the Department of General Services, Division of Consolidated Laboratory Services, Bureau of Microbiological Science, P.O. Box 1877, Richmond, Virginia 23215 *by the date specified* [*by DCLS*].

B. The laboratory must be able to demonstrate [~~they have~~ *that it has*] the equipment, reagents, space, and trained personnel necessary to perform the test.

C. Tests given "standard test status" by the Centers for Disease Control may be evaluated in this study.

D. ~~Ten~~ *Five* unknown serum samples will be mailed to each [*participating*] laboratory ~~five~~ *four* times [~~within the~~ *a*] year [*for a total of 20 samples*]. Failure to have results postmarked by the date listed may jeopardize the approval of [~~your~~ *the participating*] laboratory. The dates of shipment and the cut-off [~~date~~ *dates*] will be mailed to each participating laboratory at the beginning of the evaluation year. If [~~you do~~ *the participating laboratory does*] not receive the specimens within three days of the date of shipment, [~~notify us~~ *DCLS is to be notified*] immediately. Laboratories not participating in an evaluation set without [prior] notification of cause submitted in writing [*to DCLS*] will receive a "0" grade which will be averaged into their final scores.

E. The results reported by the reference laboratory(ies) on each series of samples will be forwarded to each participating laboratory after all the reports are received so that results may be compared. It is important that [~~you~~ *the participating laboratory*] check [~~your~~ *its*] results against those of the reference laboratory(ies) for each set [in order] to check [~~your~~ *its*] proficiency.

F. The ~~criteria~~ *criterion* for satisfactory test performance (annual approval) ~~are~~ *is* [*: to obtain*]

~~a)~~ [~~Obtaining~~] a minimum score of ~~90%~~ *80%* on agreement with the results of the reference laboratories on ~~50~~ *20* samples.

~~b) Obtaining a minimum score of 90% on reproducibility of results on duplicate specimens for five sets.~~

§ 3. Requirements [~~of~~ *to* ~~obtaining~~ *obtain*] provisional approval

Provisional approval will be granted *when* :

~~a)~~ *1.* ~~When~~ The above ~~criteria are~~ *criterion is* not met, but qualified personnel from the [*participating*] laboratory attend a workshop conducted by DGS/DCLS and demonstrate competence in test performance.

~~b)~~ *2.* ~~When~~ [*Participating*] laboratories ~~who~~ *that* have not been previously approved attain a satisfactory rating on two consecutive sets of ~~10~~ *five* specimens each and [~~who~~] continue to participate in the proficiency program. A representative of DGS/DCLS will visit new laboratories to determine whether the space, equipment, and reagents are suitable for the serologic test(s) performed and whether the technician is proficient in the performance of the tests.

§ 4. Unsatisfactory performance.

If the test performance of the [*participating*] laboratory is unsatisfactory at anytime during the study period, the space, equipment, reagents, and test performance of the laboratory may be surveyed by a representative of DGS/DCLS and, if necessary, the technician may be requested to visit a laboratory designated by DGS/DCLS for a demonstration of proficiency in the test performance.

§ 5. Laboratory approval.

A. When study is completed and the results are tabulated [, ~~for~~] each [*participating*] laboratory [; ~~you~~] will be advised by letter [*as to*] whether [~~or not your~~ *it* ~~laboratory~~] has been approved. A listing of the approved and provisionally approved laboratories will be published and distributed to physicians, laboratories, and State Health Departments.

B. Check your report carefully before mailing it. Supply all information requested. Results may be handwritten or typed; a copy should be retained for your files.

C. At the end of each evaluation year, the Division of Consolidated Laboratory Services Syphilis Serology Evaluation Laboratory will mail [~~an application~~ *a Request for Participating in Serologic Evaluation Study (DGS-22-142)*] to all participating ~~labs~~ *laboratories* to determine [~~their desire to continue~~ *its interest in continuing*] in the program. It is imperative that [~~this survey~~ *DGS-22-142*] be completed and returned [*by the participating laboratory*] before the beginning of the [~~survey~~ *study*] year. If [~~you~~ *the participating laboratory* ~~do~~ *does*] not receive [~~this~~ *an*] application to participate [~~by the end of December of the survey~~ *one month prior to the beginning of the study*] year, [~~you~~ *it*] should write or call [~~our laboratory~~ *DCLS*]. We may be reached at (804) 786-5198.

§ 6. Exemptions.

Any laboratory that participates in a Syphilis Serology Proficiency Program acceptable to DCLS and provides quarterly documentation of satisfactory testing performance as defined in subsection F of § 2, may be exempt from testing samples of the DCLS Syphilis Serology Proficiency Program. This exemption is on a year-to-year basis only. Any laboratory in an exempt status that fails to provide evidence of satisfactory testing performance shall lose approval status.

REQUEST FOR PARTICIPATION IN SEROLOGIC EVALUATION STUDY

1. Do you wish to have your laboratory participate in the Serologic Evaluation Study for approval to perform prenatal blood tests for syphilis? YES_____ NO_____

   If answer is NO, please sign and return promptly.

   If answer is YES, complete this form and return to Department of General Services, Division of Consolidated Laboratory Services, Bureau of Microbiological Science, P. O. Box 1877, Richmond, Virginia 23215.

2. Check serologic test on which you desire to be evaluated:
   VDRL_____ NON-TREPONEMAL CARD_____
   TREPONEMAL: MICROHEMAGGLUTINATION_____
   FTA-ABS_____ OTHER_____

3. How many serologic tests do you perform per day_____, per week_____?

4. Do you have the equipment, glassware, and reagents recommended for the performance of the test to be evaluated?
   YES_____ NO_____

5. Do you have a procedure manual for the test(s) performed in your laboratory? YES_____ NO_____

6. Do you wish to apply for exempt status? YES_____ NO_____
   If yes,

   a) Give name and address of the Syphilis Serology Proficiency Program you participate in._____

   b) How often do you test proficiency samples?_____

   c) How many samples do you test?_____

NOTE: Results of testing must be provided to DCLS quarterly.

~~6.~~ 7. Name and address of laboratory:

_____

_____ ZIP CODE:_____

PHONE:( )_____

~~7.~~ 8. Serologist to whom specimens are to be sent:

_____

~~8.~~ 9. Name of director or other person to whom reports and other communication(s) should be sent:

_____

_____

SIGNED:_____ TITLE:_____

DATE:_____

DGS-22-142 (REV. 10/91)

* * * * * * * *

Title of Regulation: **VR 330-05-01. Regulations for the Approval of Field Tests for Detection of Drugs.**

Statutory Authority: §§ 2.1-424 and 19.2-188.1 of the Code of Virginia.

Effective Date: April 8, 1992.

Summary:

Section 19.2-188.1 of the Code of Virginia (effective March 1, 1992) permits a law-enforcement officer to testify to the results of field tests performed on controlled substances, imitation controlled substances or marijuana, as defined in § 18.2-247, in any preliminary hearing on a violation of Article 1 (§ 18.2-247 et seq.) of Chapter 7 of Title 18.2. The Division of Forensic Science has been designated to approve such field tests. These regulations describe the requirements for application and approval of such field tests or field test kits.

The regulations also describe the approval authority, criteria for approval, the approval process, notification procedures, fee assessment, payment procedures and the publication in the Virginia Register of Regulations of a list of approved field tests or field test kits.

VR 330-05-01. Regulations for the Approval of Field Tests for Detection of Drugs.

§ 1. Definitions.

The following words and terms, when used in the regulations, shall have following meanings unless the context clearly indicates otherwise:

"Agency" means any [~~*law-enforcement officer or group of*~~ *federal, state or local government*] *law-enforcement* [~~*officers*~~ *organization*] *in the Commonwealth.*

"Approval authority" means the Director of the Division of Forensic Science or designee.

"Division" means the Division of Forensic Science, Department of General Services.

"Drug" means any controlled substance, imitation controlled substance, or marijuana, as defined in § 18.2-247.

"Field test" means any presumptive chemical test unit used outside of a chemical laboratory environment to detect the presence of a drug.

"Field test kit" means a combination of individual field tests units.

"List of approved field tests" means a list of field tests or field test kits approved by the division for use by law-enforcement agencies in the Commonwealth and periodically published by the division in the Virginia Register of Regulations in accordance with § 19.2-188.1.

"Manufacturer" means any entity which [~~*provides*~~ *makes or assembles*] *field test units or field test kits to* [*be used by*] *any law-enforcement officer or agency in the Commonwealth for the purpose of detecting a drug.*

"Manufacturers instructions and claims" means those testing procedures, requirements, instructions, precautions and proposed conclusions which are published by the manufacturer and supplied with the field tests or field test kits.

"Street drug preparations" means any drug or combination of drugs and any other substance which has been encountered or is likely to be encountered by a law-enforcement officer as a purported drug in the Commonwealth.

§ 2. Regulations.

A. Section 19.2-188.1 of the Code of Virginia provides that the Division of Forensic Science shall approve field tests for use by law-enforcement officers to enable them to testify to the results obtained in any preliminary hearing regarding whether ~~or not~~ any substance, the identity of which is at issue in such hearing, is a controlled substance, imitation controlled substance, or marijuana, as defined in § 18.2-247.

B. Any manufacturer who wishes to have field tests or field test kits approved shall submit a written request for approval to the division director [*at the following address:*

Director
Division of Forensic Science
1 North 14th Street
Richmond, VA 23219] .

Materials sufficient for at least 10 field tests shall be supplied for each drug for which the manufacturer requests approval. The materials shall include all instructions, precautions, color charts, flow charts and the like which are provided with the field test or field test kit and which describe the use and interpretation of the tests.

The manufacturer shall also include exact specifications as to the chemical composition of all chemicals or reagents used in the field tests. These shall include the volume or weight of the chemicals and the nature of their packaging.

This approval will require at least 120 days from the receipt of the written request and all needed materials from the manufacturer.

C. The division will use commonly encountered "street drug preparations" to examine those field tests for approval. In order to be approved, the field test must correctly react in a clearly observable fashion to the naked eye, and perform in accordance with manufacturers' instructions and claims.

D. Upon completion of such testing and in concurrence with the approval authority, a list of approved field tests will be published [~~*forthwith*~~] *by the division in the* [*General Notices section of the*] *Virginia Register of Regulations* [~~*in accordance with the Administrative Process Act*~~] . [*The division will notify each manufacturer in writing of the approval or disapproval of each test for which approval was requested. Should any test not be approved, the manufacturer may resubmit their request for approval of that field test according to the previously outlined procedures at any time.*] *The division may, in addition, provide copies of its approval list to any agency subject to these regulations. The division may share any information or data developed from this testing with these agencies.*

E. [~~*If any modifications are made to any field test by the manufacturer, the field test must be approved before it can be used in accordance with § 19.2-188.1.*~~ *The division may require that this approval be done as often as annually for routine purposes. If any modifications are made to an approved field test by the manufacturer, the division shall be notified in writing of the changes. If unreported modifications are discovered by the division, the division may require that all testing and approval be repeated for the particular manufacturers' approved field tests at any time. The division shall notify the manufacturer in writing of this requirement. Any modified field test must be approved before it can be used in accordance with § 19.2-188.1.*] *These changes shall include, but are not limited to any chemical, procedural or instructional modifications made to the field test.*

F. The division assumes no liability as to the safety of these field tests or field test kits, any chemicals contained therein or the procedures and instructions by which they are used.

The division further assumes no responsibility for any incorrect results or interpretations obtained from these inherently tentative presumptive chemical tests.

[*§ 3. Fees.*

Manufacturers will be charged a fee of $50 for each drug or type of drug for which individual approval is requested. The division will evaluate the manufacturers' request and notify them in writing of the amount due before testing begins. Manufacturers who wish to withdraw a request for approval shall immediately notify the division in writing. The division's assessment of the amount of payment required will be based upon a detailed evaluation of the manufacturer's request and that amount will be final. Approval will not be granted before full payment is made to the Treasurer of Virginia.]

DEPARTMENT OF HEALTH (STATE BOARD OF)

REGISTRAR'S NOTICE: This regulation is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 1 of the Code of Virginia, which excludes agency orders or regulations fixing rates or prices. The Department of Health will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **VR 355-39-01. Regulations Governing Eligibility Standards and Charges for Medical Care Services (Schedule of Charges Only).**

Statutory Authority: § 32.1-12 of the Code of Virginia.

Effective Date: April 9, 1992.

Summary:

The Department of Health bases its schedule of charges for clinical services on a coding system established by the American Medical Association (AMA). Therefore, it is necessary for the Department of Health to change its schedule of charges to conform to the new codes. Charges have been increased for prenatal visits, radiological chest exams, and activities of daily living for Northern Virginia to maximize Medicaid reimbursement for these services.

In addition, visit charges have been increased for follow-up skilled nursing home health services so that costs for providing the service to Medicare recipients will be fully recovered.

VR 355-3-01. Regulations Governing Eligibility Standards and Charges for Medical Care Services (Schedule of Charges Only).

STATE HEALTH DEPARTMENT
CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~OCTOBER 1, 1991~~ APRIL 9, 1992
EXCEPT FOR NORTHERN VIRGINIA - CHART I

By the provisions of the "Regulations Governing Eligibility Standards and Charges for Medical Care Services," promulgated by the authority of the Board of Health in accordance with § 32.1-12 of the Code of Virginia, listed below are the charges for medical care services, stating the minimum required payments to by made by patients toward their charges, according to income levels.

CPT CODE	MEDICAL CARE SERVICES(1)	MAXIMUM CHARGES PER VISIT/SERVICES(2)	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
Z9900	MATERNITY/GYNECOLOGY(3)	~~$ 30.00~~ $ 33.00	~~$ .00~~ $ .00	~~$ 3.00~~ $ 3.25	~~$ 7.50~~ $ 8.25	~~$15.00~~ $16.50	~~$22.50~~ $24.75	~~$ 30.00~~ $ 33.00
59420	Maternity Care Billed on Global Basis	$300.00	$ .00	$30.00	$75.00	$150.00	$225.00	$300.00
59430	Postpartum Visit	$ 33.00	$ .00	$ 3.30	$ 8.25	$16.50	$24.75	$ 33.00
	Maternity Care Coordination(4)							
Z9000, Z9001, Z9002, Z9003, Z9004	Risk Screening	$ 10.00	$ .00	$ 1.00	$ 2.50	$ 5.00	$ 7.50	$ 10.00
Z9104	Maternity Assessment	$ 25.00	$ .00	$ 2.50	$ 6.25	$12.50	$18.75	$ 25.00
Z9105, Z9107, Z9109	Maternity Follow-up	$ 40.00 per month x 11 months	$ .00	$ 4.00	$10.00	$20.00	$30.00	$ 40.00
	Nutritional Services							
Z9310	Original Assessment	$ 20.00	$ .00	$ .00	$ .00	$ .00	$15.00	$ 20.00
Z9311	Follow-up	$ 10.00 per encounter	$ .00	$ .00	$ .00	$ .00	$ 7.50	$ 10.00
Z9300, Z9301, or Z9302	Group Education	$ 6.00 per class or session $ 36.00 maximum	$ .00	$ .60	$ 1.50	$ 3.00	$ 4.50	$ 6.00
Z9312	Homemaker Services	$ 33.00 per visit or $ 8.00 per hour, not to exceed 4 hours	$ .00 $ .00	$ 3.30 $ .80	$ 8.25 $ 2.00	$16.50 $ 4.00	$24.75 $ 6.00	$ 33.00 $ 8.00
	CLINICAL VISITS (INCLUDES BOTH PEDIATRIC AND ADULT SERVICES) New Patients: To qualify as a new patient, patient must not have been seen by any provider in that health department for at least three years.							
99201	Visit included all three components: *Problem focused history *Problem focused examination *Straightforward medical decision making		$ .00	$ 2.50	$ 6.00	$12.00	$18.00	$ 24.00

CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~OCTOBER 1, 1991~~ APRIL 9, 1992
EXCEPT FOR NORTHERN VIRGINIA - CHART I

CPT CODE	MEDICAL CARE SERVICES(1)	MAXIMUM CHARGES PER VISIT/SERVICES(2)	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
99202	Visit included all three components: *Expanded problem focused history *Expanded problem focused exmination *Straightforward medical decision making		$ .00	$ 3.00	$ 7.00	$14.00	$21.00	$ 28.00
99203	Visit included all three components: *Detailed history *Detailed examination *Medical decision making of low complexity		$ .00	$ 3.25	$ 8.25	$16.50	$24.75	$ 33.00
99204	Visit included all three components: *Comprehensive history *Comprehensive examination *Medical decision making of moderate complexity		$ .00	$ 4.75	$11.75	$23.50	$35.00	$ 46.75
99205	Visit included all three components: *Comprehensive history *Comprenehsive examination *Medical decision making of high complexity		$ .00	$ 5.00	$12.50	$25.00	$37.50	$ 50.00
	Established patient visits: Any patient that has been seen by a provider in that health department within the last 3 years.							
99211	Visit may or may not require physician Presenting problems are minimal		$ .00	$ 1.00	$ 2.50	$ 5.00	$ 7.50	$ 10.00
99212	Visit included two of three components: *Problem focused history *Problem focused examination *straightforward medical decision making		$ .00	$ 2.00	$ 4.75	$ 9.50	$14.25	$ 19.00
99213	Visit included two of three components: *Expanded problem focused history *Expanded problem focused exmination *Medical decision of low complexity		$ .00	$ 2.75	$ 6.50	$13.25	$19.75	$ 26.50
99214	Visit included two of three components: *Detailed history *Detailed examination *Medical decision making of moderate complexity		$ .00	$ 3.50	$ 8.75	$26.25	$24.75	$ 35.00

CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~OCTOBER 1, 1991~~ APRIL 9, 1992
EXCEPT FOR NORTHERN VIRGINIA - CHART I

CPT CODE	MEDICAL CARE SERVICES(1)	MAXIMUM CHARGES PER VISIT/SERVICES(2)	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
99215	Visit included two of three components: *Comprehensive history *Comprehensive examination *Medical decision making of high complexity		$ .00	$ 4.50	$11.25	$22.50	$33.75	$ 45.00
	PREVENTIVE MEDICINE SERVICES (These codes are to be used primarily for well baby visits. They are the codes to be used for EPSDT billing.)							
	New Patient							
99381	Age under 1 year		$ .00	$ 3.50	$ 8.75	$17.50	$26.25	$ 35.00
99382	Age 1 through 4 years		$ .00	$ 4.00	$ 9.75	$19.50	$29.25	$ 39.00
99383	Age 5 through 11 years		$ .00	$ 4.00	$ 9.75	$19.50	$29.25	$ 39.00
99384	Age 12 through 17 years		$ .00	$ 3.50	$ 8.75	$17.50	$26.25	$ 35.00
99385	Age 18 through 21 years		$ .00	$ 3.75	$ 9.50	$19.00	$28.50	$ 38.00
	Established Patient							
99391	Age under 1 year		$ .00	$ 3.50	$ 8.75	$17.50	$26.25	$ 35.00
99392	Age 1 through 4 years		$ .00	$ 3.50	$ 9.00	$18.00	$27.00	$ 36.00
99393	Age 5 through 11 years		$ .00	$ 3.50	$ 9.00	$18.00	$27.00	$ 36.00
99394	Age 12 through 17 years		$ .00	$ 3.00	$ 7.75	$15.50	$23.25	$ 31.00
99395	Age 18 through 21 years		$ .00	$ 3.75	$ 9.50	$19.00	$28.50	$ 38.00
	~~PEDIATRIC/WELL BABY(5)~~							
	~~New Patient, Comprehensive Visit~~	~~$ 50.00~~	~~$ .00~~	~~$ 5.00~~	~~$12.50~~	~~$25.00~~	~~$37.50~~	~~$ 50.00~~
	~~Established Patient, Comprehensive Visit~~	~~$ 45.00~~	~~$ .00~~	~~$ 4.50~~	~~$11.25~~	~~$22.50~~	~~$33.75~~	~~$ 45.00~~
	~~Follow-up/Problem Visit~~	~~$ 27.00~~	~~$ .00~~	~~$ 2.70~~	~~$ 6.75~~	~~$13.50~~	~~$20.25~~	~~$ 27.00~~
	~~Brief Visit~~	~~$ 19.00~~	~~$ .00~~	~~$ 1.90~~	~~$ 4.75~~	~~$ 9.50~~	~~$14.25~~	~~$ 19.00~~
	~~EPSDT Visits(6)~~							
	Infant Care Coordination(4)							
Z9000, Z9001, Z9002, Z9004	Risk Screening	$ 10.00	$ .00	$ 1.00	$ 2.50	$ 5.00	$ 7.50	$ 10.00
Z9104	Infant Assessment	$ 25.00	$ .00	$ 2.50	$ 6.25	$12.50	$18.75	$ 25.00
Z9106, Z9108, Z9110	Follow-up	$ 40.00 per month x 24 months	$ .00	$ 4.00	$10.00	$20.00	$30.00	$ 40.00
	FAMILY PLANNING~~(7)~~(5)							
Z9007	Initial/Annual Visit	$ 50.00	$ .00	$ 5.00	$12.50	$25.00	$37.50	$ 50.00
Z9009	Follow-up/Problem Visit	$ 20.00	$ .00	$ 2.00	$ 5.00	$10.00	$15.00	$ 20.00
	~~GENERAL MEDICAL (includes gynecology)(8)~~							
	~~New Patient, Comprehensive Visit~~	~~$ 50.00~~	~~$ .00~~	~~$ 5.00~~	~~$12.50~~	~~$25.00~~	~~$37.50~~	~~$ 50.00~~
	~~Established Patient, Comprehensive Visit~~	~~$ 45.00~~	~~$ .00~~	~~$ 4.50~~	~~$11.25~~	~~$22.50~~	~~$33.75~~	~~$ 45.00~~

CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~OCTOBER 1, 1991~~ APRIL 9, 1992
EXCEPT FOR NORTHERN VIRGINIA - CHART I

CPT CODE	MEDICAL CARE SERVICES(1)	MAXIMUM CHARGES PER VISIT/SERVICES(2)	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
	~~Follow-up/Problem Visit~~	~~$ 27.00~~	~~$ .00~~	~~$ 2.70~~	~~$ 6.75~~	~~$13.50~~	~~$20.25~~	~~$ 27.00~~
	~~Brief Visit~~	~~$ 19.00~~	~~$ .00~~	~~$ 1.90~~	~~$ 4.75~~	~~$ 9.50~~	~~$14.25~~	~~$ 19.00~~
	COLPOSCOPY SERVICES							
57454	Colposcopy with Biopsy	$ 90.00	$ .00	$ 9.00	$22.50	$45.00	$67.50	$ 90.00
57511	Colposcopy with Biopsy and Cryosurgery	$130.00	$ .00	$13.00	$32.50	$65.00	$97.50	$130.00
	DENTAL SERVICES~~(9)~~(6)		-------BASED ON MEDIAN PRIVATE PRACTICE PROFESSIONAL FEES------					
	SPECIAL SERVICES WITHOUT ELIGIBILITY~~(10)~~(7)							
36415	Venipuncture	$ 7.00	----------FLAT RATE CHARGE----------					
	~~Pregnancy Testing~~	~~FREE~~	----------~~SERVICE PROVIDED FREE STATEWIDE~~----------					
90030	Administration of Prescribed Medication and/or Nonroutine Immunizations PLUS: Cost of Vaccine when furnished by Health Department	$ 3.50	----------FLAT RATE CHARGE----------					
	Blood Pressure Check	FREE	----------SERVICE PROVIDED FREE STATEWIDE----------					
86580	PPD/Tuberculin Testing	$ 3.15	----------FLAT RATE CHARGE----------					
71010	Radiological Examination (Chest)	$ ~~18.00~~ 20.00	----------FLAT RATE CHARGE----------					
	Activities of Daily Living~~(11)~~(8)	$ 9.00 per hour	----------FLAT RATE CHARGE----------					
	Cholesterol Screening and Counseling	$ 5.00	----------FLAT RATE CHARGE----------					
	Medical Record Copying	$ .50 per page	----------FLAT RATE CHARGE----------					
	ELIGIBILITY IS REQUIRED ON THE FOLLOWING:							
	Pharmacy Professional Fee	$ 4.40	$ .00	$ .50	$ 1.00	$ 2.25	$ 3.25	$ 4.40
	PLUS: Cost of Drugs or Vaccine		0%	10%	25%	50%	75%	100%
	Other X-ray Services~~(12)~~(9)		----------~~MEDICAID RATE~~---------- BASED ON REASONABLE COSTS AS DETERMINED BY THE DEPT. OF MEDICAL ASSIST. SVCS MAXIMUM PAYMENT LEVELS					
	Other Laboratory Services~~(13)~~(10)		----------~~MEDICAID RATE~~---------- BASED ON REASONABLE COSTS AS DETERMINED BY THE DEPT. OF MEDICAL ASSIST. SVCS MAXIMUM PAYMENT LEVELS					
	OTHER SERVICES							
	Children's Specialty Services (Annual)	$120.00	$ .00	$12.00	$30.00	$60.00	$90.00	$120.00
	HOME HEALTH SERVICES~~(14)~~		----------~~60% OF MEDICAID CHARGES~~----------					
	Skilled Nursing							
	Assessment	$ 94.00	$ .00	$ 9.40	$23.50	$47.00	$70.50	$ 94.00
	Follow-up	$ 85.00	$ .00	$ 8.50	$21.25	$42.50	$63.75	$ 85.00
	Comprehensive	$155.00	$ .00	$15.50	$38.75	$77.50	$116.25	$155.00
	Physical Therapy							
	Assessment	$ 91.00	$ .00	$ 9.10	$22.75	$45.50	$68.25	$ 91.00
	Follow-up	$ 75.00	$ .00	$ 7.50	$18.75	$37.50	$56.25	$ 75.00

CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~OCTOBER 1, 1991~~ APRIL 9, 1992
EXCEPT FOR NORTHERN VIRGINIA - CHART I

CPT CODE	MEDICAL CARE SERVICES(1)	MAXIMUM CHARGES PER VISIT/SERVICES(2)	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
	Occupational Therapy							
	Assessment	$ 93.00	$ .00	$ 9.30	$23.25	$46.50	$69.75	$ 93.00
	Follow-up	$ 77.00	$ .00	$ 7.70	$19.25	$38.50	$57.75	$ 77.00
	Speech Therapy							
	Assessment	$ 97.00	$ .00	$ 9.70	$24.25	$48.50	$72.75	$ 97.00
	Follow-up	$ 81.00	$ .00	$ 8.10	$20.25	$40.50	$60.75	$ 81.00
	Home Health Aide	$ 46.00	$ .00	$ 4.60	$11.50	$23.00	$34.50	$ 46.00
	Medical Social Worker	$109.00	$ .00	$10.90	$27.25	$54.50	$81.75	$109.00
	CHILD DEVELOPMENT SERVICES							
	(according to Physicians' Current Procedural Terminology)							
	Medical Services							
	Limited, new patient	$ 22.00	$ .00	$ 2.20	$ 5.50	$11.00	$16.50	$ 22.00
	established patient	$ 17.00	$ .00	$ 1.70	$ 4.25	$ 8.50	$12.75	$ 17.00
	Intermediate, new patient	$ 23.00	$ .00	$ 2.30	$ 5.75	$11.50	$17.25	$ 23.00
	established patient	$ 19.00	$ .00	$ 1.90	$ 4.75	$ 9.50	$14.25	$ 19.00
	Comprehensive, new patient	$ 37.00	$ .00	$ 3.70	$ 9.25	$18.50	$27.75	$ 37.00
	established patient	$ 20.00	$ .00	$ 2.00	$ 5.00	$10.00	$15.00	$ 20.00
	Initial Consultation, Interm.	$ 21.00	$ .00	$ 2.10	$ 5.25	$10.50	$15.75	$ 21.00
	Follow-up Consultation, Interm.	$ 10.50	$ .00	$ 1.05	$ 2.65	$ 5.25	$ 7.90	$ 10.50
	Pharmocological Management	$ 8.50	$ .00	$ .85	$ 2.10	$ 4.25	$ 6.35	$ 8.50
	Developmental Screening	$ 8.50	$ .00	$ .85	$ 2.10	$ 4.25	$ 6.35	$ 8.50
	Health Education	$ 10.50	$ .00	$ 1.05	$ 2.65	$ 5.25	$ 7.90	$ 10.50
	Mental Health Services							
	Psychological Evaluation per hr.	$105.00	$ .00	$10.50	$26.25	$52.50	$78.75	$105.00
	Psycho-social Assessment	$ 30.00	$ .00	$ 3.00	$ 7.50	$15.00	$22.50	$ 30.00
	Individual Psychotherapy per 1/2 hour	$ 15.75	$ .00	$ 1.60	$ 3.95	$ 7.90	$11.85	$ 15.75
	Family Psychotherapy	$ 10.50	$ .00	$ 1.05	$ 2.65	$ 5.25	$ 7.90	$ 10.50
	Group Psychotherapy	$ 10.50	$ .00	$ 1.05	$ 2.65	$ 5.25	$ 7.90	$ 10.50
	Multifamily Psychotherapy	$ 10.50	$ .00	$ 1.05	$ 2.65	$ 5.25	$ 7.90	$ 10.50
	Educational Services							
	Educational Diagnostic Evaluation	-NC-	----------SERVICE PROVIDED FREE STATEWIDE----------					
	School Visit/Consultation	-NC-	----------SERVICE PROVIDED FREE STATEWIDE----------					
	Classroom Observation	-NC-	----------SERVICE PROVIDED FREE STATEWIDE----------					
	Case Management Services							
	Interdisciplinary Medical Conference	$ 26.00	$ .00	$ 2.60	$ 6.50	$13.00	$19.50	$ 26.00
	Medical Conference with Patient and/or Family	$ 27.00	$ .00	$ 2.70	$ 6.75	$13.50	$20.25	$ 27.00
	Other Case Management Activity	-NC-	----------SERVICE PROVIDED FREE STATEWIDE----------					
	Progress Review	-NC-	----------SERVICE PROVIDED FREE STATEWIDE----------					

STATE HEALTH DEPARTMENT
CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~OCTOBER 1, 1991~~ APRIL 9, 1992
NORTHERN VIRGINIA - CHART II

By the provisions of the "Regulations Governing Eligibility Standards and Charges for Medical Care Services," promulgated by the authority of the Board of Health in accordance with § 32.1-12 of the Code of Virginia, listed below are the charges for medical care services, stating the minimum required payments to by made by patients toward their charges, according to income levels.

CPT CODE	MEDICAL CARE SERVICES(1)	MAXIMUM CHARGES PER VISIT/SERVICES(2)	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
Z9900	MATERNITY/GYNECOLOGY(3)	~~$ 33.00~~ $ 37.00	~~$ .00~~ $ .00	~~$ 3.30~~ $ 3.75	~~$ 8.25~~ $ 9.25	~~$16.50~~ $18.50	~~$24.75~~ $27.75	~~$ 33.00~~ $ 37.00
59420	Maternity Care Billed on Global Basis	$330.00	$ .00	$33.00	$82.50	$165.00	$247.50	$330.00
59430	Postpartum Visit	$ 36.00	$ .00	$ 3.60	$ 9.00	$18.00	$27.00	$ 36.00
	Maternity Care Coordination(4)							
Z9900, Z9001, Z9002, Z9003, Z9004	Risk Screening	$ 11.50	$ .00	$ 1.25	$ 3.00	$ 5.75	$ 8.75	$ 11.50
Z9104	Maternity Assessment	$ 28.50	$ .00	$ 2.85	$ 7.25	$14.25	$21.50	$ 28.50
Z9105, Z9107, Z9109	Maternity Follow-up	$ 45.50 per month x 11 months	$ .00	$ 4.55	$11.50	$22.75	$34.25	$ 45.50
	Nutritional Services							
Z9310	Original Assessment	$ 22.75	$ .00	$ 2.50	$ 5.75	$11.50	$17.00	$ 22.75
Z9311	Follow-up	$ 11.50 per encounter	$ .00	$ 1.25	$ 3.00	$ 5.75	$ 8.75	$ 11.50
Z9300, Z9301, or Z9302	Group Education	$ 7.00 per class or session $ 41.00 maximum	$ .00	$ .75	$ 1.75	$ 3.50	$ 5.25	$ 7.00
Z9312	Homemaker Services	$ 37.50 per visit or $ 9.25 per hour, not to exceed 4 hours	$ .00 $ .00	$ 3.75 $ .95	$ 9.50 $ 1.85	$18.75 $ 4.75	$28.25 $ 6.95	$ 37.50 $ 9.25
	CLINICAL VISITS (INCLUDES BOTH PEDIATRIC AND ADULT SERVICES) New Patients: To qualify as a new patient, patient must not have been seen by any provider in that health department for at least three years.							
99201	Visit included all three components: *Problem focused history *Problem focused examination *Straightforward medical decision making		$ .00	$ 2.75	$ 6.75	$13.50	$20.25	$ 27.00

CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~OCTOBER 1, 1991~~ APRIL 9, 1992
NORTHERN VIRGINIA - CHART II

CPT CODE	MEDICAL CARE SERVICES(1)	MAXIMUM CHARGES PER VISIT/SERVICES(2)	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
99202	Visit included all three components: *Expanded problem focused history *Expanded problem focused exmination *Straightforward medical decision making		$ .00	$ 3.00	$ 7.75	$15.50	$23.25	$ 31.00
99203	Visit included all three components: *Detailed history *Detailed examination *Medical decision making of low complexity		$ .00	$ 3.75	$ 9.25	$18.50	$27.75	$ 37.00
99204	Visit included all three components: *Comprehensive history *Comprehensive examination *Medical decision making of moderate complexity		$ .00	$ 5.00	$12.75	$25.50	$38.25	$ 51.00
99205	Visit included all three components: *Comprehensive history *Comprenehsive examination *Medical decision making of high complexity		$ .00	$ 5.50	$13.75	$27.50	$41.25	$ 55.00
	Established patient visits: Any patient that has been seen by a provider in that health department within the last 3 years.							
99211	Visit may or may not require physician Presenting problems are minimal		$ .00	$ 1.00	$ 2.75	$ 5.50	$ 8.25	$ 11.00
99212	Visit included two of three components: *Problem focused history *Problem focused examination *straightforward medical decision making		$ .00	$ 2.00	$ 5.25	$10.50	$15.75	$ 21.00
99213	Visit included two of three components: *Expanded problem focused history *Expanded problem focused exmination *Medical decision of low complexity		$ .00	$ 3.00	$ 7.50	$15.00	$22.50	$ 30.00
99214	Visit included two of three components: *Detailed history *Detailed examination *Medical decision making of moderate complexity		$ .00	$ 4.00	$ 9.75	$19.50	$29.25	$ 39.00

CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~OCTOBER 1, 1991~~ APRIL 9, 1992
NORTHERN VIRGINIA - CHART II

CPT CODE	MEDICAL CARE SERVICES(1)	MAXIMUM CHARGES PER VISIT/SERVICES(2)	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
99215	Visit included two of three components: *Comprehensive history *Comprehensive examination *Medical decision making of high complexity		$ .00	$ 5.00	$12.50	$25.00	$37.50	$ 50.00
	PREVENTIVE MEDICINE SERVICES (These codes are to be used primarily for well baby visits. They are the codes to be used for EPSDT billing.)							
	New Patient							
99381	Age under 1 year		$ .00	$ 4.00	$ 9.75	$19.50	$29.25	$ 39.00
99382	Age 1 through 4 years		$ .00	$ 4.25	$10.75	$21.50	$32.25	$ 43.00
99383	Age 5 through 11 years		$ .00	$ 4.25	$10.75	$21.50	$32.25	$ 43.00
99384	Age 12 through 17 years		$ .00	$ 4.00	$ 9.75	$19.50	$29.25	$ 39.00
99385	Age 18 through 21 years		$ .00	$ 4.25	$10.50	$21.00	$31.50	$ 42.00
	Established Patient							
99391	Age under 1 year		$ .00	$ 4.00	$ 9.75	$19.50	$29.25	$ 39.00
99392	Age 1 through 4 years		$ .00	$ 4.00	$10.00	$20.00	$30.00	$ 40.00
99393	Age 5 through 11 years		$ .00	$ 4.00	$10.00	$20.00	$30.00	$ 40.00
99394	Age 12 through 17 years		$ .00	$ 3.50	$ 8.75	$17.50	$26.25	$ 35.00
99395	Age 18 through 21 years		$ .00	$ 4.25	$10.50	$21.00	$31.50	$ 42.00
	~~PEDIATRIC/WELL-BABY(5)~~							
	~~New Patient, Comprehensive Visit~~	~~$ 55.00~~	~~$ .00~~	~~$ 5.50~~	~~$13.75~~	~~$27.50~~	~~$41.25~~	~~$ 55.00~~
	~~Established Patient,~~ ~~Comprehensive Visit~~	~~$ 50.00~~	~~$ .00~~	~~$ 5.00~~	~~$12.50~~	~~$25.00~~	~~$37.50~~	~~$ 50.00~~
	~~Follow-up/Problem Visit~~	~~$ 30.00~~	~~$ .00~~	~~$ 3.00~~	~~$ 7.50~~	~~$15.00~~	~~$22.50~~	~~$ 30.00~~
	~~Brief Visit~~	~~$ 21.00~~	~~$ .00~~	~~$ 2.10~~	~~$ 5.25~~	~~$10.50~~	~~$15.75~~	~~$ 21.00~~
	~~EPSDT Visits(6)~~							
	Infant Care Coordination(4)							
Z9000, Z9001, Z9002, Z9004	Risk Screening	$ 11.50	$ .00	$ 1.85	$ 3.00	$ 5.75	$ 8.75	$ 11.50
Z9104	Infant Assessment	$ 28.50	$ .00	$ 2.85	$ 7.25	$14.25	$21.50	$ 28.50
Z9106, Z9108, Z9110	Follow-up	$ 45.00 per month x 24 months	$ .00	$ 4.60	$11.25	$22.55	$33.75	$ 45.00
	FAMILY PLANNING~~(7)~~(5)							
09007	Initial/Annual Visit	$ 56.00	$ .00	$ 5.60	$14.00	$28.00	$42.00	$ 56.00
09008	Follow-up/Problem Visit	$ 22.75	$ .00	$ 2.25	$ 5.75	$11.25	$17.00	$ 22.75
	~~GENERAL MEDICAL (includes gynecology)(8)~~							
	~~New Patient, Comprehensive Visit~~	~~$ 55.00~~	~~$ .00~~	~~$ 5.50~~	~~$13.75~~	~~$27.50~~	~~$41.25~~	~~$ 55.00~~
	~~Established Patient,~~ ~~Comprehensive Visit~~	~~$ 50.00~~	~~$ .00~~	~~$ 5.00~~	~~$12.50~~	~~$25.00~~	~~$37.50~~	~~$ 50.00~~

Page 8

CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~OCTOBER 1, 1991~~ APRIL 9, 1992
NORTHERN VIRGINIA – CHART II

CPT CODE	MEDICAL CARE SERVICES(1)	MAXIMUM CHARGES PER VISIT/SERVICES(2)	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
	~~Follow-up/Problem Visit~~	~~$ 30.00~~	~~$ .00~~	~~$ 3.00~~	~~$ 7.50~~	~~$15.00~~	~~$22.50~~	~~$ 30.00~~
	~~Brief Visit~~	~~$ 21.00~~	~~$ .00~~	~~$ 2.10~~	~~$ 5.25~~	~~$10.50~~	~~$15.75~~	~~$ 21.00~~
	COLPOSCOPY SERVICES							
57454	Colposcopy with Biopsy	$100.00	$ .00	$10.00	$25.00	$50.00	$75.00	$100.00
57511	Colposcopy with Biopsy and Cryosurgery	$145.00	$ .00	$14.50	$36.25	$72.50	$98.75	$145.00
	DENTAL SERVICES~~(9)~~(6)	-------BASED ON MEDIAN PRIVATE PRACTICE PROFESSIONAL FEES-------						
	SPECIAL SERVICES WITHOUT ELIGIBILITY~~(10)~~(7)							
36415	Venipuncture	$ 8.00	----------FLAT RATE CHARGE----------					
	~~Pregnancy Testing~~	~~FREE~~	----------~~SERVICE PROVIDED FREE STATEWIDE~~----------					
90030	Medication and/or Nonroutine Immunizations PLUS: Cost of Vaccine when furnished by Health Department	$ 4.00	----------FLAT RATE CHARGE----------					
	Blood Pressure Check	FREE	----------FLAT RATE CHARGE----------					
86580	PPD/Tuberculin Testing	$ 3.55	----------SERVICE PROVIDED FREE STATEWIDE----------					
71010	Radiological Examination (Chest)	$ ~~20.50~~ 22.00	----------SERVICE PROVIDED FREE STATEWIDE----------					
	Activities of Daily Living~~(11)~~(8)	$ ~~10.00~~ 11.00 per hour	----------SERVICE PROVIDED FREE STATEWIDE----------					
	Cholesterol Screening and Counseling	$ 6.00	----------SERVICE PROVIDED FREE STATEWIDE----------					
	Medical Record Copying	$ .50 per page	----------SERVICE PROVIDED FREE STATEWIDE----------					
	ELIGIBILITY IS REQUIRED ON THE FOLLOWING:							
	Pharmacy Professional Fee PLUS: Cost of Drugs or Vaccine	$ 4.40	$ .00	$ .50	$ 1.00	$ 2.25	$ 3.25	$ 4.40
	Other X-ray Services~~(12)~~(9)	----------~~MEDICAID RATE~~---------- BASED ON REASONABLE COSTS AS DETERMINED BY THE DEPT. OF MEDICAL ASSIST. SVCS MAXIMUM PAYMENT LEVELS						
	Other Laboratory Services~~(13)~~(10)	----------~~MEDICAID RATE~~---------- BASED ON REASONABLE COSTS AS DETERMINED BY THE DEPT. OF MEDICAL ASSIST. SVCS MAXIMUM PAYMENT LEVELS						
	OTHER SERVICES							
	Children's Specialty Services (Annual)	$136.00	$ .00	$13.50	$34.00	$68.00	$102.00	$136.00
	HOME HEALTH SERVICES~~(14)~~	----------~~60% OF MEDICAID CHARGES~~----------						
	Skilled Nursing							
	Assessment	$ 94.00	$ .00	$ 9.40	$23.50	$47.00	$70.50	$ 94.00
	Follow-up	$ 85.00	$ .00	$ 8.50	$21.25	$42.50	$63.75	$ 85.00
	Comprehensive	$155.00	$ .00	$15.50	$38.75	$77.50	$116.25	$155.00
	Physical Therapy							
	Assessment	$ 91.00	$ .00	$ 9.10	$22.75	$45.50	$68.25	$ 91.00
	Follow-up	$ 75.00	$ .00	$ 7.50	$18.75	$37.50	$56.25	$ 75.00

CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~OCTOBER 1, 1991~~ APRIL 9, 1992
NORTHERN VIRGINIA - CHART II

CPT CODE	MEDICAL CARE SERVICES(1)	MAXIMUM CHARGES PER VISIT/SERVICES(2)	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
	Occupational Therapy							
	Assessment	$ 93.00	$ .00	$ 9.30	$23.25	$46.50	$69.75	$ 93.00
	Follow-up	$ 77.00	$ .00	$ 7.70	$19.25	$38.50	$57.75	$ 77.00
	Speech Therapy							
	Assessment	$ 97.00	$ .00	$ 9.70	$24.25	$48.50	$72.75	$ 97.00
	Follow-up	$ 81.00	$ .00	$ 8.10	$20.25	$40.50	$60.75	$ 81.00
	Home Health Aide	$ 46.00	$ .00	$ 4.60	$11.50	$23.00	$34.50	$ 46.00
	Medical Social Worker	$109.00	$ .00	$10.90	$27.25	$54.50	$81.75	$109.00
	CHILD DEVELOPMENT SERVICES							
	(according to Physicians' Current Procedural Terminology)							
	Medical Services							
	Limited, new patient	$ 25.00	$ .00	$ 2.50	$ 6.25	$12.50	$18.75	$ 25.00
	established patient	$ 19.30	$ .00	$ 1.95	$ 4.85	$ 9.65	$14.50	$ 19.30
	Intermediate, new patient	$ 26.00	$ .00	$ 2.60	$ 6.50	$13.00	$19.50	$ 26.00
	established patient	$ 21.60	$ .00	$ 2.15	$ 5.40	$10.80	$16.20	$ 21.60
	Comprehensive, new patient	$ 42.00	$ .00	$ 4.20	$10.50	$21.00	$31.50	$ 42.00
	established patient	$ 22.75	$ .00	$ 2.50	$ 5.75	$11.50	$17.00	$ 22.75
	Initial Consultation, Interm.	$ 24.00	$ .00	$ 2.40	$ 6.00	$12.00	$18.00	$ 24.00
	Follow-up Consultation, Interm.	$ 12.00	$ .00	$ 1.20	$ 3.00	$ 6.00	$ 9.00	$ 12.00
	Pharmocological Management	$ 9.50	$ .00	$ .95	$ 2.40	$ 4.75	$ 7.15	$ 9.50
	Developmental Screening	$ 9.50	$ .00	$ .95	$ 2.40	$ 4.75	$ 7.15	$ 9.50
	Health Education	$ 12.00	$ .00	$ 1.20	$ 3.00	$ 6.00	$ 9.00	$ 12.00
	Mental Health Services							
	Psychological Evaluation per hr.	$120.00	$ .00	$12.00	$30.00	$60.00	$90.00	$120.00
	Psycho-social Assessment	$ 34.00	$ .00	$ 3.40	$ 8.50	$17.00	$25.50	$ 34.00
	Individual Psychotherapy per 1/2 hour	$ 18.00	$ .00	$ 1.80	$ 4.50	$ 9.00	$13.50	$ 18.00
	Family Psychotherapy	$ 12.00	$ .00	$ 1.20	$ 3.00	$ 6.00	$ 9.00	$ 12.00
	Group Psychotherapy	$ 12.00	$ .00	$ 1.20	$ 3.00	$ 6.00	$ 9.00	$ 12.00
	Multifamily Psychotherapy	$ 12.00	$ .00	$ 1.20	$ 3.00	$ 6.00	$ 9.00	$ 12.00
	Educational Services							
	Educational Diagnostic Evaluation	-NC-	----------SERVICE PROVIDED FREE STATEWIDE----------					
	School Visit/Consultation	-NC-	----------SERVICE PROVIDED FREE STATEWIDE----------					
	Classroom Observation	-NC-	----------SERVICE PROVIDED FREE STATEWIDE----------					
	Case Management Services							
	Interdisciplinary Medical Conference	$ 29.50	$ .00	$ 2.95	$ 7.35	$14.75	$22.10	$ 29.50
	Medical Conference with Patient and/or Family	$ 30.50	$ .00	$ 3.05	$ 7.65	$15.25	$22.90	$ 30.50
	Other Case Management Activity	-NC-	----------SERVICE PROVIDED FREE STATEWIDE----------					
	Progress Review	-NC-	----------SERVICE PROVIDED FREE STATEWIDE----------					

ALL FOOTNOTES FOR STATEWIDE CHARGES STILL APPLY TO NORTHERN VIRGINIA CHARGES

CHARGES AND PAYMENTS BY INCOME LEVELS
~~OCTOBER 1, 1991~~ APRIL 9, 1992

FOOTNOTES

1. ~~For any service not specifically listed, the maximum Medicaid reimbursement level will be the charge. If Medicaid does not reimburse for a particular service, a charge may be established through the Office of Community Health Services.~~ For any service not listed, please contact the Office of Community Health Services so that a charge may be established.

2. Maximum Charges per Visit:

   a. If the service is obtained through contracts with providers of the department, charges will be those charged the department as stated in the contract or the set charges, whichever is more.

   b. The listed charges include all procedures such as routine lab work or x-ray as required in each program protocol for all patients.

   c. Health Department maximum charges shall be: Income A - Free; Income B - 10% of charges; Income C - 25% charges; Income D - 50% of charges; Income E - 75% of charges; Income F - 100% of charges. See Income Levels Schedules in the Eligibility Section of the CHS manual for more details.

3. Maternity:

   a. Maternity patients covered by Medicaid may be charged either on a per visit basis or for global care.

      Maternity patients covered by private insurance will be billed on a global basis. At the end of the pregnancy, the insurance company is to be billed $300 for antenatal care. The billing code is 59420.

   b. All women making a postpartum visit are to be charged for the visit. To bill as a postpartum visit, use CPT code 59430. If family planning services are provided, this visit may be billed as a family planning visit (CPT code 09007 for Medicaid; appropriate office visit code for private insurances).

4. Maternal and Infant Care Coordination:

   Services must meet Medicaid's guidelines before charging the patient for the services.

   Charges may be deferred if the determination is made that the patient needs the services, but cannot pay for them at the time of service. Documentation of the waiver for deferment must be on file in the patient's medical folder. Refer to "Waiver of Payments" section of Regulations Governing Eligibility Standards and Charges for Medical Care Services.

~~5. Pediatric/Well-Baby:~~

~~New Patient/Comprehensive Visit is defined as the first time an individual is seen, when a patient record is established, and a comprehensive evaluation is done by the provider. The correct CPT code is 90020.~~

~~Established Patient/Comprehensive Visit is the description to be used anytime a patient who already has an established medical record receives a comprehensive evaluation from a provider. The correct CPT code is 90080.~~

~~Follow-up/Problem Visit is to be charged whenever services less than a comprehensive evaluation are provided. Examples would include, but not be limited to, ongoing care for chronic conditions, acute care, and more detailed follow-up to a comprehensive exam. For billing purposes, this is an intermediate visit, established patient. The CPT code is 90060.~~

~~A brief service is defined as an encounter with a patient who is required to return for specific follow-up of a medical condition. This can be used in conjunction with all clinics except maternity. For billing, this is a brief visit, established patient (CPT 90040).~~

~~6. EPSDT Visits:~~

~~These are to be used for well child exams for children on Medicaid. Correct codes and charges for the exam are as follows:~~

	~~New Patient~~		~~Established Patient~~	
	~~Code~~	~~Charge~~	~~Code~~	~~Charge~~
~~Age 12 to 17~~	~~90751~~	~~$35.00~~	~~90761~~	~~$31.00~~
~~Age 5 to 11~~	~~90752~~	~~39.00~~	~~90762~~	~~36.00~~
~~Age 1 to 4~~	~~90753~~	~~39.00~~	~~90763~~	~~36.00~~
~~Under 1 year~~	~~90754~~	~~30.00~~	~~90764~~	~~35.00~~

~~7.~~ 5. Family Planning:

For non-Medicaid patients, the contraceptive method selected is included in the cost of the initial and yearly visits.

If the patient has Medicaid and is given contraceptives at the clinic visit, bill for two procedures: one for the clinic visit and one for the contraceptives. Districts with pharmacies are to bill the prescription filling fee.

Billing codes for Medicaid are 09007 for the initial/yearly exam and 09009 for the follow-up/problem visits. If private insurance is to be billed, use the appropriate visit and code as described in item 3 b above.

~~8. General Medical including Gynecology:~~

~~See item 5 above for description of visit levels and CPT codes.~~

~~All visits for gynecological problems are to use the CPT codes. Do not use codes related to maternity.~~

~~9.~~ 6. Dental:

The charges for dental services are based on average professional charges in the private sector. Charge schedules may be obtained from the Division of Dental Health.

For any service requiring the services of a dental lab, the patient will be required to pay the full lab charge. The professional fee is $30.00 per hour. Contact Dental Health for specific charges.

~~10.~~ 7. Special Services:

Service charges are to be applied statewide except when indicated as free. Flat rate services must be paid at the time the services are provided.

~~11.~~ 8. ADL Services:

ADL services are provided to patients who do not qualify for Medicaid benefits. All ADL service collections are to be charged to the General Medical subprogram activity.

~~12.~~ 9. Other X-Ray Services:

~~The charges for other x-ray services are to be the same as the maximum charges allowed by Medicaid.~~ These services are to be charged whenever they are ordered by the provider and are not part of the routine examination protocol for all clinic patients.

~~13.~~ 10. Other Lab Services:

~~The charges for other lab services are to be the same as the maximum charges allowed by Medicaid.~~ These services are to be charged whenever they are ordered by the provider and are not part of the routine examination protocol for all clinic patients.

Contract Lab Work: When lab work is sent to contract labs and the patient is covered by Medicaid, a handling fee of $3.00 (CPT code 99000) should be charged. (Medicare will not pay a handling fee, but will pay the venipuncture as below.) For all other patients, the charges for the lab work should be the Medicaid rate for the test(s) ordered.

If a venipuncture was needed to draw the sample, you may bill for the venipuncture.

~~14. Home Health Services:~~

~~Current charges are as follows:~~

~~Skilled Nursing Visit~~	~~$48.90~~
~~Physical Therapy~~	~~43.00~~
~~Occupational Therapy~~	~~44.27~~
~~Speech Therapy~~	~~46.48~~
~~Home Health Aide~~	~~25.73~~
~~Medical Social Work*~~	~~61.60~~

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: **State Plan for Medical Assistance Relating to Reduction of Threshold Days for Hospital Utilization Review and Second Surgical Opinion.**

VR 460-03-3.1100. Amount, Duration and Scope of Services.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: January 1, 1992.

Summary:

The purpose of this action is to promulgate permanent regulations to supersede the current emergency regulations providing for the same policies.

The section of the State Plan for Medical Assistance affected by this regulatory action is the Amount, Duration, and Scope of Services narrative (Attachment 3.1 A & B Supplement 1) for inpatient hospital services, outpatient hospital, and physician services.

Reduction of Threshold Days for Hospital Utilization Review (UR).

DMAS adopted its current limits on inpatient hospital lengths of stay in 1982. For all admissions of patients 21 years of age and older that exceed 14 days (up to a maximum of 21 days), the hospital must attach medical justification records to the billing invoice. (Patients younger than 21 years must, by federal law, be exempted from this sort of service limit.) Each of these claims is reviewed before payment by a registered nurse and all days determined not to be medically necessary are denied. The hospital is notified of these reduced days in its remittance vouchers.

This regulation reduces the limit placed on inpatient hospital lengths of stay for which claims must be manually reviewed from 14 days to 7 days. Hospitals will now be required to attach medical justification for all claims for lengths of stay exceeding 7 days. Under the authority of this new policy, fewer inpatient hospital claims will be paid automatically by the computerized billing system.

Second Surgical Opinion Program.

The Second Surgical Opinion Program (SSOP) was implemented in 1984 with a list of 10 surgical procedures requiring a second opinion. Procedures were considered for the program based upon high utilization volume, potential for abuse, high failure rates, or cost-effectiveness of the procedure.

The program objectives are to provide additional information to the patient when considering a recommendation for surgery, to monitor the utilization trends of identified procedures, and to prevent unnecessary surgeries. If unnecessary surgeries are prevented or alternative therapies implemented, then risk to the patient would decline and the cost-effectiveness of medical intervention would improve. Recipients receiving a second opinion that differed from the initial recommendation were under no obligation to accept the second opinion.

DMAS performed an overall review of the program and its previous evaluations. The review indicated the SSOP has not been successful in achieving its objectives, cost savings cannot be directly linked to the presence of the program, and that alternative programs could be implemented that would be more effective and less inconvenient to both Medicaid recipients and providers. Therefore, the recommendation to discontinue the second surgical opinion requirement was presented to and approved by the Board of Medical Assistance Services on June 10, 1991.

VR 460-03-3.1100. Amount, Duration and Scope of Services.

General.

The provision of the following 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.

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

A. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under 15 days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed 14 days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection F of this section.)

B. Medicaid does not pay the medicare (Title XVIII) coinsurance for hospital care after 21 days regardless of the length-of-stay covered by the other insurance. (See exception to subsection F of this section.)

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

D. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional 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.

E. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Hospital claims with admission dates on Friday or Saturday 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 admissions will be denied.

F. Coverage of inpatient hospitalization will be limited to a total of 21 days for all admissions within a fixed period, which would begin with the first day inpatient hospital services are furnished to an eligible recipient and end 60 days from the day of the first admission. There may be multiple admissions during this 60-day period; however, when total days exceed 21, all subsequent claims will be reviewed. Claims which exceed 21 days within 60 days with a different diagnosis and medical justification will be paid. Any claim which has the same or similar diagnosis will be denied.

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 acute care 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. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

G. ~~Reimbursement will not be provided for inpatient hospitalization for any selected elective surgical procedures that require a second surgical opinion unless a properly executed second surgical opinion form has been obtained from the physician and submitted with the hospital invoice for payment, or is a justified emergency or exemption. The requirements for second surgical opinion do not apply to recipients in the retroactive eligibility period.~~ [*Repealed.*]

H. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the mandatory outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions. The requirements for mandatory outpatient surgery do not apply to recipients in the retroactive eligibility period.

I. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. 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. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

J. The department may exempt portions or all of the utilization review documentation requirements of subsections A, D, E, F as it pertains to recipients under age 21, G, or H in writing for specific hospitals from time to time as part of their ongoing hospital utilization review peformance evaluation. These exemptions are based on utilization review performance and review edit criteria which determine an individual hospital's review status as specified in the hospital provider manual. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterlization, hysterectomy or abortion procedures were performed, shall be subject to medical documentation requirements.

K. Hospitals qualifying for an exemption of all documentation requirements except as described in subsection J above shall be granted "delegated review status" and shall, while the exemption remains in effect, not be required to submit medical documentation to support pended claims on a prepayment hospital utilization review basis to the extent allowed by federal or state law or regulation. The following audit conditions apply to delegated review status for hospitals:

1. The department shall conduct periodic on-site post-payment audits of qualifying hospitals using a statistically valid sampling of paid claims for the purpose of reviewing the medical necessity of inpatient stays.

2. The hospital shall make all medical records of which medical reviews will be necessary available upon request, and shall provide an appropriate place for the department's auditors to conduct such review.

3. The qualifying hospital will immediately refund to the department in accordance with § 32.1-325.1 A and B of the Code of Virginia the full amount of any initial overpayment identified during such audit.

4. The hospital may appeal adverse medical necessity and overpayment decisions pursuant to the current administrative process for appeals of post-payment review decisions.

5. The department may, at its option, depending on the utilization review performance determined by an audit based on criteria set forth in the hospital provider manual, remove a hospital from delegated review status and reapply certain or all prepayment utilization review documentation requirements.

§ 2. Outpatient hospital and rural health clinic services.

2a. Outpatient hospital services.

1. Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

a. Are furnished to outpatients;

b. Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist; and

c. Are furnished by an institution that:

(1) Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and

(2) Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare.

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

3. Reimbursement will not be provided for outpatient hospital services for any selected elective surgical procedures that require a second surgical opinion unless a properly executed second surgical opinion form has been obtained from the physician and submitted with the invoice for payment, or is a justified emergency or exemption.

2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

The same service limitations apply to rural health clinics as to all other services.

2c. 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).

The same service limitations apply to FQHCs as to all other services.

§ 3. Other laboratory and x-ray services.

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

§ 4. Skilled nursing facility services, EPSDT and family planning.

4a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

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

4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. 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 acute care facilities, and the accompanying attendant physician care, 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.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4c. Family planning services and supplies for individuals of child-bearing age.

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

§ 5. 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. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension (subject to the approval of the Psychiatric Review Board) of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. These limitations also apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology.

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 were carried to term.

G. Physician visits to inpatient hospital patients are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses and is further restricted to medically necessary 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 acute care 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 determined to be medically unjustified will be adjusted.

H. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine *and psychologists clinical licensed by the Board of Psychology* are covered.

I. ~~Reimbursement will not be provided for physician services for those selected elective surgical procedures requiring a second surgical opinion unless a properly executed second surgical opinion form has been submitted with the invoice for payment, or is a justified emergency or exemption. The requirements for second surgical opinion do not apply to recipients in a retroactive eligibility period.~~ [*Repealed.*]

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.

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. 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. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

§ 6. 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. Optometric services.

1. Diagnostic examination and optometric treatment procedures and services by ophthamologists, 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.

Not provided.

D. Other practitioners' services.

1. Clinical psychologists' services.

a. These limitations apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

b. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology are covered.

§ 7. Home health services.

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

B. Nursing services provided by a home health agency.

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

2. Patients may receive up to 32 visits by a licensed nurse within a 60-day period without authorization. A patient may receive a maximum of 64 nursing visits annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services.

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

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

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

3. For home health aide services, patients may receive up to 32 visits within a 60-day period without authorization from DMAS. A recipient may receive a maximum of 64 visits annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services.

D. Medical supplies, equipment, and appliances suitable for use in the home.

1. All medically necessary supplies, equipment, and appliances are covered for patients of the home health agency. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.

2. Medical supplies, equipment, and appliances for all others are limited to home renal dialysis equipment and supplies, respiratory equipment and oxygen, and ostomy supplies, as authorized by the agency.

3. Supplies, equipment, or appliances that are not covered include, but are not limited to, the following:

a. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners.

b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office.

c. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales).

d. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface; mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience (i.e., electric wheelchair plus a manual chair); cleansing wipes.

e. Prosthesis, except for artificial arms, legs, and their supportive devices which must be preauthorized by the DMAS central office (effective July 1, 1989).

f. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness

or injury or to improve the functioning of a malformed body member (for example, over-the-counter drugs; dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; support stockings; and nonlegend drugs.

g. Orthotics, including braces, splints, and supports.

h. Home or vehicle modifications.

i. Items not suitable for or used primarily in the home setting (i.e., car seats, equipment to be used while at school, etc.).

j. Equipment that the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.).

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

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

2. Patients may receive up to 24 visits for each rehabilitative therapy service ordered within a 60-day period without authorization. Patients may receive up to 48 visits for each rehabilitative service ordered annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services.

§ 8. Private duty nursing services.

Not provided.

§ 9. Clinic services.

A. 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.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;

2. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. Except in the case of nurse-midwife services, as specified in 42 dentist.

§ 10. Dental services.

A. Dental services are limited to recipients under 21 years of age in fulfillment of the treatment requirements under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

B. Initial, periodic, and emergency examinations; required radiography necessary to develop a treatment plan; patient education; dental prophylaxis; fluoride treatments; dental sealants; routine amalgam and composite restorations; crown recementation; pulpotomies; emergency endodontics for temporary relief of pain; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure are dental services covered without preauthorization by the state agency.

C. All covered dental services not referenced above require preauthorization by the state agency. The following services are also covered through preauthorization: medically necessary full banded orthodontics, for handicapping malocclusions, minor tooth guidance or repositioning appliances, complete and partial dentures, surgical preparation (alveoloplasty) for prosthetics, single permanent crowns, and bridges. The following service is not covered: routine bases under restorations.

D. The state agency may place appropriate limits on a service based on medical necessity, for utilization control, or both. Examples of service limitations are: examinations, prophylaxis, fluoride treatment (once/six months); space maintenance appliances; bitewing x-ray – two films (once/12 months); routine amalgam and composite restorations (once/three years); dentures (once per 5 years); extractions, orthodontics, tooth guidance appliances, permanent crowns, and bridges, endodontics, patient education and sealants (once).

E. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare), are covered for all recipients, and also require preauthorization by the state agency.

§ 11. Physical therapy and related services.

Physical therapy and related services shall be defined as physical therapy, occupational therapy, and speech-language pathology services. These services shall be prescribed by a physician and be part of a written plan of care. Any one of these services may be offered as the sole service and shall not be contingent upon the provision of another service. All practitioners and providers of services shall be required to meet state and federal

licensing and/or certification requirements.

11a. Physical Therapy.

A. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective July 1, 1988, the Program will not provide direct reimbursement to enrolled providers for physical therapy service rendered to patients residing in long term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing homes' operating cost.

C. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11b. Occupational therapy.

A. Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for occupational therapy services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist; see Page 1, General and Page 12, Physical Therapy and Related Services.)

A. These services are provided by or under the supervision of a speech pathologist or an audiologist only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for speech-language pathology services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who meets the qualifications in number 1. The program shall meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11d. Authorization for services.

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, or home health agencies shall include authorization for up to 24 visits by each ordered rehabilitative service within a 60-day period. A recipient may receive a maximum of 48 visits annually without authorization. The provider shall maintain documentation to justify the need for services.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized. This request must be signed and dated by a physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS.

11e. Documentation requirements.

A. Documentation of physical therapy, occupational therapy, and speech-language pathology services provided by a hospital-based outpatient setting, home health agency, a school division, or a rehabilitation agency shall, at a minimum:

1. Describe the clinical signs and symptoms of the patient's condition;

2. Include an accurate and complete chronological picture of the patient's clinical course and treatments;

3. Document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

4. Include a copy of the physician's orders and plan of care;

5. Include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

6. Describe changes in each patient's condition and response to the rehabilitative treatment plan;

7. (Except for school divisions) describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination; and

8. In school divisions, include an individualized education program (IEP) which describes the anticipated improvements in functional level in each school year and the time frames necessary to meet these goals.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

11f. Service limitations. The following general conditions shall apply to reimbursable physical therapy, occupational therapy, and speech-language pathology:

A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.

B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

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

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically

documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Physical therapy, occupational therapy and speech-language services are to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

§ 13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13a. Diagnostic services.

Not provided.

13b. Screening services.

Not provided.

13c. Preventive services.

Not provided.

13d. Rehabilitative services.

A. Intensive physical rehabilitation:

1. Medicaid covers intensive inpatient rehabilitation services as defined in subdivision A 4 in facilities certified as rehabilitation hospitals or rehabilitation units in acute care hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient physical rehabilitation services as defined in subdivision A 4 in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).

3. These facilities are excluded from the 21-day limit otherwise applicable to inpatient hospital services. Cost reimbursement principles are defined in Attachment 4.19-A.

4. An intensive rehabilitation program provides intensive skilled rehabilitation nursing, physical therapy, occupational therapy, and, if needed, speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation. The nursing staff must support the other disciplines in carrying out the activities of daily living, utilizing correctly the training received in therapy and furnishing other needed nursing services. The day-to-day activities must be carried out under the continuing direct supervision of a physician with special training or experience in the field of rehabilitation.

5. Nothing in this regulation is intended to preclude DMAS from negotiating individual contracts with in-state intensive physical rehabilitation facilities for those individuals with special intensive rehabilitation needs.

§ 14. Services for individuals age 65 or older in institutions for mental diseases.

14a. Inpatient hospital services.

Provided, no limitations.

14b. Skilled nursing facility services.

Provided, no limitations.

14c. Intermediate care facility.

Provided, no limitations.

§ 15. Intermediate care services and intermediate care services for institutions for mental disease and mental retardation.

15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with § 1902 (a)(31)(A) of the Act, to be in need of such care.

Provided, no limitations.

15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided, no limitations.

§ 16. Inpatient psychiatric facility services for individuals under 22 years of age.

Not provided.

§ 17. Nurse-midwife services.

Covered services for the nurse midwife are defined as those services allowed under the licensure requirements of the state statute and as specified in the Code of Federal Regulations, i.e., maternity cycle.

§ 18. Hospice care (in accordance with § 1905 (o) of the Act).

A. Covered hospice services shall be defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in the Code of Federal Regulations, Title 42, Part 418.

B. Categories of care.

As described for Medicare and applicable to Medicaid, hospice services shall entail the following four categories of daily care:

1. Routine home care is at-home care that is not continuous.

2. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered or licensed practical nurse must provide care for more than half of the period of the care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of 8 hours of care per day must be provided to qualify as continuous home care.

3. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the recipient. Respite care is limited to not more than 5 consecutive days.

4. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting.

C. Covered services.

1. As required under Medicare and applicable to Medicaid, the hospice itself must provide all or substantially all of the "core" services applicable for the terminal illness which are nursing care, physician services, social work, and counseling (bereavement, dietary, and spiritual).

2. Other services applicable for the terminal illness that must be available but are not considered "core" services are drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language pathology services.

3. These other services may be arranged, such as by contractual agreement, or provided directly by the hospice.

4. To be covered, a certification that the individual is terminally ill must have been completed by the physician and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no coverage will be provided.

5. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

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

b. Medical social services. Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

c. Physician services. Physician services must be performed by a professional who is licensed to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

d. Counseling services. Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

e. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

f. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

g. Drugs and biologicals. Only drugs used which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

h. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

i. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

D. Eligible groups.

To be eligible for hospice coverage under Medicare or Medicaid, the recipient must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the attending physician and the hospice medical director must certify the life expectancy. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

1. For the first 90-day period of hospice coverage, the hospice must obtain, within two calendar days after the period begins, a written certification statement signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. For the initial 90-day period, if the hospice cannot obtain written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

2. For any subsequent 90-day or 30-day period or a subsequent extension period during the individual's lifetime, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s). The hospice must maintain the certification statements.

§ 19. Case management services for high-risk pregnant women and children up to age 1, as defined in Supplement 2 to Attachment 3.1-A in accordance with § 1915(g)(1) of the Act.

Provided, with limitations. See Supplement 2 for detail.

§ 20. Extended services to pregnant women.

20a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

The same limitations on all covered services apply to this group as to all other recipient groups.

20b. Services for any other medical conditions that may complicate pregnancy.

The same limitations on all covered services apply to this group as to all other recipient groups.

§ 21. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of Health and Human Services.

21a. Transportation.

Nonemergency transportation is administered by local health department jurisdictions in accordance with reimbursement procedures established by the Program.

21b. Services of Christian Science nurses.

Not provided.

21c. Care and services provided in Christian Science sanitoria.

Provided, no limitations.

21d. Skilled nursing facility services for patients under 21 years of age.

Provided, no limitations.

21e. Emergency hospital services.

Provided, no limitations.

21f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Not provided.

Emergency Services for Aliens (17.e)

No payment shall be made for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law unless such services are necessary for the treatment of an emergency medical condition of the alien.

Emergency services are defined as:

Emergency treatment of accidental injury or medical condition (including emergency labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical/surgical attention could reasonably be expected to result in:

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

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Medicaid eligibility and reimbursement is conditional upon review of necessary documentation supporting the need for emergency services. Services and inpatient lengths of stay cannot exceed the limits established for other Medicaid recipients.

Claims for conditions which do not meet emergency critieria for treatment in an emergency room or for acute care hospital admissions for intensity of service or severity of illness will be denied reimbursement by the Department of Medical Assistance Services.

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Title of Regulation: **State Plan for Medical Assistance Relating to Mortgage Debt Refinancing, Nursing Facility Rate Change, and Technical Language Changes.**
VR 460-03-4.1940:1. Nursing Home Payment System (PIRS)

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: April 8, 1992.

Summary:

The purpose of this action is to promulgate permanent regulations to supersede existing emergency regulations providing for mortgage debt refinancing incentive, nursing facility rate change, and technical language changes.

The sections of the State Plan for Medical Assistance which are affected by this proposed regulation are as follows: VR 460-03-4.1940:1: §§ 2.4, 2.7, and 2.8.1.

Section 2.4 of the NHPS methodology currently provides that mortgage refinancing is permitted where the refinancing would result in a cost savings from lower rates. In other words, refinancing is permitted when it benefits the Commonwealth, but the provider has been given no specific incentive to refinance.

A DMAS study found that 18 of the responding providers had existing mortgage rates of between 11% and 15%. Nine of these providers have rates that are capped by existing interest rate upper limit provisions of the NHPS. There are approximately nine facilities that could be affected by the amendment at this time.

Therefore, § 2.4 is being modified to encourage mortgage refinancing by providing incentive payments which will be made when the refinancing benefits both the Commonwealth and the provider, as mandated by the 1991 General Assembly. This provision was the subject of an earlier emergency regulation.

Section 2.7 contains the nursing facility reimbursement formula which provides for peer group ceilings. The peer group ceilings are derived from facilities' allowable operating rates. This amendment clarifies the phrase "from the effective date of such 'interim' ceilings" as contained in § 2.7 B 1. The phrase was intended to remove duplicative allowances for inflation during adjustment of peer group medians pursuant to § 2.7 A 5 c. For most providers, the calculation of the estimated reimbursement rate for FY '91 under § 2.7 A 5 a already has an inflation allowance forecasted in the providers' fiscal years extending into FY '92. For the remaining providers, there is a forecasted inflation allowance calculated in § 2.7 A 5 a for FY '91 which is partially duplicated by an historical inflation allowance calculated in § 2.7 A 5 b for FY '91. Without this amendment, the phrase in question could be interpreted as allowing both historical and forecasted inflation adjustments for the same period of time. This was never the intent of the methodology.

Section 2.8.1 provides for the overall reduction of nursing facility per diem operating cost rates. The amendment is being made to permit the Commonwealth of Virginia and concomitantly HCFA to participate in the benefits of cost management efficiencies achieved by NF's since 1982. DMAS is adjusting per diem operating cost rates effective on or after July 5, 1991, for all NF's during the period from July 1, 1991, through June 30, 1992. The proposed rate change will reduce projected NF reimbursement by approximately 1.2% during fiscal year 1992 and will result in operating cost rates which, for the majority of NFs, are still above the peer group operating cost medians.

VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).

PART I.
INTRODUCTION.

§ 1.1. Effective October 1, 1990, the payment methodology for Nursing Facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in the following document. The formula provides for incentive payments to efficiently operated NFs and contains payment limitations for those NFs operating less efficiently. A cost efficiency incentive encourages cost containment by allowing the provider to retain a percentage of the difference between the prospectively determined operating cost rate and the ceiling.

§ 1.2. Three separate cost components are used: plant cost, operating cost and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

§ 1.3. In determining the ceiling limitations, there shall be direct patient care medians established for NFs in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for NFs in the Virginia portion of the Washington DC-MD-VA MSA, and in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Health Care Financing Administration (HCFA). A NF located in a jurisdiction which HCFA adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

§ 1.4. Institutions for mental diseases providing nursing services for individuals age 65 and older shall be exempt from the prospective payment system as defined in §§ 2.6, 2.7, 2.8, 2.19, and 2.25, as are mental retardation facilities. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare and Medicaid principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

§ 1.5. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see VR 460-03-4.1941, Uniform Expense Classification) and must be identifiable and verified by contemporaneous documentation.

All matters of reimbursement which are part of the DMAS reimbursement system shall supercede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.

PART II.
RATE DETERMINATION PROCEDURES.

Article 1.
Plant Cost Component.

§ 2.1. Plant cost.

A. Plant cost shall include actual allowable depreciation, interest, rent or lease payments for buildings and equipment as well as property insurance, property taxes and debt financing costs allowable under Medicare principles of reimbursement or as defined herein.

B. To calculate the reimbursement rate, plant cost shall be converted to a per diem amount by dividing it by the greater of actual patient days or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.

C. For NFs of 30 beds or less, to calculate the reimbursement rate, the number of patient days will be computed as not less than 85% of the daily licensed bed complement.

D. Costs related to equipment and portions of a building/facility not available for patient care related activities are nonreimbursable plant costs.

§ 2.2. New nursing facilities and bed additions.

A. 1. Providers shall be required to obtain three competitive bids when (i) constructing a new physical plant or renovating a section of the plant when changing the licensed bed capacity, and (ii) purchasing fixed equipment or major movable equipment related to such projects.

2. All bids must be obtained in an open competitive market manner, and subject to disclosure to DMAS prior to initial rate setting. (Related parties see § 2.10.)

B. Reimbursable costs for building and fixed equipment shall be based upon the 3/4 (25% of the surveyed projects with costs above the median, 75% with costs below the median) square foot costs for NFs published annually in the R.S. Means Building Construction Cost Data as adjusted by the appropriate R.S. Means Square Foot Costs "Location Factor" for Virginia for the locality in which the NF is located. Where the specific location is not listed in the R.S. Means Square Foot Costs "Location Factor" for Virginia, the facility's zip code shall be used to determine the appropriate locality factor from the U.S. Postal Services National Five Digit Zip Code for Virginia and the

R.S. Means Square Foot Costs "Location Factors." The provider shall have the option of selecting the construction cost limit which is effective on the date the Certificate of Public Need (COPN) is issued or the date the NF is licensed. Total cost shall be calculated by multiplying the above 3/4 square foot cost by 385 square feet (the average per bed square footage). Total costs for building additions shall be calculated by multiplying the square footage of the project by the applicable components of the construction cost in the R.S. Means Square Foot Costs, not to exceed the total per bed cost for a new NF. Reasonable limits for renovations shall be determined by the appropriate costs in the R.S. Means Repair and Remodeling Cost Data, not to exceed the total R.S. Means Building Construction Cost Data 3/4 square foot costs for nursing homes.

C. New NFs and bed additions to existing NFs must have prior approval under the state's Certificate of Public Need Law and Licensure regulations in order to receive Medicaid reimbursement.

D. However in no case shall allowable reimbursed costs exceed 110% of the amounts approved in the original COPN, or 100% of the amounts approved in the original COPN as modified by any "significant change" COPN, where a provider has satisfied the requirements of the State Department of Health with respect to obtaining prior written approval for a "significant change" to a COPN which has previously been issued.

§ 2.3. Major capital expenditures.

A. Major capital expenditures include, but are not limited to, major renovations (without bed increase), additions, modernization, other renovations, upgrading to new standards, and equipment purchases. Major capital expenditures shall be any capital expenditures costing $100,000 or more each, in aggregate for like items, or in aggregate for a particular project. These include purchases of similar type equipment or like items within a one calendar year period (not necessarily the provider's reporting period).

B. Providers (including related organizations as defined in § 2.10) shall be required to obtain three competitive bids and if applicable, a Certificate of Public Need before initiating any major capital expenditures. All bids must be obtained in an open competitive manner, and subject to disclosure to the DMAS prior to initial rate setting. (Related parties see § 2.10.)

C. Useful life shall be determined by the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (AHA). If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

D. Major capital additions, modernization, renovations, and costs associated with upgrading the NF to new standards shall be subject to cost limitations based upon the applicable components of the construction cost limits determined in accordance with § 2.2 B.

§ 2.4. Financing.

A. The DMAS shall continue its policy to disallow cost increases due to the refinancing of a mortgage debt, except when required by the mortgage holder to finance expansions or renovations. Refinancing shall also be permitted in cases where refinancing would produce a lower interest rate and result in a cost savings. The total net aggregate allowable costs incurred for all cost reporting periods related to the refinancing cannot exceed the total net aggregate costs that would have been allowable had the refinancing not occurred.

1. Refinancing incentive. Effective July 1, 1991, for mortgages refinanced on or after that date, the DMAS will pay a refinancing incentive to encourage nursing facilities to refinance fixed-rate, fixed-term mortgage debt when such arrangements would benefit both the Commonwealth and the providers. The refinancing incentive payments will be made for the 10-year period following an allowable refinancing action, or through the end of the refinancing period should the loan be less than 10 years, subject to a savings being realized by application of the refinancing calculation for each of these years. The refinancing incentive payment shall be computed on the net savings from such refinancing applicable to each provider cost reporting period. Interest expense and amortization of loan costs on mortgage debt applicable to the cost report period for mortgage debt which is refinanced shall be compared to the interest expense and amortization of loan costs on the new mortgage debt for the cost reporting period.

2. Calculation of refinancing incentive. The incentive shall be computed by calculating two index numbers, the old debt financing index and the new debt financing index. The old debt financing index shall be computed by multiplying the term (months) which would have been remaining on the old debt at the end of the provider's cost report period by the interest rate for the old debt. The new debt index shall be computed by multiplying the remaining term (months) of the new debt at the end of the cost reporting period by the new interest rate. The new debt index shall be divided by the old debt index to achieve a savings ratio for the period. The savings ratio shall be subtracted from a factor of 1 to determine the refinancing incentive factor.

3. Calculation of net savings. The gross savings for the period shall be computed by subtracting the allowable new debt interest for the period from the allowable old debt interest for the period. The net savings for the period shall be computed by subtracting allowable new loan costs for the period from allowable gross savings applicable to the period. Any remaining unamortized old loan costs may be

recovered in full to the extent of net savings produced for the period.

4. Calculation of incentive amount. The net savings for the period, after deduction of any unamortized old loan and debt cancellation costs, shall be multiplied by the refinancing incentive factor to determine the refinancing incentive amount. The result shall be the incentive payment for the cost reporting period, which shall be included in the cost report settlement, subject to per diem computations under § 2.1 B, 2.1 C, and 2.14 A.

5. Where a savings is produced by a provider refinancing his old mortgage for a longer time period, the DMAS shall calculate the refinancing incentive and payment in accordance with §§ 2.4 A 1 through 2.4 A 4 for the incentive period. Should the calculation produce both positive and negative incentives, the provider's total incentive payments shall not exceed any net positive amount for the entire incentive period. Where a savings is produced by refinancing with either a principal balloon payment at the end of the refinancing period, or a variable interest rate, no incentive payment will be made, since the true savings to the Commonwealth cannot be accurately computed.

6. All refinancings must be supported by adequate and verifiable documentation and allowable under DMAS regulations to receive the refinancing savings incentive.

B. Interest rate upper limit.

Financing for all NFs and expansions which require a COPN and all renovations and purchases shall be subject to the following limitations:

1. Interest expenses for debt financing which is exempt from federal income taxes shall be limited to:

The average weekly rates for Baa municipal rated bonds as published in Cragie Incorporated Municipal Finance Newsletter as published weekly (Representative reoffering from general obligation bonds), plus one percentage point (100 basis points), during the week in which commitment for construction financing or closing for permanent financing takes place.

2. a. Effective on and after July 1, 1990, the interest rate upper limit for debt financing by NFs that are subject to prospective reimbursement shall be the average of the rate for 10-year and 30-year U.S. Treasury Constant Maturities, as published in the weekly Federal Reserve Statistical Release (H.15), plus two percentage points (200 basis points).

This limit (i) shall apply only to debt financing which is not exempt from federal income tax, and (ii) shall not be available to NF's which are eligible for such tax exempt financing unless and until a NF has demonstrated to the DMAS that the NF failed, in a good faith effort, to obtain any available debt financing which is exempt from federal income tax. For construction financing, the limit shall be determined as of the date on which commitment takes place. For permanent financing, the limit shall be determined as of the date of closing. The limit shall apply to allowable interest expenses during the term of the financing.

b. The new interest rate upper limit shall also apply, effective July 1, 1990, to construction financing committed to or permanent financing closed after December 31, 1986, but before July 1, 1990, which is not exempt from federal income tax. The limit shall be determined as of July 1, 1990, and shall apply to allowable interest expenses for the term of the financing remaining on or after July 1, 1990.

3. Variable interest rate upper limit.

a. The limitation set forth in §§ 2.4 B 1 and 2.4 B 2 shall be applied to debt financing which bears a variable interest rate as follows. The interest rate upper limit shall be determined on the date on which commitment for construction financing or closing for permanent financing takes place, and shall apply to allowable interest expenses during the term of such financing as if a fixed interest rate for the financing period had been obtained. A "fixed rate loan amortization schedule" shall be created for the loan period, using the interest rate cap in effect on the date of commitment for construction financing or date of closing for permanent financing.

b. If the interest rate for any cost reporting period is below the limit determined in subdivision 3 a above, no adjustment will be made to the providers interest expense for that period, and a "carryover credit" to the extent of the amount allowable under the "fixed rate loan amortization schedule" will be created, but not paid. If the interest rate in a future cost reporting period is above the limit determined in subdivision 3 a above, the provider will be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or his actual cost, whichever is less.

c. The provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of interest claimed under the "carryover credit," and shall submit such a schedule with each cost report.

4. The limitation set forth in § 2.4 B 1, 2, and 3 shall be applicable to financing for land, buildings, fixed equipment, major movable equipment, working capital for construction and permanent financing.

5. Where bond issues are used as a source of financing, the date of sale shall be considered as the date of closing.

6. The aggregate of the following costs shall be limited to 5.0% of the total allowable project costs:

a. Examination Fees

b. Guarantee Fees

c. Financing Expenses (service fees, placement fees, feasibility studies, etc.)

d. Underwriters Discounts

e. Loan Points

7. The aggregate of the following financing costs shall be limited to 2.0% of the total allowable project costs:

a. Legal Fees

b. Cost Certification Fees

c. Title and Recording Costs

d. Printing and Engraving Costs

e. Rating Agency Fees

C. DMAS shall allow costs associated with mortgage life insurance premiums in accordance with § 2130 of the HCFA-Pub. 15, Provider Reimbursement Manual (PRM-15).

D. Interest expense on a debt service reserve fund is an allowable expense if required by the terms of the financing agreement. However, interest income resulting from such fund shall be used by DMAS to offset interest expense.

§ 2.5. Purchases of nursing facilities (NF).

A. In the event of a sale of a NF, the purchaser must have a current license and certification to receive DMAS reimbursement as a provider.

B. The following reimbursement principles shall apply to the purchase of a NF:

1. The allowable cost of a bona fide sale of a facility (whether or not the parties to the sale were, are, or will be providers of Medicaid services) shall be the lowest of the sales price, the replacement cost value determined by independent appraisal, or the limitations of Part XVI - Revaluation of Assets. Revaluation of assets shall be permitted only when a bona fide sale of assets occurs.

2. Notwithstanding the provisions of § 2.10, where there is a sale between related parties (whether or not they were, are or will be providers of Medicaid services), the buyer's allowable cost basis for the nursing facility shall be the seller's allowable depreciated historical cost (net book value), as determined for Medicaid reimbursement.

3. For purposes of Medicaid reimbursement, a "bona fide" sale shall mean a transfer of title and possession for consideration between parties which are not related. Parties shall be deemed to be "related" if they are related by reasons of common ownership or control. If the parties are members of an immediate family, the sale shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control." See § 2.10 C for definitions of "common ownership," "control," "immediate family," and "significant ownership or control."

4. The useful life of the fixed assets of the facility shall be determined by AHA guidelines.

5. The buyer's basis in the purchased assets shall be reduced by the value of the depreciation recapture due the state by the provider-seller, until arrangements for repayment have been agreed upon by DMAS.

6. In the event the NF is owned by the seller for less than five years, the reimbursable cost basis of the purchased NF to the buyer, shall be the seller's allowable historical cost as determined by DMAS.

C. An appraisal expert shall be defined as an individual or a firm that is experienced and specializes in multi-purpose appraisals of plant assets involving the establishing or reconstructing of the historical cost of such assets. Such an appraisal expert employs a specially trained and supervised staff with a complete range of appraisal and cost construction techniques; is experienced in appraisals of plant assets used by providers, and demonstrates a knowledge and understanding of the regulations involving applicable reimbursement principles, particularly those pertinent to depreciation; and is unrelated to either the buyer or seller.

D. At a minimum, appraisals must include a breakdown by cost category as follows:

1. Building; fixed equipment; movable equipment; land; land improvements.

2. The estimated useful life computed in accordance with AHA guidelines of the three categories, building, fixed equipment, and movable equipment must be included in the appraisal. This information shall be utilized to compute depreciation schedules.

E. Depreciation recapture.

1. The provider-seller of the facility shall make a retrospective settlement with DMAS in instances where a gain was made on disposition. The department shall recapture the depreciation paid to the provider by Medicaid for the period of participation in the Program to the extent there is gain realized on the sale of the depreciable assets. A final cost report and refund of depreciation expense, where applicable, shall be due within 30 days from the transfer of title (as defined below).

2. No depreciation adjustment shall be made in the event of a loss or abandonment.

F. Reimbursable depreciation.

1. For the purpose of this section, "sale or transfer" shall mean any agreement between the transferor and the transferee by which the former, in consideration of the payment or promise of payment of a certain price in money, transfers to the latter the title and possession of the property.

2. Upon the sale or transfer of the real and tangible personal property comprising a licensed nursing facility certified to provide services to DMAS, the transferor or other person liable therein shall reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing such services and subject to recapture under the provisions of the State Plan for Medical Assistance. The amount of reimbursable depreciation shall be paid to the Commonwealth within 30 days of the sale or transfer of the real property unless an alternative form of repayment, the term of which shall not exceed one year, is approved by the director.

3. Prior to the transfer, the transferor shall file a written request by certified or registered mail to the director for a letter of verification that he either does not owe the Commonwealth any amount for reimbursable depreciation or that he has repaid any amount owed the Commonwealth for reimbursable depreciation or that an alternative form of repayment has been approved by the director. The request for a letter of verification shall state:

a. That a sale or transfer is about to be made;

b. The location and general description of the property to be sold or transferred;

c. The names and addresses of the transferee and transferor and all such business names and addresses of the transferor for the last three years; and

d. Whether or not there is a debt owing to the Commonwealth for the amount of depreciation charges previously allowed and reimbursed as a reasonable cost to the transferor under the Virginia Medical Assistance Program.

4. Within 90 days after receipt of the request, the director shall determine whether or not there is an amount due to the Commonwealth by the nursing facility by reason of depreciation charges previously allowed and reimbursed as a reasonable cost under DMAS and shall notify the transferor of such sum, if any.

5. The transferor shall provide a copy of this section and a copy of his request for a letter of verification to the prospective transferee via certified mail at least 30 days prior to the transfer. However, whether or not the transferor provides a copy of this section and his request for verification to the prospective transferee as required herein, the transferee shall be deemed to be notified of the requirements of this law.

6. After the transferor has made arrangements satisfactory to the director to repay the amount due or if there is no amount due, the director shall issue a letter of verification to the transferor in recordable form stating that the transferor has complied with the provisions of this section and setting forth the term of any alternative repayment agreement. The failure of the transferor to reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing service to DMAS in a timely manner renders the transfer of the nursing facility ineffective as to the Commonwealth.

7. Upon a finding by the director that such sale or transfer is ineffective as to the Commonwealth, DMAS may collect any sum owing by any means available by law, including devising a schedule for reducing the Medicaid reimbursement to the transferee up to the amount owed the Commonwealth for reimbursable depreciation by the transferor or other person liable therein. Medicaid reimbursement to the transferee shall continue to be so reduced until repayment is made in full or the terms of the repayment are agreed to by the transferor or person liable therein.

8. In the event the transferor or other person liable therein defaults on any such repayment agreement the reductions of Medicaid reimbursement to the transferee may resume.

An action brought or initiated to reduce the transferee's Medicaid reimbursement or an action for attachment or levy shall not be brought or initiated more than six months after the date on which the sale or transfer has taken place unless the sale or transfer has been concealed or a letter of verification has not been obtained by the transferor or the transferor defaults on a repayment agreement approved by the director.

Article 2.

Operating Cost Component.

§ 2.6. Operating cost.

A. Operating cost shall be the total allowable inpatient cost less plant cost and NATCEPs costs. See Part VII for rate determination procedures for NATCEPs costs. To calculate the reimbursement rate, operating cost shall be converted to a per diem amount by dividing it by the greater of actual patient days, or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.

B. For NFs of 30 beds or less, to calculate the reimbursement rate the number of patient days will continue to be computed as not less than 85% of the daily licensed bed complement.

§ 2.7. Nursing facility reimbursement formula.

A. Effective on and after October 1, 1990, all NFs subject to the prospective payment system shall be reimbursed under a revised formula entitled "The Patient Intensity Rating System (PIRS)." PIRS is a patient based methodology which links NF's per diem rates to the intensity of services required by a NF's patient mix. Three classes were developed which group patients together based on similar functional characteristics and service needs.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.

2. In accordance with § 1.3, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in VR 460-03-1491. Indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA and for the rest of the state. Indirect patient care operating costs shall include all other operating costs, not defined in VR 460-03-4.1941 as direct patient care operating costs and NATCEPs costs.

3. Each NF's Service Intensity Index (SII) shall be calculated for each semiannual period of a NF's fiscal year based upon data reported by that NF and entered into DMAS' Long Term Care Information System (LTCIS). Data will be reported on the multidimensional assessment form prescribed by DMAS (now DMAS-95) at the time of admission and then twice a year for every Medicaid recipient in a NF. The NF's SII, derived from the assessment data, will be normalized by dividing it by the average for all NF's in the state.

See VR 460-03-4.1944 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NF's facility score and the methodology of computing the NF's semiannual SIIs.

4. The normalized SII shall be used to calculate the initial direct patient care operating cost peer group medians. It shall also be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NF's subsequent fiscal years.

a. The normalized SII, as determined during the quarter ended September 30, 1990, shall be used to calculate the initial direct patient care operating cost peer group medians.

b. A NF's direct patient care operating cost prospective ceiling shall be the product of the NF's peer group direct patient care ceiling and the NF's normalized SII for the previous semiannual period. A NF's direct patient care operating cost prospective ceiling will be calculated semiannually.

c. An SSI rate adjustment, if any, shall be applied to a NF's prospective direct patient care operating cost base rate for each semiannual period of a NF's fiscal year. The SII determined in the second semiannual period of the previous fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the first semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate. The SII determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the second semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate.

d. See VR 460-03-4.1944 for an illustration of how the SII is used to adjust direct patient care operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate.

5. An adjustment factor shall be applied to both the direct patient care and indirect patient care peer group medians to determine the appropriate initial peer group ceilings.

a. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during fiscal year 1991 under the prospective payment system in effect through September 30, 1990, as modified to incorporate the estimated additional NF reimbursement mandated by the provisions of § 1902(a)(13)(A) of the Social Security Act as amended by § 4211(b)(1) of the

Omnibus Budget Reconciliation Act of 1987.

b. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during FY 1991 under the PIRS prospective payment system.

c. The DMAS shall determine the differential between a and b above and shall adjust the peer group medians within the PIRS as appropriate to reduce the differential to zero.

d. The adjusted PIRS peer group medians shall become the initial peer group ceilings.

B. The allowance for inflation shall be based on the percentage of change in the moving average of the Skilled Nursing Facility Market basket of Routine Service Costs, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the quarter in which the NF's most recent fiscal year ended. NFs shall have their prospective operating cost ceilings and prospective operating cost rates established in accordance with the following methodology:

1. The initial peer group ceilings established under § 2.7 A shall be the final peer group ceilings for a NF's first full or partial fiscal year under PIRS and shall be considered as the initial "interim ceilings" for calculating the subsequent fiscal year's peer group ceilings. Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the ~~most recent~~ *initial* "interim" ceilings ~~for 100% of historical inflation, from the effective date of such "interim" ceilings to the beginning of the NF's next fiscal year to obtain new "interim" ceilings, and 50% of the forecasted inflation to the end of the NF's next fiscal year~~ *by a "percentage factor" which shall eliminate any allowances for inflation after September 30, 1990, calculated in both §§ 2.7 A 5 a and 2.7 A 5 c. The adjusted initial "interim" ceilings shall be considered as the final "interim ceiling." Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the final "interim" ceiling, as determined above, by 100% of historical inflation from October 1, 1990, to the beginning of the NFs next fiscal year to obtain new "interim" ceilings, and 50% of the forecasted inflation to the end of the NFs next fiscal year* .

2. A NF's average allowable operating cost rates, as determined from its most recent fiscal year's cost report, shall be adjusted by 50% of historical inflation and 50% of the forecasted inflation to calculate its prospective operating cost base rates.

C. The PIRS method shall still require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost rates or prospective operating ceilings.

D. Nonoperating costs.

1. Allowable plant costs shall be reimbursed in accordance with Part II, Article 1. Plant costs shall not include the component of cost related to making or producing a supply or service.

2. NATCEPs cost shall be reimbursed in accordance with Part VII.

E. The prospective rate for each NF shall be based upon operating cost and plant cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of nonreimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of nonreimbursable plant costs and NATCEPs costs shall be reflected in the year in which the nonreimbursable costs are included.

F. For those NFs whose operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable operating cost rates and the peer group ceilings under the PIRS.

1. The table below presents four incentive examples under the PIRS:

Peer Group Ceilings	Allowable Cost Per Day		Difference % of Ceiling	Sliding Scale	Scale % Difference
$30.00	$27.00	$3.00	10%	$ .30	10%
30.00	22.50	7.50	25%	1.88	25%
30.00	20.00	10.00	33%	2.50	25%
30.00	30.00	0		0	

2. Separate efficiency incentives shall be calculated for both the direct and indirect patient care operating ceilings and costs.

G. Quality of care requirement.

A cost efficiency incentive shall not be paid to a NF for the prorated period of time that it is not in conformance with substantive, nonwaived life, safety, or quality of care standards.

H. Sale of facility.

In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

I. Public notice.

To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

§ 2.8. Phase-in period.

A. To assist NFs in converting to the PIRS methodology, a phase-in period shall be provided until June 30, 1992.

B. From October 1, 1990, through June 30, 1991, a NF's prospective operating cost rate shall be a blended rate calculated at 33% of the PIRS operating cost rates determined by § 2.7 above and 67% of the "current" operating rate determined by subsection D below.

C. From July 1, 1991, through June 30, 1992, a NF's prospective operating cost rate shall be a blended rate calculated at 67% of the PIRS operating cost rates determined by § 2.7 above and 33% of the "current" operating rate determined by subsection D below.

D. The following methodology shall be applied to calculate a NF's "current" operating rate:

1. Each NF shall receive as its base "current" operating rate, the weighted average prospective operating cost per diems and efficiency incentive per diems if applicable, calculated by DMAS to be effective September 30, 1990.

2. The base "current" operating rate established above shall be the "current" operating rate for the NF's first partial fiscal year under PIRS. The base "current" operating rate shall be adjusted by appropriate allowance for historical inflation and 50% of the forecasted inflation based on the methodology contained in § 2.7 B at the beginning of each of the NF's fiscal years which starts during the phase-in period, October 1, 1990, through June 30, 1992, to determine the NF's prospective "current" operating rate. See VR 460-03-4.1944 for example calculations.

§ 2.8.1. Nursing facility rate change.

For the period beginning July 1, 1991, and ending June 30, 1992, the per diem operating rate for each NF shall be adjusted. This shall be accomplished by applying a uniform adjustment factor to the rate of each NF.

Article 3.
Allowable Cost Identification.

§ 2.9. Allowable costs.

Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see VR 460-03-4.1941, Uniform Expense Classification).

A. Certification.

The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.

B. Operating costs.

1. Direct patient care operating costs shall be defined in VR 460-03-4.1941.

2. Allowable direct patient care operating costs shall exclude (i) personal physician fees, and (ii) pharmacy services and prescribed legend and nonlegend drugs provided by nursing facilities which operate licensed in-house pharmacies. These services shall be billed directly to DMAS through separate provider agreements and DMAS shall pay directly in accordance with subsections e and f of Attachment 4.19 B of the State Plan for Medical Assistance (VR 460-02-4.1920).

3. Indirect patient care operating costs include all other operating costs, not identified as direct patient care operating costs and NATCEPs costs in VR 460-03-4.1941, which are allowable under the Medicare principles of reimbursement, except as specifically modified herein and as may be subject to individual cost or ceiling limitations.

C. Allowances/goodwill.

Bad debts, goodwill, charity, courtesy, and all other contractual allowances shall not be recognized as an allowable cost.

§ 2.10. Purchases/related organizations.

A. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization, provided that such costs do not exceed the price of comparable services, facilities or supplies. Purchases of existing NFs by related parties shall be governed by the provisions of § 2.5 B 2.

Allowable cost applicable to management services furnished to the provider by organizations related to the provider by common ownership or control shall be lesser of the cost to the related organization or the per patient day ceiling limitation established for management services cost. (See VR 460-03-4.1943, Cost Reimbursement Limitations.)

B. Related to the provider shall mean that the provider is related by reasons of common ownership or control by the organization furnishing the services, facilities, or supplies.

C. Common ownership exists when an individual or individuals or entity or entities possess significant

ownership or equity in the parties to the transaction. Control exists where an individual or individuals or entity or entities have the power, directly or indirectly, significantly to influence or direct the actions or policies of the parties to the transaction. Significant ownership or control shall be deemed to exist where an individual is a "person with an ownership or control interest" within the meaning of 42 CFR 455.101. If the parties to the transaction are members of an immediate family, as defined below, the transaction shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control," as set forth above. Immediate family shall be defined to include, but not be limited to, the following: (i) husband and wife, (ii) natural parent, child and sibling, (iii) adopted child and adoptive parent, (iv) step-parent, step-child, step-sister, and step-brother, (v) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law, and (vi) grandparent and grandchild.

D. Exception to the related organization principle.

1. Effective with cost reports having fiscal years beginning on or after July 1, 1986, an exception to the related organization principle shall be allowed. Under this exception, charges by a related organization to a provider for goods or services shall be allowable cost to the provider if all four of the conditions set out below are met.

2. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of DMAS that the following criteria have been met:

a. The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the provider organization.

b. A substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of goods or services furnished by the organization. In determining whether the activities are of similar type, it is important to also consider the scope of the activity.

For example, a full service management contract would not be considered the same type of business activity as a minor data processing contract. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arms-length bargaining by well informed buyers and sellers.

c. The goods or services shall be those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions. This requirement means that institutions such as the provider typically obtain the good or services from outside sources rather than producing the item internally.

d. The charge to the provider is in line with the charge for such services, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such goods or services. The phrase "open market" takes the same meaning as "open, competitive market" in subdivision b above.

3. Where all of the conditions of this exception are met, the charges by the supplier to the provider for such goods or services shall be allowable as costs.

4. This exception does not apply to the purchase, lease or construction of assets such as property, buildings, fixed equipment or major movable equipment. The terms "goods and services" may not be interpreted or construed to mean capital costs associated with such purchases, leases, or construction.

E. Three competitive bids shall not be required for the building and fixed equipment components of a construction project outlined in § 2.2. Reimbursement shall be in accordance with § 2.10 A with the limitations stated in § 2.2 B.

§ 2.11. Administrator/owner compensation.

A. Administrators' compensation, whether administrators are owners or non-owners, shall be based on a schedule adopted by DMAS and varied according to facility bed size. The compensation schedule shall be adjusted annually to reflect cost-of-living increases and shall be published and distributed to providers annually. The administrator's compensation schedule covers only the position of administrator and assistants and does not include the compensation of owners employed in capacities other than the NF administrator (see VR 460-03-4.1943, Cost Reimbursement Limitations).

B. Administrator compensation shall mean remuneration paid regardless of the form in which it is paid. This includes, but shall not be limited to, salaries, professional fees, insurance premiums (if the benefits accrue to the employer/owner or his beneficiary) director fees, personal use of automobiles, consultant fees, management fees, travel allowances, relocation expenses in excess of IRS guidelines, meal allowances, bonuses, pension plan costs, and deferred compensation plans. Management fees, consulting fees, and other services performed by owners shall be included in the total compensation if they are performing administrative duties regardless of how such services may be classified by the provider.

C. Compensation for all administrators (owner and nonowner) shall be based upon a 40 hour week to determine reasonableness of compensation.

D. Owner/administrator employment documentation.

1. Owners who perform services for a NF as an administrator and also perform additional duties must maintain adequate documentation to show that the additional duties were performed beyond the normal 40 hour week as an administrator. The additional duties must be necessary for the operation of the NF and related to patient care.

2. Services provided by owners, whether in employee capacity, through management contracts, or through home office relationships shall be compared to the cost and services provided in arms-length transactions.

3. Compensation for such services shall be adjusted where such compensation exceeds that paid in such arms-length transaction or where there is a duplication of duties normally rendered by an administrator. No reimbursement shall be allowed for compensation where owner services cannot be documented and audited.

§ 2.12. Depreciation.

The allowance for depreciation shall be restricted to the straight line method with a useful life in compliance with AHA guidelines. If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

§ 2.13. Rent/Leases.

Rent or lease expenses shall be limited by the provisions of VR 460-03-4.1942, Leasing of Facilities.

§ 2.14. Provider payments.

A. Limitations.

1. Payments to providers, shall not exceed charges for covered services except for (i) public providers furnishing services free of charge or at a nominal charge (ii) nonpublic provider whose charges are 60% or less of the allowable reimbursement represented by the charges and that demonstrates its charges are less than allowable reimbursement because its customary practice is to charge patients based on their ability to pay. Nominal charge shall be defined as total charges that are 60% or less of the allowable reimbursement of services represented by these charges. Providers qualifying in this section shall receive allowable reimbursement as determined in this Plan.

2. Allowable reimbursement in excess of charges may be carried forward for payment in the two succeeding cost reporting periods. A new provider may carry forward unreimbursed allowable reimbursement in the five succeeding cost reporting periods.

3. Providers may be reimbursed the carry forward to a succeeding cost reporting period (i) if total charges for the services provided in that subsequent period exceed the total allowable reimbursement in that period (ii) to the extent that the accumulation of the carry forward and the allowable reimbursement in that subsequent period do not exceed the providers' direct and indirect care operating ceilings plus allowable plant cost.

B. Payment for service shall be based upon the rate in effect when the service was rendered.

C. An interim settlement shall be made by DMAS within 90 days after receipt and review of the cost report. The word "review," for purposes of interim settlement, shall include verification that all financial and other data specifically requested by DMAS is submitted with the cost report. Review shall also mean examination of the cost report and other required submission for obvious errors, inconsistency, inclusion of past disallowed costs, unresolved prior year cost adjustments and a complete signed cost report that conforms to the current DMAS requirements herein.

However, an interim settlement shall not be made when one of the following conditions exists.

1. Cost report filed by a terminated provider;

2. Insolvency of the provider at the time the cost report is submitted;

3. Lack of a valid provider agreement and decertification;

4. Moneys owed to DMAS;

5. Errors or inconsistencies in the cost report; or

6. Incomplete/nonacceptable cost report.

§ 2.15. Legal fees/accounting.

A. Costs claimed for legal/accounting fees shall be limited to reasonable and customary fees for specific services rendered. Such costs must be related to patient care as defined by Medicare principles of reimbursement and subject to applicable regulations herein. Documentation for legal costs must be available at the time of audit.

B. Retainer fees shall be considered an allowable cost up to the limits established in VR 460-03-4.1943, Cost Reimbursement Limitations.

C. As mandated by the Omnibus Budget Reconciliation Act of 1990, effective November 5, 1990, reimbursement of

legal expenses for frivolous litigation shall be denied if the action is initiated on or after November 5, 1990. Frivolous litigation is any action initiated by the nursing facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action.

§ 2.16. Documentation.

Adequate documentation supporting cost claims must be provided at the time of interim settlement, cost settlement, audit, and final settlement.

§ 2.17. Fraud and abuse.

Previously disallowed costs which are under appeal and affect more than one cost reporting period shall be disclosed in subsequent cost reports if the provider wishes to reserve appeal rights for such subsequent cost reports. The reimbursement effect of such appealed costs shall be computed by the provider and submitted to DMAS with the cost report. Where such disclosure is not made to DMAS, the inclusion of previously disallowed costs may be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General.

Article 4.
New Nursing Facilities.

§ 2.18. Interim rate.

A. For all new or expanded NFs the 95% occupancy requirement shall be waived for establishing the first cost reporting period interim rate. This first cost reporting period shall not exceed 12 months from the date of the NF's certification.

B. Upon a showing of good cause, and approval of the DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate, or being treated as a new NF.

C. The 95% occupancy requirement shall be applied to the first and subsequent cost reporting periods' actual costs for establishing such NF's second and future cost reporting periods' prospective reimbursement rates. The 95% occupancy requirement shall be considered as having been satisfied if the new NF achieved a 95% occupancy at any point in time during the first cost reporting period.

D. A new NF's interim rate for the first cost reporting period shall be determined based upon the lower of its anticipated allowable cost determined from a detailed budget (or pro forma cost report) prepared by the provider and accepted by the DMAS, or the appropriate operating ceilings or charges.

E. Any NF receiving reimbursement under new NF status shall not be eligible to receive the blended phase-in period rate under § 2.8.

F. During its first semiannual period of operation, a newly constructed or newly enrolled NF shall have an assigned SII based upon its peer group's average SII for direct patient care. An expanded NF receiving new NF treatment, shall receive the SII calculated for its last semiannual period prior to obtaining new NF status.

§ 2.19. Final rate.

The DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined above in § 2.18 A, C, E, and F.

Upon determination of the actual allowable operating cost for direct patient care and indirect patient care the per diem amounts shall be used to determine if the provider is below the peer group ceiling used to set its interim rate. If costs are below those ceilings, an efficiency incentive shall be paid at settlement of the first year cost report.

This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable operating cost and the peer group ceiling used to set the interim rate. (Refer to § 2.7 F.)

Article 5.
Cost Reports.

§ 2.20. Cost report submission.

A. Cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, it is considered delinquent. The cost report shall be deemed complete when DMAS has received all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows. Multi-facility providers not having individual facility financial statements shall submit the "G" series schedules from the cost report plus a statement of changes in cash flow and corporate consolidated financial statements;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

B. When cost reports are delinquent, the provider's interim rate shall be reduced by 20% the first month and an additional 20% of the original interim rate for each subsequent month the report has not been submitted. DMAS shall notify the provider of the schedule of reductions which shall start on the first day of the following month. For example, for a September 30 fiscal year end, notification will be mailed in early January stating that payments will be reduced starting with the first payment in February.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

§ 2.21. Reporting form.

All cost reports shall be submitted on uniform reporting forms provided by the DMAS, or by Medicare if applicable. Such cost reports, subsequent to the initial cost report period, shall cover a 12-month period. Any exceptions must be approved by the DMAS.

§ 2.22. Accounting method.

The accrual method of accounting and cost reporting is mandated for all providers.

§ 2.23. Cost report extensions.

A. Extension for submission of a cost report may be granted if the provider can document extraordinary circumstances beyond its control.

B. Extraordinary circumstances do not include:

1. Absence or changes of chief finance officer, controller or bookkeeper;

2. Financial statements not completed;

3. Office or building renovations;

4. Home office cost report not completed;

5. Change of stock ownership;

6. Change of intermediary;

7. Conversion to computer; or

8. Use of reimbursement specialist.

§ 2.24. Fiscal year changes.

All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year.

Article 6.
Prospective Rates.

§ 2.25. Time frames.

A. A prospective rate shall be determined by DMAS within 90 days of the receipt of a complete cost report. (See § 2.20 A.) Rate adjustments shall be made retroactive to the first day of the provider's new cost reporting year. Where a field audit is necessary to set a prospective rate, the DMAS shall have an additional 90 days to determine any appropriate adjustments to the prospective rate as a result of such field audit. This time period shall be extended if delays are attributed to the provider.

B. Subsequent to establishing the prospective rate DMAS shall conclude the desk audit of a providers' cost report and determine if further field audit activity is necessary. The DMAS will seek repayment or make retroactive settlements when audit adjustments are made to costs claimed for reimbursement.

Article 7.
Retrospective rates.

§ 2.26. The retrospective method of reimbursement shall be used for Mental Health/Mental Retardation facilities.

§ 2.27. (reserved)

Article 8.
Record Retention.

§ 2.28. Time frames.

A. All of the NF's accounting and related records, including the general ledger, books of original entry, and statistical data must be maintained for a minimum of five years, or until all affected cost reports are final settled.

B. Certain information must be maintained for the duration of the provider's participation in the DMAS and until such time as all cost reports are settled. Examples of such information are set forth in § 2.29.

§ 2.29. Types of records to be maintained.

Information which must be maintained for the duration of the provider's participation in the DMAS includes, but is not limited to:

1. Real and tangible property records, including leases and the underlying cost of ownership;

2. Itemized depreciation schedules;

3. Mortgage documents, loan agreements, and amortization schedules;

4. Copies of all cost reports filed with the DMAS together with supporting financial statements.

§ 2.30. Record availability.

The records must be available for audits by DMAS staff. Where such records are not available, costs shall be disallowed.

Article 9.
Audits.

§ 2.31. Audit overview.

Desk audits shall be performed to verify the completeness and accuracy of the cost report, and reasonableness of costs claimed for reimbursement. Field audits, as determined necessary by the DMAS, shall be performed on the records of each participating provider to determine that costs included for reimbursement were accurately determined and reasonable, and do not exceed the ceilings or other reimbursement limitations established by the DMAS.

§ 2.32. Scope of audit.

The scope of the audit includes, but shall not be limited to: trial balance verification, analysis of fixed assets, indebtedness, selected revenues, leases and the underlying cost of ownership, rentals and other contractual obligations, and costs to related organizations. The audit scope may also include various other analyses and studies relating to issues and questions unique to the NF and identified by the DMAS. Census and related statistics, patient trust funds, and billing procedures are also subject to audit.

§ 2.33. Field audit requirements.

Field audits shall be required as follows:

1. For the first cost report on all new NF's.

2. For the first cost report in which costs for bed additions or other expansions are included.

3. When a NF is sold, purchased, or leased.

4. As determined by DMAS desk audit.

§ 2.34. Provider notification.

The provider shall be notified in writing of all adjustments to be made to a cost report resulting from desk or field audit with stated reasons and references to the appropriate principles of reimbursement or other appropriate regulatory cites.

§ 2.35. Field audit exit conference.

A. The provider shall be offered an exit conference to be executed within 15 days following completion of the on-site audit activities, unless other time frames are mutually agreed to by the DMAS and provider. Where two or more providers are part of a chain organization or under common ownership, DMAS shall have up to 90 days after completion of all related on-site audit activities to offer an exit conference for all such NFs. The exit conference shall be conducted at the site of the audit or at a location mutually agreeable to the DMAS and the provider.

B. The purpose of the exit conference shall be to enable the DMAS auditor to discuss such matters as the auditor deems necessary, to review the proposed field audit adjustments, and to present supportive references. The provider will be given an opportunity during the exit conference to present additional documentation and agreement or disagreement with the audit adjustments.

C. All remaining adjustments, including those for which additional documentation is insufficient or not accepted by the DMAS, shall be applied to the applicable cost report(s) regardless of the provider's approval or disapproval.

D. The provider shall sign an exit conference form that acknowledges the review of proposed adjustments.

E. After the exit conference the DMAS shall perform a review of all remaining field audit adjustments. Within a reasonable time and after all documents have been submitted by the provider, the DMAS shall transmit in writing to the provider a final field audit adjustment report (FAAR), which will include all remaining adjustments not resolved during the exit conference. The provider shall have 15 days from the date of the letter which transmits the FAAR, to submit any additional documentation which may affect adjustments in the FAAR.

§ 2.36. Audit delay.

In the event the provider delays or refuses to permit an audit to occur or to continue or otherwise interferes with the audit process, payments to the provider shall be reduced as stated in § 2.20 B.

§ 2.37. Field audit time frames.

A. If a field audit is necessary after receipt of a complete cost report, such audit shall be initiated within three years following the date of the last notification of program reimbursement and the on site activities, including exit conferences, shall be concluded within 180 days from the date the field audit begins. Where audits are performed on cost reports for multiple years or providers, the time frames shall be reasonably extended for the benefit of the DMAS and subject to the provisions of § 2.35.

B. Documented delays on the part of the provider will automatically extend the above time frames to the extent of the time delayed.

C. Extensions of the time frames shall be granted to the department for good cause shown.

D. Disputes relating to the timeliness established in §§ 2.35 and 2.37, or to the grant of extensions to the DMAS, shall be resolved by application to the Director of the DMAS or his designee.

PART III.
APPEALS.

§ 3.1. General.

A. NF's have the right to appeal the DMAS's interpretation and application of state and federal Medicaid and applicable Medicare principles of reimbursement in accordance with the Administrative Process Act, § 9-6.14.1 et seq. and § 32.1-325.1 of the Code of Virginia.

B. Nonappealable issues.

1. The use of state and federal Medicaid and applicable Medicare principles of reimbursement.

2. The organization of participating NF's into peer groups according to location as a proxy for cost variation across facilities with similar operating characteristics. The use of individual ceilings as a proxy for determining efficient operation within each peer group.

3. Calculation of the initial peer group ceilings using the most recent cost settled data available to DMAS that reflects NF operating costs inflated to September 30, 1990.

4. The use of the moving average of the Skilled Nursing Facility market basket of routine service costs, as developed by Data Resources, Incorporated, adjusted for Virginia, as the prospective escalator.

5. The establishment of separate ceilings for direct operating costs and indirect operating costs.

6. The use of Service Intensity Indexes to identify the resource needs of given NFs patient mix relative to the needs present in other NFs.

7. The development of Service Intensity Indexes based on:

a. Determination of resource indexes for each patient class that measures relative resource cost.

b. Determination of each NF's average relative resource cost index across all patients.

c. Standardizing the average relative resource cost indexes of each NF across all NF's.

8. The use of the DMAS Long Term Care Information System (LTCIS), assessment form (currently DMAS-95), Virginia Center on Aging Study, the State of Maryland Time and Motion Study of the Provision of Nursing Service in Long Term Care Facilities, and the KPMG Peat Marwick Survey of Virginia long-term care NF's nursing wages to determine the patient class system and resource indexes for each patient class.

9. The establishment of payment rates based on service intensity indexes.

§ 3.2. Conditions for appeal.

A. An appeal shall not be heard until the following conditions are met:

1. Where appeals result from desk or field audit adjustments, the provider shall have received a notification of program reimbursement (NPR) in writing from the DMAS.

2. Any and all moneys due to DMAS shall be paid in full, unless a repayment plan has been agreed to by the Director of the Division of Cost Settlement and Audit.

3. All first level appeal requests shall be filed in writing with the DMAS within 90 days following the receipt of a DMAS notice of program reimbursement that adjustments have been made to a specific cost report.

§ 3.3. Appeal procedure.

A. There shall be two levels of administrative appeal.

B. Informal appeals shall be decided by the Director of the Division of Cost Settlement and Audit after an informal fact finding conference is held. The decision of the Director of Cost Settlement and Audit shall be sent in writing to the provider within 30 days following conclusion of the informal fact finding conference.

C. If the provider disagrees with such initial decision the provider may, at its discretion, file a notice of appeal to the Director of the DMAS. Such notice shall be in writing and filed within 30 days of receipt of the initial decision.

D. Within 30 days of the receipt of such notice of appeal, the director shall appoint a hearing officer to conduct the proceedings, to review the issues and the evidence presented, and to make a written recommendation.

E. The director shall notify the provider of his final decision within 45 days of receipt of the appointed hearing officer's written recommendation, or after the parties have filed exceptions to the recommendations, whichever is later.

F. The director's final written decision shall conclude the provider's administrative appeal.

§ 3.4. Formal hearing procedures.

Formal hearing procedures, as developed by DMAS, shall control the conduct of the formal administrative proceedings.

§ 3.5. Appeals time frames.

Appeal time frames noted throughout this section may be extended for the following reasons;

A. The provider submits a written request prior to the due date requesting an extension for good cause and the DMAS approves the extension.

B. Delays on the part of the NF documented by the DMAS shall automatically extend DMAS's time frame to the extent of the time delayed.

C. Extensions of time frames shall be granted to the DMAS for good cause shown.

D. When appeals for multiple years are submitted by a NF or a chain organization or common owners are coordinating appeals for more than one NF, the time frames shall be reasonably extended for the benefit of the DMAS.

E. Disputes relating to the time lines established in § 3.3 B or to the grant of extensions to the DMAS shall be resolved by application to the Director of the DMAS or his designee.

PART IV.
INDIVIDUAL EXPENSE LIMITATION.

In addition to operating costs being subject to peer group ceilings, costs are further subject to maximum limitations as defined in VR 460-03-4.1943, Cost Reimbursement Limitations.

PART V.
COST REPORT PREPARATION INSTRUCTIONS.

Instructions for preparing NF cost reports will be provided by the DMAS.

PART VI.
STOCK TRANSACTIONS.

§ 6.1. Stock acquisition.

The acquisition of the capital stock of a provider does not constitute a basis for revaluation of the provider's assets. Any cost associated with such an acquisition shall not be an allowable cost. The provider selling its stock continues as a provider after the sale, and the purchaser is only a stockholder of the provider.

§ 6.2. Merger of unrelated parties.

A. In the case of a merger which combines two or more unrelated corporations under the regulations of the Code of Virginia, there will be only one surviving corporation. If the surviving corporation, which will own the assets and liabilities of the merged corporation, is not a provider, a Certificate of Public Need, if applicable, must be issued to the surviving corporation.

B. The nonsurviving corporation shall be subject to the policies applicable to terminated providers, including those relating to gain or loss on sales of NFs.

§ 6.3. Merger of related parties.

The statutory merger of two or more related parties or the consolidation of two or more related providers resulting in a new corporate entity shall be treated as a transaction between related parties. No revaluation shall be permitted for the surviving corporation.

PART VII.
NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM AND COMPETENCY EVALUATION PROGRAMS (NATCEPs).

§ 7.1. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) amended § 1903(a)(2)(B) of the Social Security Act to fund actual NATCEPs costs incurred by NFs separately from the NF's medical assistance services reimbursement rates.

§ 7.2. NATCEPs costs.

A. NATCEPs costs shall be as defined in VR 460-03-4.1941.

B. To calculate the reimbursement rate, NATCEPs costs contained in the most recently filed cost report shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days.

C. The NATCEPs interim reimbursement rate determined in § 7.2 B shall be added to the prospective operating cost and plant cost components or charges, whichever is lower, to determine the NF's prospective rate. The NATCEPs interim reimbursement rate shall not be adjusted for inflation.

D. Reimbursement of NF costs for training and competency evaluation of nurse aides must take into account the NF's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid shall not be charged for that portion of NATCEPs costs which are properly charged to Medicare or private pay services. The final retrospective reimbursement for NATCEPs costs shall be the reimbursement rate as calculated from the most recently filed cost report by the methodology in § 7.2 B times the Medicaid patient days from the DMAS MMR-240.

E. Disallowance of nonreimbursable NATCEPs costs shall be reflected in the year in which the nonreimbursable costs were claimed.

F. Payments to providers for allowable NATCEPs costs shall not be considered in the comparison of the lower allowable reimbursement or charges for covered services, as outlined in § 2.14 A.

PART VIII.
(Reserved)

PART IX.
USE OF MMR-240.

All providers must use the data from computer printout MMR-240 based upon a 60-day accrual period.

PART X.
COMMINGLED INVESTMENT INCOME.

DMAS shall treat funds commingled for investment purposes in accordance with PRM-15, § 202.6.

PART XI.
PROVIDER NOTIFICATION.

DMAS shall notify providers of State Plan changes affecting reimbursement 30 days prior to the enactment of such changes.

PART XII.
START-UP COSTS AND ORGANIZATIONAL COSTS.

§ 12.1. Start-up costs.

A. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they shall be capitalized as deferred charges and amortized over a 60-month time frame.

B. Start-up costs may include, but are not limited to, administrative and nursing salaries; heat, gas, and electricity; taxes, insurance; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as operating costs must be appropriately classified as such and excluded from start-up costs.

C. Start-up costs that are incurred immediately before a provider enters the Program and that are determined by the provider, subject to the DMAS approval, to be immaterial need not be capitalized but rather may be charged to operations in the first cost reporting period.

D. Where a provider incurs start-up costs while in the Program and these costs are determined by the provider, subject to the DMAS approval, to be immaterial, these costs shall not be capitalized but shall be charged to operations in the periods incurred.

§ 12.2. Applicability.

A. Start-up cost time frames.

1. Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient (whether Medicaid or non-Medicaid) is admitted for treatment, or where the start-up costs apply only to nonrevenue producing patient care functions or nonallowable functions, to the time the areas are used for their intended purposes.

2. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility shall be accumulated in a single deferred charge account and shall be amortized when the first patient is admitted for treatment.

3. If a provider intends to prepare portions of its facility on a piecemeal basis (i.e., preparation of a floor or wing of a provider's facility is delayed), start-up costs shall be capitalized and amortized separately for the portion or portions of the provider's facility prepared during different time periods.

4. Moreover, if a provider expands its NF by constructing or purchasing additional buildings or wings, start-up costs shall be capitalized and amortized separately for these areas.

B. Depreciation time frames.

1. Costs of the provider's facility and building equipment shall be depreciated using the straight line method over the lives of these assets starting with the month the first patient is admitted for treatment.

2. Where portions of the provider's NF are prepared for patient care services after the initial start-up period, those asset costs applicable to each portion shall be depreciated over the remaining lives of the applicable assets. If the portion of the NF is a nonrevenue-producing patient care area or nonallowable area, depreciation shall begin when the area is opened for its intended purpose. Costs of major movable equipment, however, shall be depreciated over the useful life of each item starting with the month the item is placed into operation.

§ 12.3. Organizational costs.

A. Organizational costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organizational

costs extend over more than one accounting period and thus affect the costs of future periods of operations.

B. Allowable organizational costs shall include, but not be limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders and fees paid to states for incorporation.

C. The following types of costs shall not be considered allowable organizational costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate state or federal authorities, stamp taxes, etc.

D. Allowable organization costs shall generally be capitalized by the organization. However, if DMAS concludes that these costs are not material when compared to total allowable costs, they may be included in allowable indirect operating costs for the initial cost reporting period. In all other circumstances, allowable organization costs shall be amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.

PART XIII.
DMAS AUTHORIZATION.

§ 13.1 Access to records.

A. DMAS shall be authorized to request and review, either through a desk or field audit, all information related to the provider's cost report that is necessary to ascertain the propriety and allocation of costs (in accordance with Medicare and Medicaid rules, regulations, and limitations) to patient care and nonpatient care activities.

B. Examples of such information shall include, but not be limited to, all accounting records, mortgages, deeds, contracts, meeting minutes, salary schedules, home office services, cost reports, and financial statements.

C. This access also applies to related organizations as defined in § 2.10 who provide assets and other goods and services to the provider.

PART XIV.
HOME OFFICE COSTS.

§ 14.1. General.

Home office costs shall be allowable to the extent they are reasonable, relate to patient care, and provide cost savings to the provider.

§ 14.2. Purchases.

Provider purchases from related organizations, whether for services, or supplies, shall be limited to the lower of the related organizations actual cost or the price of comparable purchases made elsewhere.

§ 14.3. Allocation of home office costs.

Home office costs shall be allocated in accordance with § 2150.3, PRM-15.

§ 14.4. Nonrelated management services.

Home office costs associated with providing management services to nonrelated entities shall not be recognized as allowable reimbursable cost.

§ 14.5. Allowable and nonallowable home office costs.

Allowable and nonallowable home office costs shall be recognized in accordance with § 2150.2, PRM-15.

§ 14.6. Equity capital.

Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

PART XV.
REFUND OF OVERPAYMENTS.

§ 15.1. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk audit, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS' determination of the overpayment.

§ 15.2. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall be used to reduce the balance of the overpayment.

§ 15.3. Payment schedule.

A. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request in writing an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly

request in writing an extended repayment schedule.

B. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of DMAS may approve a repayment schedule of up to 36 months.

C. A provider shall have no more than one extended repayment schedule in place at one time. If subsequent audits identify additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amounts.

D. If, during the time an extended repayment schedule is in effect, the provider ceases to be a participating provider or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

E. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered from interim payments to the provider or by lump sum payments.

§ 15.4. Extension request documentation.

In the written request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

§ 15.5. Interest charge on extended repayment.

A. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

B. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

C. The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

PART XVI.
REVALUATION OF ASSETS.

§ 16.1. Change of ownership.

A. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, reimbursement for capital upon the change of ownership of a NF is restricted to the lesser of:

1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year, or

2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

B. To comply with the provisions of COBRA 1985, effective October 1, 1986, the DMAS shall separately apply the following computations to the capital assets of each facility which has undergone a change of ownership:

1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index, or

2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U).

C. Change of ownership is deemed to have occurred only when there has been a bona fide sale of assets of a NF (See § 2.5 B 3 for the definition of "bona fide" sale).

D. Reimbursement for capital assets which have been revalued when a facility has undergone a change of ownership shall be limited to the lesser of:

1. The amounts computed in subsection B above;

2. Appraised replacement cost value; or

3. Purchase price.

* * *

NOTICE: The forms used in administering the above regulations are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Nursing Facility Uniform Cost Report Under Title XIX - Facility Description and Statistical Data (Schedule A)
Certification by Officer or Administrator of Provider (Schedule A-2)
Reclassification and Adjustment of Trial Balance of Expenses (Schedule B)
Classifications (Schedule B-1)
Analysis of Administrative and General - Other (Schedule B-2)
Adjustment to Expenses (Schedule B-4)
Cost Allocation - Employee Benefits (Schedule B-5)
Computation of Title XIX Direct Patient Care Ancillary Service Costs (Schedule C)
Statement of Cost of Services and Related Organizations (Schedule D)
Statement of Compensation of Owners (Schedule E)
Part II Statement of Compensation Administrators and/or Assistant Administrators (Schedule F)
Balance Sheet (Schedule G)
Statement of Patient Revenues (Schedule G-1)
Statement of Operations (Schedule G-2)
Computation of Title XIX (Medicaid) Base Costs and Prospective Rate/PIRS (Schedule H)
Computation of Prospective Direct and Indirect Patient Care Profit Incentive Rates (Schedule H-1)
Calculation of Medical Service Reimbursement Settlement (Schedule J)
Calculation of NATCEPs Reimbursement Settlement (Schedule J-1)
Debt and Interest Expenses (Schedule K)
Limitation on Federal Participation for Capital Expenditures Questionnaire (Schedule L)
Nurse Aide Training and Competency Evaluation Program Costs and Competency Evaluation Programs (NATCEPs) (Schedule N)
Certification by Officer or Administrator of Provider (Schedule A-1)
Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Statistical Data (Worksheet S-3)
Reclassification and Adjustment of Trial Balance of Expenses (Worksheet A)
Reclassification (Worksheet A-6)
Adjustments to Expenses (Worksheet A-8)
Statement of Costs of Services from Related Organizations (Supplemental Worksheet A-8)
Cost Allocation - General Service Costs (Worksheet B, Part I)
Cost Allocation - Statistical Basis (Worksheet B-1)
Allocation of Capital-Related Costs (Worksheet B, Part II)
Departmental Cost Distribution (Worksheet C)
Computation of Patient Intensity Reimbursement System Base Operating Costs (Schedule A-3)
Computation of Direct Patient Care Nursing Service Costs (Schedule A-4)

BOARD OF MEDICINE

Title of Regulation: **VR 465-05-1. Regulations Governing the Practice of Physicians' Assistants.**

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Effective Date: April 8, 1992.

Summary:

These regulations protect the health, safety, and welfare of the citizens of the Commonwealth by establishing requirements for license, license fees, and renewal of license.

The amendments to the current regulations redefine the license renewal period to be biennial in each odd-numbered year in the birth month of the licensee; adjust the renewal fee to reflect the extended renewal period; and delete the term "certification" and insert the term "licensure" to comply with the recodification of Title 54.1 of the Code of Virginia.

VR 465-05-01. Regulations Governing the Practice of Physicians' Assistants.

PART I.
GENERAL PROVISIONS.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meanings, unless the context clearly indicates otherwise:

"Assistant to a Doctor of Medicine, Osteopathy, or Podiatry," or *"Physician's Assistant,"* means an individual who is qualified as an auxiliary paramedical person by academic and clinical training and is functioning in a dependent-employee relationship with a doctor of medicine, osteopathy, or podiatry licensed by the board.

"Board" means the Virginia Board of Medicine.

"Committee" means the Advisory Committee on Physician's Assistants appointed by the president of the board to advise the board on matters relating to physician's assistants. The committee is composed of four members of the board, one supervising physician, and two

physician's assistants.

"Group practice" means the practice of a group of two or more doctors of medicine, osteopathy, or podiatry licensed by the board who practice as a partnership or professional corporation.

"Institution" means a hospital, nursing home or other health care facility, community health center, public health center, industrial medicine or corporation clinic, a medical service facility, student health center, or other setting approved by the board.

"NCCPA" means the National Commission on Certification of Physician Assistants.

"Protocol" means a set of directions developed by the supervising physician that defines the supervisory relationship between the physician assistant and the physician and the circumstances under which the physician will see and evaluate the patient.

~~*"Supervising physician"* means a doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth of Virginia who has registered with the board and who has accepted responsibility for the supervision of the service that a physician's assistant renders.~~

"Supervision means" :

1. *"Alternate supervising physician"* means a member of the same group or professional corporation or partnership of any licensee, any hospital or any commercial enterprise with the supervising physician. Such alternating supervising physician shall be a physician licensed in the Commonwealth of Virginia who has registered with the board and who has accepted responsibility for the supervision of the service that a physician's assistant renders.

2. *"Direct supervision"* means the physician is in the room in which a procedure is being performed.

3. *"General supervision"* means the supervising physician is easily available and can be physically present within one hour.

4. *"Personal supervision"* means the supervising physician is within the facility in which the physician's assistant is functioning.

5. *"Supervising physician"* means the supervising physician who makes application to the board for licensure of the assistant.

6. *"Substitute supervising physician"* means a doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth of Virginia who has accepted responsibility for the supervision of the service that a physician's assistant renders in the absence of such assistant's supervising physician.

§ 1.2. Applicability.

These regulations apply to physician's assistants only, as defined in § 1.1.

§ 1.3. A separate board regulation, VR 465-01-01, entitled Public Participation Guidelines, which provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine, is incorporated by reference in these regulations.

PART II.
REQUIREMENTS FOR PRACTICE AS A PHYSICIAN'S ASSISTANT.

§ 2.1. Requirements, general.

A. No person shall practice as a physician's assistant in the Commonwealth of Virginia except as provided in these regulations.

B. All services rendered by a physician's assistant shall be performed only under the supervision of a doctor of medicine, osteopathy, or podiatry licensed by this board to practice in the Commonwealth of Virginia.

§ 2.2. ~~Certification,~~ *Licensure:* Entry requirements and application.

A. A ~~certificate~~ *license* to practice as a physician's assistant shall be obtained from the board before such assistant begins to practice with a supervising doctor of medicine, osteopathy, or podiatry.

B. Entry requirements.

An applicant for ~~certification~~ *licensure* shall:

1. Possess the educational qualifications prescribed in § 2.3 of these regulations; and

2. Meet the requirements for examination prescribed in §§ 3.1 through 3.3 of these regulations.

C. Application for board approval of a physician's assistant shall be submitted to the board by the supervising physician under whom the assistant will work, and who will assume the responsibility for the assistant's performance. By submitting the application, the supervising physician attests to the general competence of the assistant. In a group or institutional practice setting, the supervising physician shall be the contact for the board regardless of whether the supervision has been delegated to an alternate or substitute supervising physician.

D. The application shall:

1. Be made on forms supplied by the board and completed in every detail;

2. Spell out the roles and functions of the assistant

with a protocol acceptable to the board and any such protocols shall take into account such factors as the number of patients, the types of illness treated by the physician, the nature of the treatment, special procedures, and the nature of the physician's availability in ensuring direct physician involvement at an early stage and regularly thereafter;

The board may require, at its discretion, in a supplement to the application, information regarding the level of supervision, "direct," "personal" or "general," with which the supervising physician plans to supervise the physician's assistant for selected tasks. The board may also require the supervising physician to document the assistant's competence in performing such tasks.

3. Provide that if, for any reason, the assistant discontinues working in the employment and under the supervision of the licensed practitioner who submitted the application:

a. Such assistant and the employing practitioner shall so inform the board and the assistant's approval shall terminate.

b. A new application shall be submitted to the board and approved by the board in order for the assistant either to be reemployed by the same practitioner or to accept new employment with another supervising physician.

E. The application fee prescribed in § 5.1 of these regulations shall be paid at the time the application is filed.

§ 2.3. Educational requirements.

An applicant for ~~certification~~ *licensure* shall:

1. Have successfully completed a prescribed curriculum of academic study in a school or institution accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association and accredited by the American Academy of Physician Assistants; and

2. Present documented evidence of eligibility for the NCCPA examination or completed ~~certification~~ *licensure* requirements.

PART III.
EXAMINATION.

§ 3.1. The proficiency examination of the NCCPA constitutes the board examination required of all applicants for ~~certification~~ *licensure* .

§ 3.2. Provisional registration.

An applicant who has met the requirements of the board at the time his initial application is submitted may be granted provisional registration by the board if he meets the provisions of § 54.1-2950 of the Code of Virginia and § 2.3 of these regulations. Such provisional ~~registration~~ *licensure* shall be subject to the following conditions:

A. The provisional ~~registration~~ *licensure* shall be valid until the applicant takes the next subsequent NCCPA examination and its results are reported, but this period of validity shall not exceed 30 days following the reporting of the examination scores.

B. An applicant who fails the examination may be granted individual consideration by the board and granted an extension of the provisional ~~registration~~ *licensure* upon evidence that he is eligible for admission to the next scheduled board examination.

§ 3.3. Examination.

A. Every applicant shall take the NCCPA examination at the time scheduled by the NCCPA.

B. An applicant who fails the examination three consecutive times shall surrender his ~~certificate~~ *license* to practice until proof has been provided to the board that the standards of NCCPA have been met.

§ 3.4. Renewal of ~~certificate~~ *license* .

A. Every ~~certified~~ *licensed* physician's assistant intending to continue ~~his~~ *to* practice shall ~~annually on or before July 1~~ *biennially renew the license in each odd numbered year in the licensee's birth month* :

1. Register with the board for renewal of his ~~certificate~~ *license* ;

2. Present documented evidence of compliance with continuing medical education standards established by the NCCPA; and

3. Pay the ~~prescribed~~ renewal fee *as prescribed in § 5.1 B* at the time ~~he files for~~ *of filing the license* renewal.

B. Any physician's assistant who allows his NCCPA certification to lapse shall be considered not ~~certified~~ *licensed* by the board. Any such assistant who proposes to resume his practice shall make a new application for ~~certification~~ *licensure* .

PART IV.
INDIVIDUAL RESPONSIBILITIES.

§ 4.1. Individual responsibilities.

A supervising physician and the physician's assistants working with him shall observe the following division of responsibilities in the care of patients:

A. The supervising physician shall:

1. See and evaluate any patient who presents ~~with~~ the same complaint twice in a single episode of care and has failed to improve significantly. Such physician involvement shall occur not less frequently than every fourth visit for a continuing illness.

2. Review the record of services rendered the patient by the physician's assistant and sign such records within 24 hours after any such care was rendered by the assistant.

3. Be responsible for all invasive procedures. Under general supervision, a physician's assistant may insert a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow-directed catheter, and may perform minor suturing, venipucture, and subcutaneous intramuscular or intravenous injection.

All other invasive procedures not listed above must be performed under direct supervision unless, after directly supervising the performance of a specific invasive procedure three times or more, the supervising physician attests to the competence of the physician's assistant to perform the specific procedure without direct supervision by certifying to the board in writing the number of times the specific procedure has been performed and that the physician's assistant is competent to perform the specific procedure. After such certification has been accepted and approved by the board, the physician's assistant may perform the procedure under general supervision.

B. The physician's assistant shall not render independent health care. Such assistant:

1. Shall perform only those medical care services that are within the scope of the practice and proficiency of the supervising physician as prescribed in the physician's assistants protocol;

2. Shall not sign prescriptions;

3. Shall, during the course of performing his duties, wear identification showing clearly that he is a physician's assistant.

C. If the assistant is to perform duties away from the supervising physician, such supervising physician shall obtain board approval in advance for any such arrangement and shall establish written policies to protect the patient.

D. If, due to illness, vacation, or unexpected absence, the supervising physician is unable to supervise personally the activities of his assistant, such supervising physician may temporarily delegate the responsibility to another doctor of medicine, osteopathy, or podiatry. The employing supervising physician so delegating his responsibility shall report such arrangement for coverage, with the reason therefor, to the board office in writing, subject to the following provisions:

1. For planned absence, such notification shall be received at the board office at least one month prior to the supervising physician's absence;

2. For sudden illness or other unexpected absence, the board office shall be notified as promptly as possible, but in no event later than one week;

3. Temporary coverage may not exceed four weeks unless special permission is granted by the board.

E. With respect to assistants employed by institutions, the following additional regulations shall apply:

1. No assistant may render care to a patient unless the physician responsible for that patient has signed an application to act as supervising physician for that assistant. The board shall make available appropriate forms for physicians to join the application for an assistant employed by an institution.

2. Any such application as described in subdivision 1 above shall delineate the duties which said physician authorizes the assistant to perform.

3. The assistant shall as soon as circumstances may dictate but, within an hour, report to the supervising physician concerning the examination of the patient. The assistant shall also record his findings in appropriate institutional records.

4. No physician assistant shall perform the initial evaluation, or institute treatment of a patient who presents to the emergency room or is admitted to the hospital for a life threatening illness or injury. In noncritical care areas, the physician assistant may perform the initial evaluation in an inpatient setting provided the supervising physician evaluates the patient within eight hours of the physician assistant's initial evaluation.

PART V.
FEES.

§ 5.1. The following fees are required:

A. The application fee, payable at the time application is filed, shall be $100.

B. The ~~annual~~ *biennial* fee for renewal of ~~registration,~~ *license shall be $80* payable ~~on or before July 1, shall be $40~~ *in each odd numbered year in the birth month of the licensee* .

C. An additional fee to cover administrative costs for processing a late application may be imposed by the board. The additional fee for late renewal of licensure

shall be $10 for each renewal cycle.

* * *

NOTICE: The forms used in administering the Physician's Assistants Regulations are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Board of Medicine, 1601 Rolling Hills Drive, Suite 200, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Instructions for Completing Physician Assistant Application.
Application for Certification as a Physician's Assistant (DHP-30-056), Revised 8/91.
Protocol of Physician's Assistant's Duties (Form #1).
Physician Assistant Invasive Procedures Protocol (Form #2).
Employment Verification (HRB-30-056) # B.
License Verification (HRB-30-056) # C.

* * * * * * * *

Title of Regulation: **VR 465-10-01. Certification of Radiological Technology Practitioners.**

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Effective Date: April 8, 1992.

Summary:

These regulations establish the requirements for certification of persons practicing as radiological technology practitioners in the Commonwealth of Virginia and include the verification of an accredited educational program, the passing of a qualifying examination, and the completion of the prescribed application and fees. The regulations also provide for the renewal or reinstatement of certifications and for the scope of individual practice responsibilities and relationship with the referring licensed practitioner.

VR 465-10-01. Certification of Radiological Technology Practitioners.

PART I.
GENERAL PROVISIONS.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meanings, unless the context clearly indicates otherwise:

"AMA" means the American Medical Association.

"ARRT" means the American Registry of Radiologic Technologists.

"ASRT" means the American Society of Radiologic Technologists.

"Board" means the Virginia Board of Medicine.

"CAHEA" means the Committee on Allied Health Education and Accreditation of the American Medical Association.

"Certification examination" means an examination administered by the American Registry of Radiologic Technologists or other examinations approved by the board.

"Certified Radiological Technology Practitioner (C.R.T.P.)" means a person who is qualified by education or training to perform radiologic procedures and has been issued a certificate by the board.

"Committee" means the Advisory Committee on Radiological Technology.

"Practitioner" means any licensed doctor of medicine, osteopathy, podiatry, chiropractic, or dentistry who prescribes radiologic procedures for diagnostic or therapeutic purposes.

"Referral and direction" means to provide patient services using diagnostic or therapeutic modalities prescribed by a licensed practitioner.

§ 1.2. Violations.

Any violation of Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1 shall be subject to statutory sanctions as set forth in the Code of Virginia.

PART II.
REQUIREMENTS FOR PRACTICE AS A CERTIFIED RADIOLOGICAL TECHNOLOGY PRACTITIONER.

§ 2.1. Requirements, general.

A. No person shall practice as a certified radiological technology practitioner in the Commonwealth of Virginia except as provided in these regulations.

B. Certification by the board to practice as a certified radiological technology practitioner shall be by examination as prescribed in these regulations.

§ 2.2. Certification.

A. An applicant for certification to practice as a certified radiological technology practitioner shall:

1. Make an application on forms supplied by the board by responding to all questions;

2. Pay, at the time of filing the application, an application fee prescribed in subdivision 1 of § 5.1 of

these regulations;

3. Submit to the board written evidence from the American Registry of Radiologic Technologists, or other organizations approved by the board, that the applicant has passed an appropriate examination; and

4. Present such other documents as requested by the board concerning education, work experience, and employment history.

PART III.
RENEWAL OF CERTIFICATION; REINSTATEMENT.

§ 3.1. Biennial renewal of certification.

A. Each certified radiological technology practitioner shall renew his certification biennially on or before July 1 of each odd-numbered year by:

1. Paying to the board the renewal fee prescribed in subdivision 2 of § 5.1 of these regulations;

2. Submitting evidence of having a current certificate issued by the ARRT or other organizations approved by the board; and

3. Paying an additional fee to cover administrative costs for processing a late renewal application which shall be imposed by the board as prescribed in subdivision 3 of § 5.1.

§ 3.2. Reinstatement.

A. A C.R.T.P. who allows his certification to lapse for a period of two years or more and elects to reinstate his certification shall make a new application to the board and pay a fee as prescribed in subdivision 4 of § 5.1.

B. A C.R.T.P. whose certification has been revoked by the board and who requests to be reinstated must make a new application to the board and pay a fee for reinstatement of his certification as prescribed in subdivision 5 of § 5.1 and meet conditions set forth in § 54.1-2921 of the Code of Virginia.

PART IV.
PRACTICE OF THE CERTIFIED RADIOLOGICAL TECHNOLOGY PRACTITIONER (C.R.T.P.).

§ 4.1. General responsibilities.

A C.R.T.P. provides patient services using diagnostic or therapeutic modalities as referred and directed by a licensed practitioner as defined in Part I, § 1.1.

PART V.
FEES.

§ 5.1. Fees.

The following fees have been established by the board:

1. The application fee for the certified radiological technology practitioner shall be $100.

2. The fee for biennial certification renewal shall be $80.

3. The fee for processing a late certification renewal shall be $25 for each renewal cycle.

4. The fee for reinstatement of a lapsed certification as prescribed in § 3.2 shall be $100.

5. The fee for reinstatement of a revoked certification shall be $500.

6. The fee for a letter of good standing or verification to another state for certification shall be $10.

Attachment E

DHP-030-081
Rev. 10/91

COMMONWEALTH of VIRGINIA

DEPARTMENT OF HEALTH PROFESSIONS
BOARD OF MEDICINE
1601 ROLLING HILLS DRIVE
RICHMOND, VA 23229-5005
(804) 662-9908

APPLICATION
FOR CERTIFICATION
TO PRACTICE
AS A
RADIOLOGICAL TECHNOLOGY
PRACTITIONER CERTIFIED

SECURELY PASTE
A PASSPORT SIZE
PHOTOGRAPH

TO THE BOARD OF MEDICINE OF VIRGINIA:

I HEREBY MAKE APPLICATION FOR CERTIFICATION TO PRACTICE AS A RADIOLOGICAL TECHNOLOGY PRACTITIONER IN THE COMMONWEALTH OF VIRGINIA AND SUBMIT THE FOLLOWING STATEMENTS:

1. NAME IN FULL (PLEASE PRINT OR TYPE)

(LAST)	(FIRST)	(MIDDLE/MAIDEN)	(JR./SR.)
(STREET)	(CITY)	(STATE)	(ZIP CODE)
(DATE OF BIRTH) MO DAY YR	(PLACE OF BIRTH)	(SOCIAL SECURITY NUMBER)	
(GRADUATION DATE) MO DAY YR	(PROF. SCH. DEGREE, OR CERTIFICATE)	(SCHOOL, CITY, STATE)	

*PLEASE SUBMIT ADDRESS CHANGES IN WRITING IMMEDIATELY!

*PLEASE ATTACH CHECK OR MONEY ORDER. APPLICATIONS WILL NOT BE PROCESSED WITHOUT THE APPROPRIATE FEE. DO NOT SUBMIT FEE WITHOUT AN APPLICATION. IT WILL BE RETURNED.

APPLICANTS DO NOT USE SPACES BELOW THIS LINE — FOR OFFICE USE ONLY

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

APPROVED BY: ______________________________ Date

(CLASS)	(LICENSE NO.)	(SUFFIX)	(SCH. CODE)	(FEE)	(HOW REG.)	(BASE STATE)
(CERTIFICATE NO.)	(EXPIRATION DATE)			(DATE ISSUED)		

(ADDRESS CHANGE)

(STREET)	(CITY)	(STATE)	(ZIP CODE)

2. List in chronological order all professional practice since graduation (e.g. hospital department, outpatient centers, etc.). Also list all periods of absences from work and non-professional activity/employment of more than three months. Please account for all time. If engaged in private practice, list hospital or other professional practice.

From	To	Location and Complete Address	Position Held

ALL QUESTIONS MUST BE ANSWERED. If any of the following questions is answered YES, explain and substantiate with documentation.

3. List all jurisdictions in which you have been issued a license or certificate to practice radiologic technology: active, inactive, or expired: _____

_____

_____

Do you intend to engage in the active practice as a Radiological Technology Practitioner in the Commonwealth of Virginia?
(a) If YES, give location _____.

4. Have you ever been denied the privilege of taking an examination for licensure or certification in another state as a Radiologic Technologist? Explain. ___ Yes ___ No

5. Have you successfully completed the ARRT Certification examination? If so, provide date _____ and certification number _____. ___ Yes ___ No

6. Have you ever been denied, for any reason, a license or certificate to practice as a Radiologic Technologist in another state? Explain. ___ Yes ___ No

7. Have you ever been convicted of a violation of, or pled Nolo Contendere to any Federal, State, or local statute, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence). ___ Yes ___ No

8. Have you ever been censured, warned, requested to withdraw from or otherwise disciplined by any hospital, nursing home, or other health care facility? ___ Yes ___ No

9. Have you ever had any of the following disciplinary actions taken against your license or certificate to practice as a Radiologic Technologist, or are any such actions pending? (a) suspension or revocation (b) probation (c) reprimand or cease and desist (d) have your practice monitored. ___ Yes ___ No

10. Have you ever had any membership in a state or local professional society revoked, suspended, or involuntarily withdrawn? ___ Yes ___ No

11. Have you had any malpractice suits brought against you in the last two years? Provide details. ___ Yes ___ No

12. Have you ever been treated by, consulted with, or been under care of a professional for substance abuse? If so, provide a letter from the treating professional which includes diagnosis, treatment, and prognosis. ___ Yes ___ No

13. Have you ever received treatment or been hospitalized for a nervous, emotional or mental disorder? If so, provide a letter from your treating professional summarizing diagnosis, treatment, and prognosis. ___ Yes ___ No

14. Have you ever had a physical disease or diagnosis that may affect your performance of professional duties? If so, provide a letter from the treating professional which includes diagnosis, treatment, and prognosis. ___ Yes ___ No

15. Have you ever been adjudged mentally incompetent or been voluntarily or involuntarily committed to a mental institution? Provide details. ___ Yes ___ No

16. **AFFIDAVIT OF APPLICANT:**

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Virginia Board of Medicine any information, files, or records requested by the Board in connection with the processing of individuals and groups listed above, any information which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my certificate to practice as a Radiological Technology Practitioner in the Commonwealth of Virginia.

RIGHT THUMB PRINT

IF RIGHT THUMB IS MISSING, USE LEFT AND SO INDICATE.

THIS MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC

_____
SIGNATURE OF APPLICANT

NOTARY: City/County of _____ State of _____

Subscribed and Sworn to before me this _____ day of _____ 19____

My Commission Expires _____

_____
NOTARY PUBLIC

(NOTARY SEAL)

* *

CERTIFICATE OF PROFESSIONAL EDUCATION

It is hereby certified that _____
NAME OF APPLICANT

matriculated in _____ on _____
COURSE OF STUDY DATE

and received/will receive a diploma or certificate _____
INSTITUTION

conferring the degree or certificate _____
DEGREE

on _____.
DATE

SCHOOL SEAL

_____
(DEAN, PROGRAM DIRECTOR OR CHAIRMAN)

DHP-030-081
Rev. 10/91
RADIOLOGICAL TECHNOLOGY PRACTITIONER

Please complete top portion and forward one form to each state Board or regulatory authority where you hold or have held an Radiologic Technologist certification and/or license. Extra copies may be xeroxed if needed.

NOTE: Some states or jurisdictions require a fee, paid in advance, for providing clearance information. To expedite, you may wish to contact the applicable agencies.

* *

CLEARANCE FROM OTHER STATE BOARD OR REGULATORY AUTHORITY

I was granted license and/or certificate # _____ on _____

by the state or regulatory authority of _____. The Virginia Board of medicine requests that I submit evidence that my license and/or certification to practice in _____ is in good standing. You are hereby authorized to release any information in your files, favorable, or otherwise, directly to the Virginia Board of Medicine, 1601 Rolling Hills Drive, Richmond, Virginia 23229-5005. Your earliest attention is appreciated.

_____
Signature

_____
(Please print or type name)

* *

Executive Office of State Board or Other Regulatory Authority:

Please complete and return this form to the Virginia Board of Medicine, 1601 Rolling Hills Drive, Richmond, Virginia 23229-5005.

Name of Jurisdiction _____ Name of Licensee _____

License and/or Certificate No. _____ Date Issued _____

Licensed and/or Certified through (Check one)

☐ ARRT Examination ☐ State Board Examination

☐ Reciprocity from _____
Name of State

License and/or Certificate is: ☐ Current ☐ Lapsed

Has applicant's License and/or Certificate ever been suspended or revoked? ☐ YES ☐ NO. If so, for what reason?

_____

_____

Derogatory Information, if any _____

_____

_____
Signature

(BOARD SEAL)

_____
Title

_____
Name of Regulatory Authority

Rev. 10/91
RADIOLOGICAL TECHNOLOGY PRACTITIONER

VIRGINIA BOARD OF MEDICINE
1601 Rolling Hills Drive
Richmond, VA 23229-5005

Please print or type name of hospital or place of employment:

_____

_____

_____

_____
(Name of Applicant - Please Print)

The Virginia Board of Medicine, in its consideration of a candidate for certification, depends on information from persons and institutions regarding the candidate's employment, training, affiliations and staff privileges.

Please complete this form to the best of your ability and return it to the Board so the information you provide can be given consideration in the processing of this candidate's application in a timely manner.

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of my application.

_____
Signature of Applicant

1. Date and type of service: This individual served with us as _____

from (month) _____ (year) _____ to (month) _____ (year) _____

2. Please evaluate: (Please indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge				
Clinical judgement				
Relationship with patients				
Ethical/professional conduct				
Interest in work				
Ability to communicate				

3. Recommendation: (Please indicate with check mark)
1. Recommend highly and without reservation _____
2. Recommend as qualified and competent _____
3. Recommend with some reservation (explain) _____
4. Do not recommend (explain) _____

4. Of particular value to us in evaluating any candidate are comments regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you.

_____

_____

5. The above report is based on: (Please indicate with check mark)
1. Close personal observation _____
2. General impression _____
3. A composite of evaluations _____
4. Other _____

Date: _____ Signed: _____

_____
(Please print or type name)

(This report will become a part of the applicant's file and may be reviewed by the applicant upon demand)

BOARD OF NURSING

REGISTRAR'S NOTICE: This regulation is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Board of Nursing will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **VR 495-01-1. Board of Nursing Regulations.**

Statutory Authority: §§ 54.1-2400 and 54.1-3005 of the Code of Virginia.

Effective Date: April 10, 1992.

Summary:

Section 5.3 of the Board of Nursing Regulations has been amended to comply with the Health Care Financing Administration final rules: 42 CFR 483.151-483.156 (Medicare and Medicaid Programs; Nurse Aide Training and Competency Evaluation Programs), effective April 1, 1992.

Deviation from the wording of the final rules is only to the extent necessary to conform with the current format and language of the Board of Nursing Regulations.

VR 495-01-1. Board of Nursing Regulations.

PART I.
GENERAL PROVISIONS.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meanings, unless the context clearly indicates otherwise:

"Approval" means the process by which the board or a governmental agency in another state or foreign country evaluates and grants official recognition to nursing education programs that meet established standards not inconsistent with Virginia law.

"Associate degree nursing program" means a nursing education program preparing for registered nurse licensure, offered by a Virginia college or other institution and designed to lead to an associate degree in nursing, provided that the institution is authorized to confer such degree by the State Board of Education, State Council of Higher Education or an Act of the General Assembly.

"Baccalaureate degree nursing program" means a nursing education program preparing for registered nurse licensure, offered by a Virginia college or university and designed to lead to a baccalaureate degree with a major in nursing, provided that the institution is authorized to confer such degree by the State Board of Education, the State Council of Higher Education or an Act of the General Assembly.

"Board" means the State Board of Nursing.

"Clinical nurse specialist" means a licensed registered nurse who holds:

1. A master's degree from a board approved program which prepares the nurse to provide advanced clinical nursing services; and

2. Specialty certification from a national certifying organization acceptable to the board or an exception available from March 1, 1990, to July 1, 1990.

"Conditional approval" means a time-limited status which results when an approved nursing education program has failed to maintain requirements as set forth in § 2.2 of these regulations.

"Cooperating agency" means an agency or institution that enters into a written agreement to provide learning experiences for a nursing education program.

"Diploma nursing program" means a nursing education program preparing for registered nurse licensure, offered by a hospital and designed to lead to a diploma in nursing, provided the hospital is licensed in this state.

"National certifying organization" means an organization that has as one of its purposes the certification of a specialty in nursing based on an examination attesting to the knowledge of the nurse for practice in the specialty area.

"Nursing education program" means an entity offering a basic course of study preparing persons for licensure as registered nurses or as licensed practical nurses. A basic course of study shall include all courses required for the degree, diploma or certificate.

"Practical nursing program" means a nursing education program preparing for practical nurse licensure, offered by a Virginia school, that leads to a diploma or certificate in practical nursing, provided the school is authorized by the appropriate governmental agency.

"Program director" means a registered nurse who has been designated by the controlling authority to administer the nursing education program.

"Provisional approval" means the initial status granted to a nursing education program which shall continue until the first class has graduated and the board has taken final action on the application for approval.

"Recommendation" means a guide to actions that will assist an institution to improve and develop its nursing education program.

"Requirement" means a mandatory condition that a nursing education program must meet to be approved.

§ 1.2. Delegation of authority.

A. The executive director of the board shall issue a certificate of registration to each person who meets the requirements for initial licensure under §§ 54.1-3017, 54.1-3018, 54.1-3020 and 54.1-3021 of the Code of Virginia. Such certificates of registration shall bear the signature of the president of the board, the executive director and the director of the Department of Health Regulatory Boards.

B. The executive director shall issue license to each applicant who qualifies for such license under § 54.1-3011 of the Code of Virginia. Such licenses shall bear the name of the executive director.

C. The executive director shall be delegated the authority to execute all notices, orders and official documents of the board unless the board directs otherwise.

§ 1.3. Fees.

Fees required in connection with the licensing of applicants by the board are:

1. Application for R.N. Licensure $46
2. Application for L.P.N. Licensure $36
3. Biennial Licensure Renewal $29
4. Reinstatement Lapsed License $50
5. Duplicate License $10
6. Verification of License $10
7. Transcript of Examination Scores $5
8. Transcript of Applicant/Licensee Records $10
9. Returned Check Charge $15
10. Application for C.N.S. registration $50
11. Biennial renewal of C.N.S. registration $30
12. Reinstatement of lapsed C.N.S. registration $25
13. Verification of C.N.S. registration $25

§ 1.4. Public participation guidelines.

A. Mailing list.

The Virginia State Board of Nursing (board) will maintain a list of persons and organizations who will be mailed the following documents as they become available:

1. "Notice of intent" to promulgate regulations.

2. "Notice of public hearing" or "informational proceeding," the subject of which is proposed or existing regulation.

3. Final regulation adopted.

Any person wishing to be placed on the mailing list may do so by writing the board. In addition, the board, at its discretion, may add to the list any person, organization, or publication it believes will serve the purpose of responsible participation in the formation or promulgation of regulations. Persons on the list will be provided all above-listed information. Individuals and organizations will be periodically requested to indicate their desire to continue to receive documents or be deleted from the list. Where mail is returned as undeliverable, individuals and organizations will be deleted from the list.

B. Notice of intent.

At least 30 days prior to publication of the notice to conduct an informational proceeding as required by § 9-6.14:1 of the Code of Virginia, the board will publish a "notice of intent." This notice will contain a brief and concise statement of the possible regulation or the problem the regulation would address and invite any person to provide written comment on the subject matter. Such notice shall be transmitted to the Registrar of Regulations for inclusion in the Virginia Register of Regulations.

C. Public comment period.

At least once each biennium, the board will conduct an informational proceeding, which may take the form of a public hearing, to receive public comment on existing regulations. The purpose of the proceeding will be to solicit public comment on all existing regulations as to their effectiveness, efficiency, necessity, clarity, and cost of compliance. Notice of such proceeding will be transmitted to the Registrar of Regulations for inclusion in the Virginia Register of Regulations. Such proceedings may be held separately or in conjunction with other informational proceedings.

D. Petitions to the board.

Any person may petition the board to adopt, amend, or delete any regulation. Any petition received shall appear on the next agenda of the board. The board shall have sole authority to dispose of the petition.

E. Publication in the Virginia Register of Regulations.

At any meeting of the board or any subcommittee or advisory committee, where the formulation or adoption of

regulation occurs, the subject matter shall be transmitted to the Registrar of Regulations for inclusion in the Virginia Register of Regulations.

F. Advisory committee.

The board, in cooperation with the Council on Health Regulatory Boards, may appoint advisory committees as they deem necessary to provide for adequate citizen participation in the formation, promulgation, adoption, and review of regulations.

PART II.
NURSING EDUCATION PROGRAMS.

§ 2.1. Establishing a nursing education program.

Phase I.

A. An institution wishing to establish a nursing education program shall:

1. Submit to the board, at least 15 months in advance of expected opening date, a statement of intent to establish a nursing education program;

2. Submit to the board, along with the statement of intent, a feasibility study to include the following information:

a. Studies documenting the need for the program;

b. Purpose and type of program;

c. Availability of qualified faculty;

d. Budgeted faculty positions;

e. Availability of clinical facilities for the program;

f. Availability of academic facilities for the program;

g. Evidence of financial resources for the planning, implementation and continuation of the program;

h. Anticipated student population;

i. Tentative time schedule for planning and initiating the program; and

j. Current catalog, if applicable.

3. Respond to the board's request for additional information.

B. A site visit shall be conducted by a representative of the board.

C. The board, after review and consideration, shall either approve or disapprove Phase I.

1. If Phase I is approved, the institution may apply for provisional approval of the nursing education program as set forth in these regulations.

2. If Phase I is disapproved, the institution may request a hearing before the board and the provisions of the Administrative Process Act shall apply. (§ 9-6.14:1 et seq.)

Phase II.

D. The application for provisional approval shall be complete when the following conditions are met:

1. A program director has been appointed and there are sufficient faculty to initiate the program (§ 2.2.C of these regulations);

2. A tentative written curriculum plan developed in accordance with § 2.2.F of these regulations has been submitted; and

E. The board, after review and consideration, shall either grant or deny provisional approval.

1. If provisional approval is granted:

a. The admission of students is authorized; and

b. The program director shall submit quarterly progress reports to the board which shall include evidence of progress toward application for approval and other information as required by the board.

2. If provisional approval is denied, the institution may request a hearing before the board and the provisions of the Administrative Process Act shall apply. (§ 9-6.14:1 et seq.)

F. Following graduation of the first class, the institution shall apply for approval of the nursing education program.

Phase III.

G. The application for approval shall be complete when a self-evaluation report of compliance with § 2.2 of these regulations has been submitted and a survey visit has been made by a representative of the board.

H. The board will review and consider the self-evaluation and the survey reports at the next regularly scheduled meeting.

I. The board shall either grant or deny approval. If denied, the institution may request a hearing before the board and the provisions of the Administrative Process Act shall apply. (§ 9-6.14:1 et seq.)

§ 2.2. Requirements for approval.

A. Organization and administration.

1. The institution shall be authorized to conduct a nursing education program by charter or articles of incorporation of the controlling institution; by resolution of its board of control; or by the institution's own charter or articles of incorporation.

2. Universities, colleges, community or junior colleges, proprietary schools and public schools offering nursing education programs shall be accredited by the appropriate state agencies and the Southern Association of Colleges and Schools.

3. Hospitals conducting a nursing education program shall be accredited by the Joint Commission on Accreditation of Healthcare Organizations.

4. Any agency or institution that is utilized by a nursing education program shall be one that is authorized to conduct business in the Commonwealth of Virginia, or in the state in which the agency or institution is located.

5. The authority and responsibility for the operation of the nursing education program shall be vested in a program director who is duly licensed to practice professional nursing in Virginia and who is responsible to the controlling board, either directly or through appropriate administrative channels.

6. A written organizational plan shall indicate the lines of authority and communication of the nursing education program to the controlling body; to other departments within the controlling institution; to the cooperating agencies; and to the advisory committee, if one exists.

7. Funds shall be allocated by the controlling agency to carry out the stated purposes of the program. The program director of the nursing education program shall be responsible for the budget recommendations and administration, consistent with the established policies of the controlling agency.

B. Philosophy and objectives.

Written statements of philosophy and objectives shall be:

1. Formulated and accepted by the faculty;

2. Directed toward achieving realistic goals;

3. Directed toward the meaning of education, nursing and the learning process;

4. Descriptive of the practitioner to be prepared; and

5. The basis for planning, implementing and evaluating the total program.

C. Faculty.

1. Qualifications.

a. Every member of a nursing faculty, including the program director, shall hold a current license to practice as a registered nurse in Virginia.

b. Every member of a nursing faculty responsible for teaching students in a cooperating agency located outside the jurisdictional limits of Virginia shall meet the licensure requirements of that jurisdiction.

c. The program director and each member of the nursing faculty shall maintain professional competence through such activities as nursing practice, continuing education programs, conferences, workshops, seminars, academic courses, research projects and professional writing.

d. For baccalaureate degree programs:

(1) The program director shall hold a doctoral degree.

(2) Every member of the nursing faculty shall hold a graduate degree. Faculty members without a graduate degree with a major in nursing shall have a baccaluareate degree with a major in nursing.

(3) At least one faculty member in each clinical area shall have master's preparation in specialty.

e. For associate degree and diploma programs:

(1) The program director shall hold a graduate degree, preferably with a major in nursing.

(2) The majority of the members of the nursing faculty shall hold a graduate degree, preferably with a major in nursing.

(3) Other members of the nursing faculty shall hold a baccalaureate degree, preferably with a major in nursing.

f. For practical nursing programs.

(1) The program director shall hold a baccalaureate degree, preferably with a major in nursing.

(2) The majority of the members of the nursing faculty shall hold a baccalaureate degree, preferably with a major in nursing.

g. Exceptions to provisions of subparagraphs d, e, and f of this subsection shall be by board approval.

(1) Initial request for exception.

(a) The program director shall submit a request for initial exception in writing for considerations at a

regular board meeting prior to the term during which the nursing faculty member is scheduled to teach.

(b) A description of teaching assignment, a curriculum vitae and a statement of intent, from the prospective faculty member, to pursue the required degree shall accompany each request.

(2) Request for continuing exception.

(a) Continuing exception will be based on the progress of the nursing faculty member toward meeting the degree required by these regulations during each year for which the exception is requested.

(b) The program director shall submit the request for continuing exception in writing for consideration at a regular board meeting prior to the next term during which the nursing faculty member is scheduled to teach.

(c) A list of courses required for the degree being pursued and college transcripts showing successful completion of a minimum of two of the courses during the past academic year shall accompany each request.

(3) The executive director of the board shall be authorized to make the initial decision on requests for exceptions. Any appeal of that decision shall be in accordance with the provisions of the Administrative Process Act (§ 9-6.14:1 et seq.).

2. Number.

a. The number of faculty shall be sufficient to prepare the students to achieve the objectives of the educational program and such number shall be reasonably proportionate to:

(1) Number of students enrolled;

(2) Frequency of admissions;

(3) Education and experience of faculty members;

(4) Number and location of clinical facilities; and

(5) Total responsibilities of the faculty.

b. When students are giving direct care to patients, the ratio of students to faculty in clinical areas shall not exceed 10 students to one faculty member.

3. Conditions of employment.

a. Qualifications and responsibilities for faculty positions shall be defined in writing.

b. Faculty assignments shall allow time for class and laboratory preparation; teaching; program revision; improvement of teaching methods; academic advisement and counseling of students; participation in faculty organizations and committees; attendance at professional meetings; and participation in continuing education activities.

4. Functions.

The principal functions of the faculty shall be to:

a. Develop, implement and evaluate the philosophy and objectives of the nursing education program;

b. Participate in designing, implementing, teaching, and evaluating and revising the curriculum;

c. Develop and evaluate student admission, progression, retention and graduation policies within the framework of the controlling institution;

d. Participate in academic advisement and counseling of students; and

e. Provide opportunities for student and graduate evaluation of curriculum and teaching and program effectiveness.

5. Organization.

a. The nursing faculty shall hold regular meetings for the purpose of developing, implementing and evaluating the nursing education program. Written rules shall govern the conduct of meetings.

b. All members of the faculty shall participate in the regular faculty meetings.

c. Committees shall be established to implement the functions of the faculty.

d. Minutes of faculty and committee meetings, including actions taken, shall be recorded and available for reference.

e. There shall be provision for student participation.

D. Students.

1. Admission, promotion and graduation.

a. Requirements for admission to the nursing education program shall not be less than the statutory requirements that will permit the graduate to be admitted to the appropriate licensing examination.

(EXPLANATORY NOTE: Reference subdivision 1 of subsection A of § 54.1-3017 of the Code of Virginia: The equivalent of a four-year high school course of

study is considered to be:

(1) A General Educational Development (GED) certificate for high school equivalence; or

(2) Satisfactory completion of the college courses required by the nursing education program.)

b. Students shall be selected on the basis of established criteria and without regard to age, race, creed, sex or national origin.

c. Requirements for admission, readmission, advanced standing, progression, retention, dismissal and graduation shall be available to the students in written form.

E. Records.

1. School records.

A system of records shall be maintained and be made available to the board representative and shall include:

a. Data relating to accreditation by any agency or body,

b. Course outlines,

c. Minutes of faculty and committee meetings,

d. Reports of standardized tests,

e. Survey reports.

2. Student records.

a. A file shall be maintained for each student. Each file shall be available to the board representative and shall include:

(1) The student's application,

(2) High school transcript or copy of high school equivalence certificate,

(3) Current record of achievement.

b. A final transcript shall be retained in the permanent file of the institution.

c. Provision shall be made for the protection of student and graduate records against loss, destruction and unauthorized use.

3. School bulletin or catalogue.

Current information about the nursing education program shall be published periodically and distributed to students, applicants for admission and the board. Such information shall include:

a. Description of the program.

b. Philosophy and objectives of the controlling institution and of the nursing program.

c. Admission and graduation requirements.

d. Fees.

e. Expenses.

f. Financial aid.

g. Tuition refund policy.

h. Education facilities.

i. Living accommodations.

j. Student activities and services.

k. Curriculum plan.

l. Course descriptions.

m. Faculty-staff roster.

n. School calender.

F. Curriculum.

1. Curriculum shall reflect the philosophy and objectives of the nursing education program, and shall be consistent with the law governing the practice of nursing.

2. The ratio between nursing and nonnursing credit shall be based on a rationale to ensure sufficient preparation for the safe and effective practice of nursing.

3. Learning experiences shall be selected to fulfill curriculum objectives.

4. Nursing education programs preparing for practical nursing licensure shall include:

a. Principles and practice in nursing encompassing the attainment and maintenance of physical and mental health and the prevention of illness for individuals and groups throughout the life cycle;

b. Basic concepts of the nursing process;

c. Basic concepts of anatomy, physiology, chemistry, physics and microbiology;

d. Basic concepts of communication, growth and development, interpersonal relations, patient education and cultural diversity;

e. Ethics, nursing history and trends, vocational and legal aspects of nursing, including regulations and sections of the Code of Virginia related to nursing; and

f. Basic concepts of pharmacology, nutrition and diet therapy.

5. Nursing education programs preparing for registered nurse licensure shall include:

a. Theory and practice in nursing, encompassing the attainment and maintenance of physical and mental health and the prevention of illness throughout the life cycle for individuals, groups and communities;

b. Concepts of the nursing process;

c. Concepts of anatomy, physiology, chemistry, microbiology and physics;

d. Sociology, psychology, communications, growth and development, interpersonal relations, group dynamics, cultural diversity and humanities;

e. Concepts of pharmacology, nutrition and diet therapy, and pathophysiology;

f. Concepts of ethics, nursing history and trends, and the professional and legal aspects of nursing, including regulations and sections of the Code of Virginia related to nursing; and

g. Concepts of leadership, management and patient education.

G. Resources, facilities and services.

1. Periodic evaluations of resources, facilities and services shall be conducted by the administration, faculty, students and graduates of the nursing education program.

2. Secretarial and other support services shall be provided.

3. Classrooms, conference rooms, laboratories, clinical facilities and offices shall be available to meet the objectives of the nursing education program and the needs of the students, faculty, administration and staff.

4. The library shall have holdings that are current, pertinent and accessible to students and faculty, and sufficient in number to meet the needs of the students and faculty.

5. Written agreements with cooperating agencies shall be developed, maintained and periodically reviewed. The agreement shall:

a. Ensure full control of student education by the faculty of the nursing education program, including the selection and supervision of learning experiences.

b. Provide that an instructor shall be present on the clinical unit(s) to which students are assigned for direct patient care.

c. Provide for cooperative planning with designated agency personnel.

6. Any observational experiences shall be planned in cooperation with the agency involved to meet stated course objectives.

7. Cooperating agencies shall be approved by the appropriate accreditation, evaluation or licensing bodies, if such exist.

H. Program changes requiring board of nursing approval.

The following proposed changes require board approval prior to their implementation:

1. Proposed changes in the nursing education program's philosophy and objectives that result in program revision.

2. Proposed changes in the curriculum that result in alteration of the length of the nursing education program.

3. Proposed additions, deletions or major revisions of courses.

I. Procedure for approval of program change.

1. When a program change is contemplated, the program director shall inform the board or board representative.

2. When a program change is requested, a plan shall be submitted to the board including:

a. Proposed change,

b. Rationale for the change,

c. Relationship of the proposed change to the present program.

3. Twelve copies of these materials shall be submitted to the board at least three weeks prior to the board meeting at which the request will be considered.

§ 2.3. Procedure for maintaining approval.

A. The program director of each nursing education program shall submit an annual report to the board.

B. Each nursing education program shall be reevaluated at least every eight years and shall require:

1. A comprehensive self-evaluation report based on § 2.2 of these regulations, and

2. A survey visit by a representative(s) of the board on dates mutually acceptable to the institution and the board.

C. The self-evaluation and survey visit reports shall be presented to the board for consideration and action at a regularly scheduled board meeting. The reports and the action taken by the board shall be sent to the appropriate administrative officers of the institution. In addition, a copy shall be forwarded to the executive officer of the state agency or agencies having program approval authority or coordinating responsibilities for the governing institutions.

D. Interim visits shall be made to the institution by board representatives at any time within the eight-year period either by request or as deemed necessary by the board.

E. A nursing education program shall continue to be approved provided the requirements set forth in § 2.2 of these regulations are attained and maintained.

F. If the board determines that a nursing education program is not maintaining the requirements of § 2.2 of these regulations, the program shall be placed on conditional approval and the governing institution shall be given a reasonable period of time to correct the identified deficiencies. The institution may request a hearing before the board and the provisions of the Administrative Process Act shall apply. (§ 9-6.14:1 et seq.)

G. If the governing institution fails to correct the identified deficiencies within the time specified by the board, the board shall withdraw the approval following a hearing held pursuant to the provisions of the Administrative Process Act. (§ 9-6.14:1 et seq.) Sections 2.4 B and C of these regulations shall apply to any nursing education program whose approval has been withdrawn.

§ 2.4. Closing of an approved nursing education program.

A. Voluntary closing.

When the governing institution anticipates the closing of a nursing education program, it shall notify the board in writing, stating the reason, plan and date of intended closing. The governing institution shall choose one of the following closing procedures:

1. The program shall continue until the last class enrolled is graduated.

a. The program shall continue to meet the standards for approval until all of the enrolled students have graduated.

b. The date of closure is the date on the degree, diploma or certificate of the last graduate.

c. The governing institution shall notify the board of the closing date.

2. The program shall close after the governing institution has assisted in the transfer of students to other approved programs.

a. The program shall continue to meet the standards required for approval until all students are transferred.

b. A list of the names of students who have been transferred to approved programs and the date on which the last student was transferred shall be submitted to the board by the governing institution.

c. The date on which the last student was transferred shall be the closing date of the program.

B. Closing as a result of denial or withdrawal or approval.

When the board denies or withdraws approval of a program, the governing institution shall comply with the following procedures:

1. The program shall close after the institution has made a reasonable effort to assist in the transfer of students to other approved programs. A time frame for the transfer process shall be established by the board.

2. A list of the names of students who have transferred to approved programs and the date on which the last student was transferred shall be submitted to the board by the governing institution.

3. The date on which the last student was transferred shall be the closing date of the program.

C. Custody of records.

Provision shall be made for custody of records as follows:

1. If the governing institution continues to function, it shall assume responsibility for the records of the students and the graduates. The institution shall inform the board of the arrangements made to safeguard the records.

2. If the governing institution ceases to exist, the academic transcript of each student and graduate shall be transferred by the institution to the board for safekeeping.

§ 2.5. Clinical nurse specialist education program.

An approved program shall be offered by:

1. A nationally accredited school of nursing within a college or university that offers a master's degree in nursing designed to prepare a registered nurse for advanced practice in a clinical specialty in nursing; or

2. A college or university that offers a master's degree consistent with the requirements of a national certifying organization as defined in § 1.1 of these regulations.

PART III.
LICENSURE AND PRACTICE.

§ 3.1. Licensure by examination.

A. The board shall administer examinations for registered nurse licensure and examinations for practical nurse licensure no less than twice a year.

B. The minimum passing score on the examination for registered nurse licensure shall be determined by the board.

C. If a candidate does not take the examination when scheduled, the application shall be retained on file as required for audit and the candidate must file a new application and fee to be rescheduled.

D. Any applicant suspected of giving or receiving unauthorized assistance during the writing of the examination shall be noticed for a hearing before the board to determine whether the license shall be issued.

E. The board shall not release examination results of a candidate to any individual or agency without written authorization from the applicant or licensee.

F. An applicant for the licensing examination shall:

1. File the required application and fee no less than 60 days prior to the scheduled date of the examination.

2. Arrange for the board to receive the final certified transcript from the nursing education program at least 15 days prior to the examination date or as soon thereafter as possible. The transcript must be received prior to the reporting of the examination results to candidates.

G. Fifteen days prior to an examination date, all program directors shall submit a list of the names of those students who have completed or are expected to complete the requirements for graduation since the last examination. Any change in the status of a candidate within the above specified 15-day period shall be reported to the board immediately.

H. Practice of nursing pending receipt of examination results.

1. Graduates of approved nursing education programs may practice nursing in Virginia pending the results of the first licensing examination given by a board of nursing following their graduation, provided they have filed an application for licensure in Virginia. Candidates taking the examination in Virginia shall file the application for licensure by examination. Candidates taking the examination in other jurisdictions shall file the application for licensure by endorsement.

2. Candidates who practice nursing as provided in § 3.1 I 1 of these regulations shall use the designation "R.N. Applicant" or "L.P.N. Applicant" when signing official records.

3. The designations "R.N. Applicant" and "L.P.N. Applicant" shall not be used by applicants who do not take or who have failed the first examination for which they are eligible.

I. Applicants who fail the examination.

1. An applicant who fails the licensing examination shall not be licensed or be authorized to practice nursing in Virginia.

2. An applicant for reexamination shall file the required application and fee no less than 60 days prior to the scheduled date of the examination.

3. Applicants who have failed the licensing examination in another U.S. jurisdiction and who meet the qualifications for licensure in this jurisdiction may apply for licensure by examination in Virginia. Such applicants shall submit the required application and fee. Such applicants shall not, however, be permitted to practice nursing in Virginia until the requisite license has been issued.

§ 3.2. Licensure by endorsement.

A. A graduate of an approved nursing education program who has been licensed by examination in another U.S. jurisdiction and whose license is in good standing, or is eligible for reinstatement, if lapsed, shall be eligible for licensure by endorsement in Virginia, provided the applicant satisfies the requirements for registered nurse or practical nurse licensure.

B. An applicant for licensure by endorsement shall submit the required application and fee and submit the required form to the appropriate credentialing agency in the state of original licensure for verification of licensure. Applicants will be notified by the board after 30 days, if the completed verification form has not been received.

C. If the application is not completed within one year of

the initial filing date, the application shall be retained on file by the board as required for audit.

§ 3.3. Licensure of applicants from other countries.

A. Applicants whose basic nursing education was received in, and who are duly licensed under the laws of another country, shall be scheduled to take the licensing examination provided they meet the statutory qualifications for licensure. Verification of qualification shall be based on documents submitted as required in § 3.3 B and C of these regulations.

B. Such applicants for registered nurse licensure shall:

1. Submit evidence of a passing score on the Commission on Graduates of Foreign Nursing Schools Qualifying Examination; and

2. Submit the required application and fee for licensure by examination.

C. Such applicants for practical nurse licensure shall:

1. Request a transcript from the nursing education program to be submitted directly to the board office;

2. Provide evidence of secondary education to meet the statutory requirements;

3. Request that the credentialing agency, in the country where licensed, submit the verification of licensure; and

4. Submit the required application and fee for licensure by examination.

§ 3.4. Renewal of licenses.

A. Licensees born in even-numbered years shall renew their licenses by the last day of the birth month in even-numbered years. Licensees born in odd-numbered years shall renew their licenses by the last day of the birth month in odd-numbered years.

B. No less than 30 days prior to the last day of the licensee's birth month, an application for renewal of license shall be mailed by the board to the last known address of each licensee, who is currently licensed.

C. The licensee shall complete the application and return it with the required fee.

D. Failure to receive the application for renewal shall not relieve the licensee of the responsibility for renewing the license by the expiration date.

E. The license shall automatically lapse if the licensee fails to renew by the last day of the birth month.

F. Any person practicing nursing during the time a license has lapsed shall be considered an illegal practitioner and shall be subject to prosecution under the provisions of § 54.1-3008 of the Code of Virginia.

§ 3.5. Reinstatement of lapsed licenses.

A. A nurse whose license has lapsed shall file a reinstatement application and pay the current renewal fee and the reinstatement fee.

B. The board may request evidence that the nurse is prepared to resume practice in a competent manner.

§ 3.6. Replacement of lost license.

A. The licensee shall report in writing the loss of the original certificate of registration or the current license.

B. A duplicate license for the current renewal period shall be issued by the board upon receipt of the required form and fee.

§ 3.7. Evidence of change of name.

A licensee who has changed his name shall submit as legal proof to the board a copy of the marriage certificate or court order evidencing the change. A duplicate license shall be issued by the board upon receipt of such evidence and the required fee.

§ 3.8. Requirements for current mailing address.

A. All notices, required by law and by these regulations to be mailed by the board to any licensee, shall be validly given when mailed to the latest address on file with the board.

B. Each licensee shall maintain a record of his current mailing address with the board.

C. Any change of address by a licensee shall be submitted in writing to the board within 30 days of such change.

§ 3.9. Licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a registered nurse or a licensed dentist within the context of § 54.1-3408 of the Code of Virginia.

§ 3.10. Clinical nurse specialist registration.

A. Initial registration.

An applicant for initial registration as a clinical nurse specialist shall:

1. Be currently licensed as a registered nurse in Virginia;

2. Submit evidence of graduation from an approved program as defined in § 2.5 of these regulations;

3. Submit evidence of current specialty certification from a national certifying organization as defined in § 1.1 of these regulations; and

4. Submit the required application and fee.

B. Renewal of registration.

1. Registration as a clinical nurse specialist shall be renewed biennially at the same time the registered nurse license is renewed.

2. The clinical nurse specialist shall complete the renewal application and return it with the required fee and evidence of current specialty certification unless registered in accordance with an exception.

3. Registration as a clinical nurse specialist shall lapse if the registered nurse license is not renewed and may be reinstated as follows:

a. Reinstatement of R.N. license;

b. Payment of reinstatement and current renewal fees; and

c. Submission of evidence of continued specialty certification unless registered in accordance with an exception.

§ 3.11. Clinical nurse specialist practice.

A. The practice of clinical nurse specialists shall be consistent with the

1. Education required in § 2.5 of these regulations, and

2. Experience required for specialist certification.

B. The clinical nurse specialist shall provide those advanced nursing services that are consistent with the standards of specialist practice as established by a national certifying organization for the designated specialty and in accordance with the provisions of Title 54.1 of the Code of Virginia.

C. Advanced practice as a clinical nurse specialist shall include but shall not be limited to performance as an expert clinician to:

1. Provide direct care and counsel to individuals and groups;

2. Plan, evaluate and direct care given by others; and

3. Improve care by consultation, collaboration, teaching and the conduct of research.

PART IV.
DISCIPLINARY PROVISIONS.

§ 4.1. The board has the authority to deny, revoke or suspend a license issued, or to otherwise discipline a licensee upon proof that the licensee has violated any of the provisions of § 54.1-3007 of the Code of Virginia. For the purpose of establishing allegations to be included in the notice of hearing, the board has adopted the following definitions:

A. Fraud or deceit shall mean, but shall not be limited to:

1. Filing false credentials;

2. Falsely representing facts on an application for initial license, reinstatement or renewal of a license; or

3. Giving or receiving assistance in writing the licensing examination.

B. Unprofessional conduct shall mean, but shall not be limited to:

1. Performing acts beyond the limits of the practice of professional or practical nursing as defined in Chapter 30 of Title 54.1, or as provided by §§ 54.1-2901 and 54.1-2957 of the Code of Virginia;

2. Assuming duties and responsibilities within the practice of nursing without adequate training or when competency has not been maintained;

3. Obtaining supplies, equipment or drugs for personal or other unauthorized use;

4. Employing or assigning unqualified persons to perform functions that require a licensed practitioner of nursing;

5. Falsifying or otherwise altering patient or employer records;

6. Abusing, neglecting or abandoning patients or clients; or

7. Practice of a clinical nurse specialist beyond that defined in § 3.11 of these regulations.

8. Holding self out as or performing acts constituting the practice of a clinical nurse specialist unless so registered by the board.

§ 4.2. Any sanction imposed on the registered nurse license of a clinical nurse specialist shall have the same effect on the clinical nurse specialist registration.

PART V.
CERTIFIED NURSE AIDES.

§ 5.1. Definitions.

The following words and terms when used in these regulations, shall have the following meanings, unless the context clearly indicates otherwise:

"Nurse aide education program" means a program designed to prepare nurse aides for certification.

"Nursing facility" means a licensed nursing home or a Medicare or Medicaid certified skilled or intermediate care facility or unit.

"Primary instructor" means a registered nurse who is responsible for teaching and evaluating the students enrolled in a nurse aide education program.

"Program coordinator" means a registered nurse who is administratively responsible and accountable for a nurse aide education program.

"Program provider" means an entity which conducts a nurse aide education program.

§ 5.2. Delegation of authority.

The executive director of the board shall issue a certificate as a certified nurse aide to each applicant who qualifies for such a certificate under §§ 54.1-3025, 54.1-3026 and 54.1-3028 of the Code of Virginia.

§ 5.3. Nurse aide education programs.

A. Establishing a nurse aide education program.

1. A program provider wishing to establish a nurse aide education program shall submit an application to the board at least 90 days in advance of the expected opening date.

2. The application shall provide evidence of the ability of the institution to comply with § 5.3 B of these regulations.

3. The application shall be considered at a meeting of the board. The board shall, after review and consideration, either grant or deny approval.

4. If approval is denied the program provider may request a hearing before the board and the provisions of the Administrative Process Act shall apply. (§ 9-6.14:1 et seq.)

B. Maintaining an approved nurse aide education program.

To maintain approval, the nurse aide education program shall demonstrate evidence of compliance with the following essential elements:

1. Curriculum content and length as set forth in §§ 5.3 D and 5.3 G of these regulations.

2. Maintenance of qualified instructional personnel as set forth in § 5.3 C of these regulations.

3. Classroom facilities that meet requirements set forth in § 5. 3 H of these regulations.

4. Maintenance of records as set forth in § 5.3 E of these regulations.

5. Skills training experience in a nursing facility which ~~was not terminated from the Medicare or Medicaid programs during~~ *has not been subject to penalty or penalties as provided in 42 FR 48315(b)(2) (Medicare and Medicaid Programs: Nurse Aide Training and Competency Evaluation Programs, effective April 1, 1992) in* the past two years.

6. Agreement that board representatives may make unannounced visits to the program.

7. Impose no fee for any portion of the program on any nurse aide who, on the date on which the nurse aide begins the program, is either employed or has an offer of employment from a nursing facility.

8. Must report all substantive changes in subdivisions 1 through 7 of § 5.3 B of these regulations within 10 days of the change to the board.

C. Instructional personnel.

1. Program coordinator.

a. The program coordinator in a nursing facility based program may be the director of nursing services. The director of nursing may assume the administrative responsibility and accountability for the nurse aide education program *but shall not engage in the actual classroom and clinical teaching* . *

b. The primary instructor may be the program coordinator in any nurse aide education program.

2. Primary instructor.

a. Qualifications.

~~(1) Nursing facility based programs.~~

~~(a) The primary instructor shall hold a current Virginia license as a registered nurse; and~~

~~(b) Have at least one year of experience, within the preceding five years, in a nursing facility.~~

~~(2) Programs other than those based in nursing facilities.~~

~~(a)~~ *(1)* The primary instructor, who does the actual teaching of the students, shall hold a current

Virginia license as a registered nurse; and

~~(b)~~ *(2)* Shall have two years of experience ~~, within the preceding five years, in caring for the elderly or chronically ill of any age~~ *as a registered nurse and at least one year of experience within the previous five years in the provision of long term care facility services* . Such experience may include, but not be limited to, employment in a nurse aide education program or employment in or supervision of nursing students in a nursing facility or unit, geriatrics department, chronic care hospital, home care or other long-term care setting. Experience should include varied responsibilities, such as direct resident care, supervision and education.

b. Responsibilities. The primary instructor shall:

(1) Participate in the planning of each learning experience;

(2) Ensure that course objectives are accomplished;

(3) Ensure that the provisions of § C 6 of these regulations are maintained;

(4) Maintain records as required by § 5.3 E of these regulations; and

(5) Perform other activities necessary to comply with § 5.3 B of these regulations.

(6) Ensure that students do not perform services for which they have not received instruction and been found proficient by the instructor.

3. Other instructional personnel.

a. Qualifications.

(1) A registered nurse shall:

(a) Hold a current Virginia license as a registered nurse; and

(b) Have had at least one year, within the preceding five years, of direct patient care experience as a registered nurse with the elderly or chronically ill, or both, of any age.

(2) A licensed practical nurse shall:

(a) Hold a current Virginia license as a practical nurse;

(b) Hold a high school diploma or equivalent;

(c) Have been graduated from a state-approved practical nursing program; and

(d) Have had at least two years, within the preceding five years, of direct patient care experience with the elderly or chronically ill, or both, of any age.

b. Responsibilities. Other personnel shall provide instruction under the general supervision of the primary instructor.

4. Prior to being assigned to teach the nurse aide education program, all instructional personnel shall demonstrate competence to teach adults by one of the following:

a. Complete satisfactorily a "train-the-trainer" program approved by the board. Such a program shall be approved by the board for five years, at which time the sponsor must request reapproval of the program. The content of the program must include:

(1) Basic principles of adult learning;

(2) Teaching methods and tools for adult learners; and

(3) Evaluation strategies and measurement tools for assessing the learning outcomes; or

b. Complete satisfactorily a credit or noncredit course or courses approved by the board. Such courses shall be evaluated for approval by the board upon request from the individual taking the course. The content of such credit or noncredit course shall be comparable to that described in § 5.4 C 4 a of these regulations; or

c. Provide evidence acceptable to the board of experience in teaching adult learners within the preceding five years.

5. The program may utilize resource personnel *who have had at least one year of experience in their field* to meet the planned program objectives for specific topics.

6. When students are giving direct care to clients in clinical areas, instructional personnel must be on site *to supervise the students* and the ratio of students to each instructor shall not exceed 10 students to one instructor.

D. Curriculum.

1. The objective of the nurse aide education program shall be to prepare a nurse aide to provide quality services to clients under the supervision of licensed personnel. The graduate of the nurse aide education program shall be prepared to:

a. Communicate and interact competently (emphasis added) on a one-to-one basis with the clients;

b. Demonstrate sensitivity to clients' emotional, social, and mental health needs through skillful directed interactions;

c. Assist clients in attaining and maintaining functional independence;

d. Exhibit behavior in support and promotion of clients' rights; and

e. Demonstrate skills in observation and documentation needed to participate in the assessment of clients' health, physical condition and well-being.

2. Content. The curriculum shall include, but shall not be limited to, classroom and clinical instruction in the following:

a. Initial core curriculum (minimum 16 hours). The classroom instruction prior to the direct involvement of a student with a nursing facility client must include, at a minimum, the topics listed below:

(1) Communication and interpersonal skills,

(2) Infection control,

(3) Safety and emergency procedures, *including the Heimlich Maneuver,*

(4) Promoting client independence, and

(5) Respecting clients' rights.

b. Basic skills.

(1) Recognizing abnormal ~~signs and symptoms of common diseases and conditions (e.g., shortness of breath, rapid respirations, fever, coughs, chills, pains in chest, blue color to lips, pain in abdomen, nausea, vomiting, drowsiness, sweating, excessive thirst, pus, blood or sediment in urine, difficulty urinating, urinating in frequent small amounts, pain or burning on urination, urine with dark color or strong odor) which indicate that the licensed nurse should be notified~~ *changes in body functioning and the importance of reporting such changes to a supervisor* .

(2) Measuring and recording routine vital signs.

(3) Measuring and recording height and weight.

(4) Caring for the clients' environment.

(5) Measuring and recording fluid and food intake and output.

(6) Performing basic emergency measures.

(7) Caring for client when death is imminent.

c. Personal care skills.

(1) Bathing and oral hygiene.

(2) Grooming.

(3) Dressing.

(4) Toileting.

(5) Assisting with eating and hydration including proper feeding techniques.

(6) Caring for skin.

(7) Transfer, positioning and turning.

d. Individual client's needs including mental health and social service needs ~~and care of cognitively impaired clients~~ .

(1) Identifying the psychosocial characteristics of the populations who reside in nursing homes.

(2) Modifying *the aide's* behavior in response to behavior of clients.

(3) Identifying developmental tasks associated with the aging process.

(4) Providing training in and the opportunity for self care according to clients' capabilities.

(5) Demonstrating principles of behavior management by reinforcing appropriate behavior and causing inappropriate behavior to be reduced or eliminated.

(6) Demonstrating skills supporting age-appropriate behavior by allowing the client to make personal choices, providing and reinforcing other behavior consistent with clients' dignity.

(7) Utilizing client's family or concerned others as a source of emotional support.

(8) Responding appropriately to client's behavior.

e. Care of the cognitively impaired client.

(1) Using techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimer's and others).

(2) Communicating with cognitively impaired residents.

(3) Demonstrating and understanding the behavior of cognitively impaired residents.

(4) Responding appropriately to the behavior of cognitively impaired residents.

(5) Using methods to reduce the effects of cognitive impairment.

~~e~~ *f* . Skills for basic restorative services.

(1) Using assistive devices in *transferring,* ambulation, eating and dressing.

(2) Maintaining range of motion.

(3) Turning and positioning, both in bed and chair.

~~(4) Transferring.~~

~~(5)~~ *(4)* Bowel and bladder training.

~~(6)~~ *(5)* Caring for and using prosthetic devices.

(6) Teaching the client in self-care according to the client's abilities as directed by a supervisor.

~~f~~ *g* . Clients' rights.

(1) Providing privacy and maintaining confidentiality.

(2) Promoting the client's right to make personal choices to accommodate individual needs.

(3) Giving assistance in resolving grievances.

(4) Providing assistance necessary to participate in client and family groups and other activities.

(5) Maintaining care and security of the client's personal possessions.

(6) ~~Providing care that maintains the client free from abuse, mistreatment or neglect and reporting improper care to appropriate persons~~ *Promoting the resident's rights to be free from abuse, mistreatment and neglect and the need to report any instances of such treatment to appropriate staff* .

(7) ~~Maintaining the client's environment and care to minimize the need for physical and chemical restraints~~ *Avoiding the need for restraints in accordance with current professional standards* .

3. Unit objectives.

a. Objectives for each unit of instruction shall be stated in behavioral terms including measurable performance criteria.

b. Objectives shall be reviewed with the students at the beginning of each unit.

E. Records.

1. Each nurse aide education program shall develop an individual performance record of major duties and skills taught. This record will consist of, at a minimum, a listing of the duties and skills expected to be learned in the program, space to record when the nurse aide student performs this duty or skill, spaces to note satisfactory or unsatisfactory performance, the date of performance, and the instructor supervising the performance. At the completion of the nurse aide education program, the nurse aide and his employer must receive a copy of this record.

2. A record of the reports of graduates' performance on the approved competency evaluation program shall be maintained.

3. A record that documents the disposition of complaints against the program shall be maintained.

F. Student identification.

The nurse aide students shall wear identification that is clearly recognizable to clients, visitors and staff.

G. Length of program.

1. The program shall be at least 80 hours in length.

2. The program shall provide for at least 16 hours of instruction prior to direct involvement of a student with a nursing facility client.

3. Skills training in clinical settings shall be at least 40 hours. Five of the clinical hours may be in a setting other than a nursing home.

4. Employment orientation to facilities used in the education program must not be included in the 80 hours allotted for the program.

H. Classroom facilities.

The nurse aide education program shall provide facilities that meet federal and state requirements including

1. Comfortable temperatures.

2. Clean and safe conditions.

3. Adequate lighting.

4. Adequate space to accommodate all students.

5. All equipment needed, including audio-visual equipment and that needed for simulating resident care.

I. Program review.

1. Each nurse aide education program shall be reviewed on site by an agent of the board at least every two years following initial review.

2. The report of the site visit shall be presented to the board for consideration and action. The report and the action taken by the board shall be sent to the appropriate administrative officer of the program.

3. The program coordinator shall prepare and submit a program evaluation report on a form provided by the board in the intervening year that an on site review is not conducted.

4. A nurse aide education program shall continue to be approved provided the requirements set forth in subsections B through H of § 5.3 of these regulations are maintained.

5. If the board determines that a nurse aide education program is not maintaining the requirements of subsections B through H of § 5.3 of these regulations, *with the exception of § 5.3 B 5 of these regulations,* the program shall be placed on conditional approval and be given a reasonable period of time to correct the identified deficiencies. The program provider may request a hearing before the board and the provisions of the Administrative Process Act shall apply. (§ 9-6.14:1 et seq.)

6. If the program fails to correct the identified deficiencies within the time specified by the board, the board shall withdraw the approval following a hearing held pursuant to the provisions of the Administrative Process Act. (§ 9-6.14:1 et seq.)

J. Curriculum changes.

Changes in curriculum must be approved by the board prior to implementation and shall be submitted for approval at the time of a report of a site visit or the report submitted by the program coordinator in the intervening years.

K. Closing of a nurse education program.

When a nurse aide education program closes, the program provider shall:

1. Notify the board of the date of closing.

2. Submit to the board a list of all graduates with the date of graduation of each.

§ 5.4. Nurse aide competency evaluation.

A. The board may contract with a test service for the development and administration of a competency evaluation.

B. All individuals completing a nurse aide education program in Virginia shall successfully complete the competency evaluation required by the board prior to making application for certification and to using the title Certified Nurse Aide.

C. The board shall determine the minimum passing score on the competency evaluation.

§ 5.5. Nurse aide registry.

A. Initial certification by examination.

1. To be placed on the registry and certified, the nurse aide must:

a. Satisfactorily complete a nurse aide education program approved by the board; or

b. Be enrolled in a nursing education program preparing for registered nurse or practical nurse licensure, have completed at least one nursing course which includes clinical experience involving client care; or

c. Have completed a nursing education program preparing for registered nurse licensure or practical nurse licensure; and

d. Pass the competency evaluation required by the board; and

e. Submit the required application and fee to the board.

2. Initial certification by endorsement.

a. A graduate of a state approved nurse aide education program who has satisfactorily completed a competency evaluation program and been registered in another state may apply for certification in Virginia by endorsement.

b. An applicant for certification by endorsement shall submit the required application and fee and submit the required verification form to the credentialing agency in the state where registered, certified or licensed within the last two years.

3. Initial certification shall be for two years.

B. Renewal of certification.

1. No less than 30 days prior to the expiration date of the current certification, an application for renewal shall be mailed by the board to the last known address of each currently registered certified nurse aide.

2. The certified nurse aide shall return the completed application with the required fee and verification of performance of nursing-related activities for

compensation within the preceding two years.

3. Failure to recieve the application for renewal shall not relieve the certificate holder of the responsibility for renewing the certification by the expiration date.

4. A certified nurse aide who has not performed nursing-related activities for compensation during the two years preceding the expiration date of the certification shall repeat an approved nurse aide education program and the nurse aide competency evaluation prior to applying for recertification.

C. Reinstatement of lapsed certification.

An individual whose certification has lapsed shall file the required application and renewal fee and:

1. Verification of performance of nursing-related activities for compensation within the preceding two years; or

2. When nursing activities have not been performed during the preceding two years, evidence of having repeated an approved nurse aide education program and the nurse aide competency evaluation.

D. Evidence of change of name.

A certificate holder who has changed his name shall submit as legal proof to the board a copy of the marriage certificate or court order authorizing the change. A duplicate certificate shall be issued by the board upon receipt of such evidence and the required fee.

E. Requirements for current mailing address.

1. All notices required by law and by these regulations to be mailed by the board to any certificate holder shall be validly given when mailed to the latest address on file with the board.

2. Each certificate holder shall maintain a record of his current mailing address with the board.

3. Any change of address by a certificate holder shall be submitted in writing to the board within 30 days of such change.

§ 5.6. The board has the authority to deny, revoke or suspend a certificate issued, or to otherwise discipline a certificate holder upon proof that he has violated any of the provisions of § 54.1-3007 of the Code of Virginia. For the purpose of establishing allegations to be included in the notice of hearing, the board has adopted the following definitions:

1. Fraud or deceit shall mean, but shall not be limited to:

a. Filing false credentials;

b. Falsely representing facts on an application for initial certification, reinstatement or renewal of a certificate; or

c. Giving or receiving assistance in taking the competency evaluation.

2. Unprofessional conduct shall mean, but shall not be limited to:

a. Performing acts beyond those authorized for practice as a nurse aide as defined in Chapter 30 of Title 54.1;

b. Assuming duties and responsibilities within the practice of a nurse aide without adequate training or when competency has not been maintained;

c. Obtaining supplies, equipment or drugs for personal or other unauthorized use;

d. Falsifying or otherwise altering client or employer records;

e. Abusing, neglecting or abandoning clients; or

f. Having been denied a license or having had a license issued by the board revoked or suspended.

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~~* Implementing instructions, dated April 1980, from the Health Care Financing Administration, of the U.S. Department of Health and Human Services, state that, "When the program coordinator is the director of nursing, qualified assistance must be available so that the nursing service responsibilities of the director of nursing are covered."~~

.....

COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

910 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-3591

February 27, 1992

Mr. Bernard L. Henderson, Jr.
Board of Nursing
1601 Rolling Hills Drive, Suite 200
Richmond, Virginia 23229-5005

RE: VR 495-01-1. Board of Nursing Regulations

Dear Mr. Henderson:

After a thorough review of the above-referenced regulations and the copy of the Federal Health Care Financing Administrative Rules, 42 CFR (§§ 483.151 through 483.156), [Medicare and Medicaid Programs; Nurse Aide Training and Competency Evaluation Programs], effective April 1, 1992, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act.

This exemption from Article 2 of Chapter 1.1:1 of the Code of Virginia is allowed under the provisions of § 9-6.14:4.1 C.4.(c).

Sincerely,

Joan W. Smith
Registrar of Regulations

JWS:jbc

REAL ESTATE APPRAISER BOARD

Title of Regulation: **VR 583-01-03. Real Estate Appraiser Board Regulations.**

Statutory Authority: § 54.1-2013 of the Code of Virginia.

Effective Date: April 15, 1992.

Summary:

Pursuant to Chapter 20.1 (§ 54.1-2009 et seq.) of Title 54.1 of the Code of Virginia and in accordance with Chapter 1.1:1 (§ 9-6.14:1 et seq.) of Title 9 of the Code of Virginia, the Real Estate Appraiser Board submits its final regulation governing real estate appraisers to replace its existing emergency regulation which will expire April 14, 1992.

This new regulation establishes the qualifications for licensure of real estate appraisers in Virginia. The regulation outlines the educational, experience and examination requirements necessary for the licensure and renewal of licenses issued to certified general, certified residential and licensed residential real estate appraisers. Also included is information on certification of instructors and courses acceptable for licensure and continuing education. In addition, the regulation sets forth the standards of conduct and standards of practice that shall be maintained by licensed appraisers and certified instructors.

The final changes delete the national registry fee paid by temporary licensees to conform to federal requirements for payment of this fee. The board also revised the information provided on use of the seal. The regulation clarifies where the seal is used when preparing various appraisal reports. Record keeping requirements have been revised to state that the provider of the course will be responsible for maintaining the records, not the individual instructor. A revision to the Standards section of the regulation allows the board to take action against an applicant who provides false or fraudulent information when applying for a license or registration.

VR 583-01-03. Real Estate Appraiser Board Regulations.

PART I.
GENERAL.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, unless a different meaning is provided or is plainly required by the context, shall have the following meanings:

"Accredited colleges, universities, junior and community colleges" means those accredited institutions of higher learning approved by the Virginia Council of Higher Education or listed in the Transfer Credit Practices of Designated Educational Institutions, published by the American Association of Collegiate Registrars and Admissions Officers.

"Adult distributive or marketing education programs" means those programs offered at schools approved by the Virginia Department of Education or any other local, state, or federal government agency, board or commission to teach adult education or marketing courses.

"Appraisal Foundation" means the foundation incorporated as an Illinois Not for Profit Corporation on November 30, 1987, to establish and improve uniform appraisal standards by defining, issuing and promoting such standards.

"Appraiser Qualification Board" means the board created by the Appraisal Foundation to establish appropriate criteria for the certification and recertification of qualified appraisers by defining, issuing and promoting such qualification criteria; to disseminate such qualification criteria to states, governmental entities and others; and to develop or assist in the development of appropriate examinations for qualified appraisers.

"Business entity" means for the purpose of these regulations any corporation, partnership, association or other organization under which appraisal services are performed.

"Certified general real estate appraiser" means an individual who meets the requirements for licensure that relate to the appraisal of all types of real estate and real property and is licensed as a certified general real estate appraiser.

"Certified residential real estate appraiser" means an individual who meets the requirements for licensure for the appraisal of any residential real estate or real property of one to four residential units regardless of transaction value or complexity. Certified residential real estate appraisers may also appraise nonresidential properties with a transaction value up to $250,000.

"Classroom hour" means 50 minutes out of each 60-minute segment. The prescribed number of classroom hours includes time devoted to tests which are considered to be part of the course.

"Experience" as used in these regulations includes but is not limited to experience gained in the performance of traditional appraisal assignments, or in the performance of the following: fee and staff appraisals, ad valorem tax appraisal, review appraisal, appraisal analysis, real estate counseling, highest and best use analysis, feasibility analysis/study, and teaching of appraisal courses.

For the purpose of these regulations experience has been divided into five major categories: (i) fee and staff appraisal, (ii) ad valorem appraisal, (iii) review appraisal,

(iv) real estate consulting, and (v) teaching of real estate courses.

1. "Fee/staff appraiser experience": Fee/staff appraiser experience means experience acquired as either a sole appraiser or as a cosigner.

Sole appraiser experience is experience obtained by an individual who makes personal inspections of real estate, assembles and analyzes the relevant facts, and by the use of reason and the exercise of judgment, forms objective opinions and prepares reports as to the market value or other properly defined value of identified interests in said real estate.

Cosigner appraiser experience is experience obtained by an individual who signs an appraisal report prepared by another, thereby accepting full responsibility for the content and conclusions of the appraisal.

To qualify for fee/staff appraiser experience, an individual must have prepared written appraisal reports which meet minimum standards. For appraisal reports dated prior to July 1, 1991, these minimum standards include the following, where applicable:

a. An adequate identification of the real estate and the interests being appraised;

b. The purpose of the report, date of value, and date of report;

c. A definition of the value being appraised;

d. A determination of highest and best use;

e. An estimate of land value;

f. The usual valuation approaches for the property type being appraised or the reason for excluding any of these approaches;

g. A reconciliation and conclusion as to the property's value;

h. Disclosure of assumptions or limiting conditions, if any; and

i. Signature of appraiser.

For appraisal reports dated subsequent to July 1, 1991, the minimum standards for written appraisal reports are those as prescribed in Standard 2 of the Uniform Standards of Professional Appraisal Practice in the 1990 edition or the edition in effect at the time of the reports' preparation.

2. "Ad valorem [tax] appraisal experience" means experience obtained by an individual who assembles and analyzes the relevant facts, and who correctly employs those recognized methods and techniques that are necessary to produce and communicate credible appraisals within the context of the real property tax laws. Ad valorem [tax] appraisal experience may be obtained either through individual property appraisals or through mass appraisals as long as applicants under this category of experience can demonstrate that they are using techniques to value real property similar to those being used by fee/staff appraisers and that they are effectively utilizing the appraisal process.

To qualify for ad valorem [tax] appraisal experience for individual property appraisals, an individual must have prepared written appraisal reports which meet minimum standards. For appraisal reports dated prior to July 1, 1991, these minimum standards include the following, where applicable:

a. An adequate identification of the real estate and the interests being appraised;

b. The effective date of value;

c. A definition of the value being appraised if other than fee simple;

d. A determination of highest and best use;

e. An estimate of land value;

f. The usual valuation approaches for the property type being appraised or the reason for excluding any of these approaches;

g. A reconciliation and conclusion as to the property's value;

h. Disclosure of assumptions or limiting conditions, if any.

For appraisal reports dated subsequent to July 1, 1991, the minimum standards for written appraisal reports are those as prescribed in the Uniform Standards of Professional Appraisal Practice in the 1990 edition or the edition in effect at the time of the reports' preparation.

To qualify for ad valorem [tax] appraisal experience for mass appraisals, an individual must have prepared mass appraisals or have documented mass appraisal files which meet minimum standards. For mass appraisals dated prior to July 1, 1991, these minimum standards include the following, where applicable:

a. An adequate identification of the real estate and the interests being appraised;

b. The effective date of value;

c. A definition of the value being appraised if other

than fee simple;

d. A determination of highest and best use;

e. An estimate of land value;

f. Those recognized methods and techniques that are necessary to produce a credible appraisal.

For mass appraisal reports dated subsequent to July 1, 1991, the minimum standards for these appraisal reports are those as prescribed in Standard 6 of the Uniform Standards of Professional Appraisal Practice in the 1990 edition or the edition in effect at the time of the reports' preparation.

In addition to the preceding, to qualify for ad valorem appraisal experience, the applicant's experience log must be attested to by the applicant's supervisor.

3. "Reviewer experience" means experience obtained by an individual who examines the reports of appraisers to determine whether their conclusions are consistent with the data reported and other generally known information. An individual acting in the capacity of a reviewer does not necessarily make personal inspection of real estate, but does review and analyze relevant facts assembled by fee/staff appraisers, and by the use of reason and exercise of judgment, forms objective conclusions as to the validity of fee/staff appraisers' opinions. In cases where reviewer experience is the sole category of experience being claimed by an individual, at least 25% of the required 2,000 hours (500 hours) must be in field review wherein the individual has personally inspected the real estate which is the subject of the review.

To qualify for reviewer experience, an individual must have prepared written reports recommending the acceptance, revision, or rejection of the fee/staff appraiser's opinions, which written reports must meet minimum standards. For appraisal reviews dated prior to July 1, 1991, these minimum standards include the following, where applicable:

a. An identification of the report under review, the real estate and real property interest being appraised, the effective date of the opinion in the report under review, and the date of the review;

b. A description of the review process undertaken;

c. An opinion as to the adequacy and appropriateness of the report being reviewed, and the reasons for any disagreement;

d. An opinion as to whether the analyses, opinions, and conclusions in the report under review are appropriate and reasonable, and the development of any reasons for any disagreement;

e. Signature of reviewer.

For appraisal review reports dated subsequent to July 1, 1991, the minimum standards for these appraisal reports are those as prescribed in Standard 3 of the Uniform Standards of Professional Appraisal Practice in the 1990 edition or the edition in effect at the time of the reports' preparation.

Signing as "Review Appraiser" on an appraisal report prepared by another will not qualify an individual for experience in the reviewer category. Experience gained in this capacity will be considered under the Cosigner subcategory of Fee/staff appraiser experience.

4. "Real estate counseling experience" means experience obtained by an individual who assembles and analyzes the relevant facts and by the use of reason and the exercise of judgment, forms objective opinions concerning matters other than value estimates relating to real estate. Real estate counseling experience includes, but is not necessarily limited to, the following:

Absorption Study	Ad Valorem Tax Study
Annexation Study	Assemblage Study
Assessment Study	Condominium Conversion Study
Cost-Benefit Study	Cross Impact Study
Depreciation/Cost Study	Distressed Property Study
Economic Base Analysis	Economic Impact Study
Economic Structure Analysis	Eminent Domain Study
Feasibility Study	Highest and Best Use Study
Impact Zone Study	Investment Analysis Study
Investment Strategy Study	Land Development Study
Land Suitability Study	Land Use Study
Location Analysis Study	Market Analysis Study
Market Strategy Study	Market Turning Point Analysis
Marketability Study	Portfolio Study
Rehabilitation Study	Remodeling Study
Rental Market Study	Right of Way Study
Site Analysis Study	Utilization Study
Urban Renewal Study	Zoning Study

To qualify for real estate counseling experience, an individual must have prepared written reports which meet minimum standards. For real estate counseling reports dated prior to July 1, 1991, these minimum standards include the following, where applicable:

a. A definition of the problem;

b. An identification of the real estate under consideration (if any);

c. Disclosure of the client's objective;

d. The effective date of the consulting assignment and date of report;

e. The information considered, and the reasoning that supports the analyses, opinions, and conclusions;

f. Any assumptions and limiting conditions that affect the analyses, opinions, and conclusions;

g. Signature of real estate counselor.

For real estate counseling reports dated subsequent to July 1, 1991, the minimum standards for these appraisal reports are those as prescribed in Standard 4 of the Uniform Standards of Professional Appraisal Practice in the 1990 edition or the edition in effect at the time of the reports' preparation. Real estate counseling shall not constitute more than 1,000 hours of experience for any type of appraisal license.

5. "Teaching experience" means experience obtained by an individual in the instruction of real estate appraisal or real estate related seminars/courses as well as in the authorship of real estate appraisal and analysis publications. Experience in these areas will be considered on the following basis:

a. Seminar and course instructions: The number of approved hours is based on the published number of classroom hours stated in the official college catalog or similar publication of other educational bodies or professional organizations.

b. Authorship: Authorship of published books, journal articles and theses may count toward an applicant's experience credit as follows:

(1) Topic must relate to real estate valuation or analysis;

(2) A book will be credited 150 hours, a journal article will be credited 20 hours, and a thesis will be credited 50 hours.

Credit may be earned only once for instruction of courses having substantially equivalent content. In cases where there is more than one instructor, credit will be pro-rated based on each instructor's participation.

"Licensed residential real estate appraiser" means an individual who meets the requirements for licensure for the appraisal of any noncomplex, residential real estate or real property of one to four residential units, including federally related transactions, where the transaction value is less than $1 million. Licensed residential real estate appraisers may also appraise noncomplex, nonresidential properties with a transaction value up to $250,000.

"Licensee" means any individual holding a license issued by the Real Estate Appraiser Board to act as a certified general real estate appraiser, certified residential [real estate appraiser] , or licensed residential real estate appraiser as defined, respectively, in § 54.1-2009 of the Code of Virginia and in these regulations.

"Local, state or federal government agency, board or commission" means an entity established by any local, federal or state government to protect or promote the health, safety and welfare of its citizens.

"Proprietary school" means a privately owned school offering appraisal or appraisal related courses approved by the board.

"Provider" means accredited colleges, universities, junior and community colleges; adult distributive or marketing education programs; local, state or federal government agencies, boards or commissions; proprietary schools; or real estate appraisal or real estate related organizations.

"Real estate appraisal or real estate related organization" means any appraisal or real estate related organization formulated on a national level, where its membership extends to more than one state or territory of the United States.

"Registrant" means any corporation, partnership, association or other [~~business~~ ~~entity~~ organization] which provides appraisal services and which is registered with the Real Estate Appraiser Board in accordance with § 54.1-2011 E of the Code of Virginia.

"Substantially equivalent" is a description for any educational course or seminar, experience, or examination taken in this or another jurisdiction which is equivalent in classroom hours, course content and subject, and degree of difficulty, respectively, to those requirements outlined in these regulations and Chapter 20.1 of Title 54.1 of the Code of Virginia for licensure and renewal.

"Transaction value" means the monetary amount of a transaction which may require the services of a certified or licensed appraiser for completion. The transaction value is not always equal to the market value of the real property interest involved. For loans or other extensions of credit, the transaction value equals the amount of the loan or other extensions of credit. For sales, leases, purchases and investments in or exchanges of real property, the transaction value is the market value of the real property interest involved. For the pooling of loans or interests in real property for resale or purchase, the transaction value is the amount of the loan or the market value of real property calculated with respect to each such loan or interest in real property.

"Uniform Standards of Professional Appraisal Practice" means those standards promulgated by the Appraisal Standards Board of the Appraisal Foundation for use by all appraisers in the preparation of appraisal reports.

PART II.
ENTRY.

§ 2.1. Requirement for registration.

A business entity seeking to provide appraisal services shall register with the board by completing an application

furnished by the board describing the location, nature and operation of its practice, and the name and address of the registered agent, an associate, or a partner of the business entity. Along with a completed application form, domestic corporations shall provide a copy of the Certificate of Incorporation as issued by the State Corporation Commission, foreign (out-of-state) corporations shall provide a copy of the Certificate of Authority from the State Corporation Commission, partnerships shall provide a copy of the certified Partnership Certificate, and other business entities trading under a fictitious name shall provide a copy of the certificate filed with the clerk of the court where business is to be conducted.

§ 2.2. General qualifications for licensure.

Every applicant to the Real Estate Appraiser Board for a certified general, certified residential, or licensed residential real estate appraiser license shall meet the following qualifications:

1. The applicant shall be of good moral character, honest, truthful, and competent to transact the business of a licensed real estate appraiser in such a manner as to safeguard the interests of the public.

2. The applicant shall meet the current educational and experience requirements and submit a license application to the Department of Commerce or its agent prior to the time the applicant is approved to take the licensing examination. Applications received by the department or its agent must be complete within 12 months of the date of the receipt of the license application and fee by the Department of Commerce or its agent.

3. The applicant shall be in good standing as a real estate appraiser in every jurisdiction where licensed or certified; the applicant may not have had a license or certification which was suspended, revoked or surrendered in connection with a disciplinary action or which has been the subject of discipline in any jurisdiction prior to applying for licensure in Virginia.

4. The applicant may not have been convicted, found guilty or pled guilty, regardless of adjudication, in any jurisdiction of a misdemeanor involving moral turpitude or of any felony. Any plea of nolo contendere shall be considered a conviction for purposes of this subdivision. The record of a conviction authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where convicted shall be admissible as prima facie evidence of such conviction.

5. The applicant shall be at least 18 years old.

6. Applicants for licensure who do not meet the requirements set forth in subdivisions 3 and 4 of this section may be approved for licensure following consideration of their application by the board.

§ 2.3. Additional qualifications for licensure of licensed residential real estate appraisers.

An applicant for a license as a licensed residential real estate appraiser shall meet the following educational, experience and examination requirements in addition to those set forth in § 2.2 of these regulations:

1. The applicant shall have successfully completed 75 classroom hours of approved real estate appraisal courses from accredited colleges, universities, junior and community colleges; adult distributive or marketing education programs; local, state or federal government agencies, boards or commissions; proprietary schools; or real estate appraisal or real estate related organizations.

2. The applicant shall have a minimum of two calendar years and 2,000 hours experience as an appraiser. The maximum number of appraisal credit hours which may be awarded in one calendar year is 1,000 hours. Hours may be treated as cumulative in order to achieve the necessary 2,000 hours of appraisal experience. The applicant shall execute an affidavit as a part of the application for licensure attesting to his experience in the field of real estate appraisal. This experience must be supported by adequate written reports or file memoranda which shall be made available to the board upon request.

3. Within 12 months after being approved by the board to take the licensed residential real estate appraiser examination, the applicant shall have registered for and passed a written examination provided by the board or by a testing service acting on behalf of the board.

§ 2.4. Additional qualifications for licensure for certified residential real estate appraisers.

An applicant for a license as a certified residential real estate appraiser shall meet the following educational, experience and examination requirements in addition to those set forth in § 2.2 of these regulations:

1. The applicant shall have successfully completed 105 classroom hours of approved real estate appraisal courses from accredited colleges, universities, junior and community colleges; adult distributive or marketing education programs; local, state or federal government agencies, boards or commissions; proprietary schools; or real estate appraisal or real estate related organizations or other providers approved by the board. The 105 classroom hours may include the 75 classroom hours required for the licensed residential real estate appraiser.

After January 1, 1994, applicants must complete 165 classroom hours of real estate appraisal courses which shall include coverage of required subjects.

2. The applicant shall have a minimum of two calendar years and 2,000 hours experience as a real estate appraiser. The maximum number of appraisal credit hours which may be awarded in one calendar year is 1,000 hours. Hours may be treated as cumulative in order to achieve the necessary 2,000 hours of appraisal experience. The applicant shall execute an affidavit as a part of the application for licensure attesting to his experience in the field of real estate appraisal. This experience must be supported by adequate written reports or file memoranda which shall be made available to the board upon request.

3. Within 12 months after being approved by the board to take the certified residential real estate appraiser examination, the applicant shall have registered for and passed a written examination provided by the board or by a testing service acting on behalf of the board.

§ 2.5. Additional qualifications for licensure for certified general real estate appraisers.

An applicant for a license as a certified general real estate appraiser shall meet the following educational, experience, and examination requirements in addition to those set forth in § 2.2 of these regulations:

1. The applicant shall have successfully completed 165 classroom hours of approved real estate appraisal courses from accredited colleges, universities, junior and community colleges; adult distributive or marketing education programs; local, state or federal government agencies, boards or commissions; proprietary schools; or real estate appraisal or real estate related organizations. The 165 classroom hours may include the 75 classroom hours required for the licensed residential real estate appraiser, or the 105 classroom hours required for the certified residential real estate appraiser.

All applicants for licensure as a certified general real estate appraiser must complete an advanced level appraisal course of at least 30 classroom hours in the appraisal of nonresidential properties.

2. The applicant shall have a minimum of two calendar years and 2,000 hours experience as a real estate appraiser. The maximum number of appraisal credit hours which may be awarded in one calendar year is 1,000 hours. Hours may be treated as cumulative in order to achieve the necessary 2,000 hours of appraisal experience. For all applicants for a certified general real estate appraiser license, at least 50% of the appraisal experience required (1,000 hours) must be in nonresidential appraisal assignments.

The applicant shall execute an affidavit as a part of the application for licensure attesting to his experience in the field of real estate appraisal. This experience must be supported by adequate written reports or file memoranda which shall be made available to the board upon request.

3. Within 12 months after being approved by the board to take the certified general real estate appraiser examination, the applicant shall have registered for and passed a written examination provided by the board or by a testing service acting on behalf of the board.

§ 2.6. Qualifications for licensure by reciprocity.

Every applicant to the Real Estate Appraiser Board for a license by reciprocity shall have met the following qualifications:

1. An individual who is currently licensed or certified as a real estate appraiser in another jurisdiction may obtain a Virginia real estate appraiser license by providing documentation that the applicant has met educational, experience and examination requirements that are substantially equivalent to those required in Virginia for the appropriate level of licensure. All reciprocal applicants shall be required to pass the Virginia appraiser law and regulation section of the licensing examination prior to licensure.

2. The applicant shall be at least 18 years of age.

3. The applicant shall sign, as part of the application, an affidavit certifying that the applicant has read and understands the Virginia real estate appraiser license law and the regulations of the Real Estate Appraiser Board.

4. The applicant shall be in good standing as a licensed or certified real estate appraiser in every jurisdiction where licensed or certified; the applicant may not have had a license or certification as a real estate appraiser which was suspended, revoked, or surrendered in connection with a disciplinary action or which has been the subject of discipline in any jurisdiction prior to applying for licensure in Virginia.

5. The applicant shall be of good moral character, honest, truthful, and competent to transact the business of a licensed real estate appraiser in such a manner as to safeguard the interests of the public.

6. The applicant may not have been convicted, found guilty or pled guilty, regardless of adjudication, in any jurisdiction of a misdemeanor involving moral turpitude or of any felony. Any plea of nolo contendere shall be considered a conviction for purposes of this subdivision. The record of a conviction authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where convicted shall be admissible as prima facie evidence of such conviction.

7. Applicants for licensure who do not meet the requirements set forth in subdivisions 4 and 6 of this section may be approved for licensure following consideration by the board.

§ 2.7. Qualifications for temporary licensure as a certified general real estate appraiser, certified residential real estate appraiser or licensed residential real estate appraiser.

An individual who is currently licensed or certified as a real estate appraiser in another jurisdiction may obtain a temporary Virginia real estate appraiser's license as required by Section 1121 of the Federal Financial Institutions Reform, Recovery and Enforcement Act of 1989.

The appraiser's certification or license issued by another state shall be recognized as equivalent to a Virginia license provided that:

1. The appraiser's business is of a temporary nature, and is limited to one specific assignment.

2. The education, experience and general examination completed in the jurisdiction of original licensure is deemed to be substantially equivalent to those required for the appropriate level of licensure in Virginia.

3. The applicant shall sign, as part of the application, an affidavit certifying that the applicant has read and understands the Virginia real estate appraiser license law and the regulations of the Real Estate Appraiser Board.

4. The applicant shall be in good standing as a licensed or certified real estate appraiser in every jurisdiction where licensed or certified; the applicant may not have had a license or certification as a real estate appraiser which was suspended, revoked, or surrendered in connection with a disciplinary action or which has been the subject of discipline in any jurisdiction prior to applying for licensure in Virginia.

5. The applicant shall be of good moral character, honest, truthful, and competent to transact the business of a real estate appraiser in such a manner as to safeguard the interest of the public.

6. The applicant may not have been convicted, found guilty or pled guilty, regardless of adjudication, in any jurisdiction of a misdemeanor involving moral turpitude or of any felony. Any plea of nolo contendere shall be considered a conviction for purposes of this subdivision. The record of a conviction authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where convicted shall be admissible as prima facie evidence of such conviction.

7. Applicants for licensure who do not meet the requirements set forth in subdivisions 4 and 6 of this section may be approved for licensure following consideration by the board.

8. The applicant shall be at least 18 years of age.

Applicants for temporary licensure shall verify the above information on an application form provided by the board. A temporary license cannot be renewed.

§ 2.8. Requirement for the certification of appraisal education instructors.

Pursuant to the mandate of Title 11 of the Federal Financial Institutions Reform, Recovery and Enforcement Act of 1989, and § 54.1-2013 of the Code of Virginia, instructing appraisal educational offerings to satisfy the prelicensure education qualifications for licensure of real estate appraisers shall be certified by the board. Instructors employed or contracted by accredited colleges, universities, junior and community colleges, or adult distributive or marketing education programs are not required to be certified by the board.

§ 2.9. Qualifications for the certification of instructors.

Qualifications for certification:

1. Baccalaureate degree in real estate, economics, finance or business, and have satisfied the state appraisal licensing educational requirements for the level being instructed; or

2. Baccalaureate degree and a current appraisal license for the level being instructed; or

3. Seven years of discipline-free active experience acquired in the appraisal field in the past 10 years and a current appraisal license for the level being instructed.

§ 2.10. Application and registration fees.

All application fees for licenses and registrations are nonrefundable.

1. Application fees for registrations, certificates and licenses are as follows:

Registration of business entity	*$ 75*
Certified General Real Estate Appraiser	*$120*
Temporary Certified General Real Estate Appraiser	*$120*
Certified Residential Real Estate Appraiser	*$120*
Temporary Certified Residential Real Estate Appraiser	*$120*

Licensed Residential Real Estate Appraiser $120

Temporary Licensed Residential Real Estate Appraiser $120

Certification of licensure ..... $ 25

Instructor Certification $200

2. Examination fees. Examination fees are identical for all appraiser licensing examinations.

Examination fee to take the General or Residential section, and the State Laws and Regulations section $95

Examination fee to take the General or Residential section only $85

Examination fee to take the State Rules and Regulations section only $50

3. National Registry Fee Assessment for all permanent license applicants $50

To be assessed of each applicant in accordance with Section 1109 of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989. If the applicant fails to qualify for licensure, then this assessment fee will be refunded.

[~~*National Registry Fee Assessment for all temporary license applicants*~~ ..... ~~*$25*~~

~~*To be assessed of each temporary appraiser license applicant in accordance with Section 1109 of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989. If the applicant fails to qualify for licensure, then this assessment fee will be refunded.*~~]

PART III.
RENEWAL OF
LICENSE/REGISTRATION/CERTIFICATION.

§ 3.1. Renewal required.

Licenses issued under these regulations for certified general real estate appraisers, certified residential real estate appraisers and licensed residential real estate appraisers and registrations issued for business entities shall expire two years from the last day of the month in which they were issued, as indicated on the license or registration. Certifications issued under these regulations for instructors shall expire two years from the last day of the month in which they were issued, as indicated on the certification.

§ 3.2. Qualifications for renewal.

A. Continuing education requirements.

As a condition of renewal, and under § 54.1-2014 of the Code of Virginia, all certified general real estate appraisers, certified residential real estate appraisers, and licensed residential real estate appraisers, resident or nonresident, shall be required to complete continuing education courses satisfactorily within each licensing term.

1. Continuing education requirements for certified general real estate appraisers.

a. Certified general real estate appraisers must satisfactorily complete continuing education courses or seminars offered by accredited colleges, universities, junior and community colleges; adult distributive or marketing education programs; local, state or federal government agencies, boards or commissions; proprietary schools; or real estate appraisal or real estate related organizations of not less than 20 classroom hours during each licensing term.

b. Certified general real estate appraisers may also satisfy continuing education requirements by participation other than as a student in educational processes and programs approved by the board to be substantially equivalent for continuing education purposes including, but not limited to teaching, program development, or authorship of textbooks.

c. Three of the classroom hours completed to satisfy the continuing education requirements shall be a course approved by the board on recent developments in federal, state and local real estate appraisal law and regulation.

2. Continuing education requirements for certified residential real estate appraisers.

a. Certified residential real estate appraisers must satisfactorily complete continuing education courses or seminars offered by accredited colleges, universities, junior and community colleges; adult distributive or marketing education programs; local, state or federal government agencies, boards or commissions; proprietary schools; or real estate appraisal or real estate related organizations of not less than 20 classroom hours during each licensing term.

b. Certified residential real estate appraisers may also satisfy continuing education requirements by participation other than as a student in educational processes and programs approved by the board to be substantially equivalent for continuing education purposes including but not limited to teaching, program development, or authorship of textbooks.

c. Three of the classroom hours completed to satisfy the continuing education requirements shall be a course approved by the board on recent developments in federal, state and local real estate

appraisal law and regulation.

3. Continuing education requirements for licensed residential real estate appraisers.

a. Licensed residential real estate appraisers must satisfactorily complete continuing education courses or seminars offered by accredited colleges, universities, junior and community colleges; adult distributive or marketing education programs; local, state or federal government agencies, boards or commissions; proprietary schools; or real estate appraisal or real estate related organization of not less than 20 classroom hours during each licensing term.

b. Licensed residential real estate appraisers may also satisfy continuing education requirements by participation other than as a student in educational processes and programs approved by the board to be substantially equivalent for continuing education purposes including, but not limited to teaching, program development, or authorship of textbooks.

c. Licensed residential real estate appraisers must satisfactorily complete a three classroom hour continuing education course approved by the board on recent developments in federal, state and local real estate appraisal law and regulation.

B. Applicants for renewal of a license shall meet the standards for entry as set forth in subdivisions 1, 3 and 4 of § 2.2 of these regulations.

C. Applicants for the renewal of a registration shall meet the requirement for registration as set forth in § 2.1.

D. Applicants for the renewal of a certificate shall meet the standards for entry as set forth in § 2.9.

§ 3.3. Procedures for renewal.

A. The board will mail a renewal application form to the licensee and certificate holder at the last known home address and to the registered firm or at the last known business address. This form shall outline the procedures for renewal. Failure to receive the renewal application form shall not relieve the licensee, certificate holder or the registrant of the obligation to renew.

B. Prior to the expiration date shown on the license or registration, each licensee, certificate holder or registrant desiring to renew the license or registration shall return to the board the completed renewal application form and the appropriate renewal and registry fees as outlined in § 3.4 of these regulations.

C. The date on which the renewal application form and the appropriate fees are received by the Department of Commerce or its agent will determine whether the licensee, certificate holder or registrant is eligible for renewal. If either the renewal application form or renewal fee, including the registry fee, is received by the Department of Commerce or its agent after the expiration date, the license, certification or registration cannot be renewed and the licensee, certificate holder, or registrant shall reapply for licensure as a new applicant, meeting current education, examination and experience requirements.

§ 3.4. Fees for renewal.

A. National registry fee assessment.

In accordance with the requirements of Section 1109 of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989, $50 of the biennial renewal fee assessed for all certified general real estate appraisers, certified residential and licensed residential real estate appraisers shall be submitted to the Appraisal Subcommittee. All remaining fees for renewal are nonrefundable.

B. Renewal fees are as follows:

Certified general real estate appraiser	*$165*
Certified residential real estate appraiser	*$165*
Licensed residential real estate appraiser	*$165*
Registered business entity	*$ 75*
Certified instructor	*$200*

§ 3.5. Board discretion to deny renewal.

The board may deny renewal of a license, certification or registration for the same reasons as it may refuse initial licensure or registration or discipline a current licensee or registrant.

PART IV.
STANDARDS.

§ 4.1. Grounds for disciplinary action.

The board has the power to fine any licensee, registrant or certificate holder, and to suspend or revoke any license, registration or certification issued under the provisions of Chapter 20.1 of Title 54.1 of the Code of Virginia and the regulations of the board, in accordance with §§ 54.1-201(7), 54.1-202 and the provisions of the Administrative Process Act, Chapter 1.1:1 of Title 9 of the Code of Virginia, when any licensee, registrant or certificate holder has been found to have violated or cooperated with others in violating any provision of Chapter 20.1 of Title 54.1 of the Code of Virginia, any relevant provision of the Uniform Standards of Professional Appraisal Practice as developed by the Appraisal Standards Board of the Appraisal Foundation[1], or any regulation of the board.

§ 4.2. Standards of ethical conduct.

In obtaining a real estate appraiser license and performing a real estate appraisal, a licensee shall comply with the Ethics Provisions of the Uniform Standards of Professional Appraisal Practice and the following standards of ethical conduct:

1. All applicants for licensure shall follow all rules established by the board with regard to conduct at the examination. Such rules shall include any written instructions communicated prior to the examination date and any instruction communicated at the site, either written or oral, on the date of the examination. Failure to comply with all rules established by the board or a testing service acting on behalf of the board with regard to conduct at the examination shall be grounds for denial of a license.

2. A licensee, certificate holder or registrant shall not obtain [or attempt to obtain] a license, certification or registration by false or fraudulent representation.

3. A licensee, registrant or certificate holder shall not make any misrepresentation.

§ 4.3. Standards of professional practice.

A. Maintenance of licenses.

1. Change of address.[2]

a. Certified general real estate appraisers, certified residential real estate appraisers and licensed residential real estate appraisers shall at all times keep the board informed in writing of their current home address.

b. Registered real estate appraisal business entities shall at all times keep the board informed in writing of their current business address.

c. Certified instructors as defined in §§ 2.8 and 2.9 of these regulations, shall at all times keep the board informed in writing of their current home address.

2. Change of name.[3]

a. Certified general real estate appraisers, certified residential real estate appraisers, licensed residential real estate appraisers and certified instructors shall promptly notify the board in writing and provide appropriate written legal verification of any change of name.

b. Registered real estate appraisal business entities shall promptly notify the board of any change of name or change of business structure in writing. In addition to written notification, corporations shall provide a copy of the Certificate of Amendment from the State Corporation Commission, partnerships shall provide a copy of a certified Partnership Certificate, and other business entities trading under a fictitious name shall provide a copy of the certificate filed with the clerk of the court where business is to be conducted.

3. Upon the the change of name or address of the registered agent, associate, or partner, or sole proprietor designated by a real estate appraisal business entity, the business entity shall notify the board in writing of the change within 30 days of such event.

4. No license, certification or registration issued by the board shall be assigned or otherwise transferred.

5. All licensees, certificate holders and registrants shall operate under the name in which the license or registration is issued.

6. All certificates of licensure, registration or certification in any form are the property of the Real Estate Appraiser Board. Upon death of a licensee, dissolution or restructure of a registered business entity, or change of a licensee's, registrant's, or certificate holder's name or address, such licenses, registrations, or certificates must be returned with proper instructions and supplemental material to the board within 30 days of such event.

7. All appraiser licenses issued by the board shall be visibly displayed.

B. Use of seal.

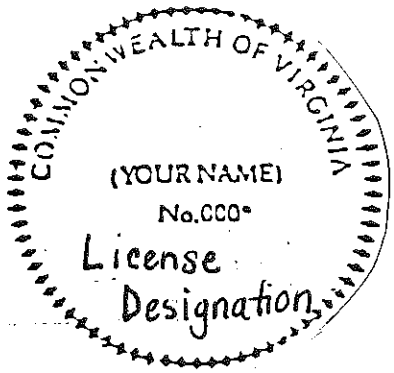
1. The authorized application of a licensed appraiser's seal shall indicate that the licensee has exercised complete direction and control over the appraisal. Therefore, no licensee shall affix his seal to any appraisal which has been prepared by an unlicensed person unless such work was performed under the direction and supervision of the licensee in accordance with § 54.1-2011 C of the Code of Virginia.

2. All original appraisal reports shall be issued under seal and signed by the licensed appraiser. [~~Such signature and seal shall appear on any page containing the final estimate or conclusion of value.~~ For narrative and letter appraisals, the signature, seal, and final value conclusion shall appear on the letter of transmittal and certification page. For form appraisals, the signature and seal shall appear on the page designated for the appraiser's signature and final estimate of value.] All temporary licensed real estate appraisers shall sign and affix their temporary license to the appraisal report [or letter] for which they obtained the license to authenticate such report [or letter] .

a. An appraiser may provide written reports, market analysis studies or valuations, which do not constitute appraisals, provided, that such reports, studies or evaluations shall contain a conspicuous statement that such reports, studies or valuations are not an appraisal as defined in § 54.1-2009 of the Code of Virginia.

b. Application of the seal and signature indicates acceptance of responsibility for work shown thereon.

c. The seal shall conform in detail and size to the design illustrated below:



**The number on the seal shall be the [10-digit] number [or the last 6 digits, or the last significant digits] on the license issued by the board.*

C. Development of appraisal.

In developing a real property appraisal, an appraiser shall comply with the provisions of Standard I of the Uniform Standards of Professional Appraisal Practice (USPAP) [in the 1990 edition or the edition in effect at the time of the reports' preparation] .[4]

D. Appraisal report requirements.

In reporting a real property appraisal, an appraiser shall meet the requirements of Standard II of the Uniform Standards of Professional Appraisal Practice [in the 1990 edition or the edition in effect at the time of the reports' preparation] .

E. Reviewing an appraisal.

In performing a review appraisal, a licensee shall comply with the requirements of Standard III of the Uniform Standards of Professional Appraisal Practice [in the 1990 edition or the edition in effect at the time of the reports' preparation. The reviewer's signature and seal shall appear on the certification page of the report] .

[~~F. Real estate consulting services.~~

~~In performing real estate consulting services, a licensee shall comply with the requirements of Standard IV of the Uniform Standards of Professional Appraisal Practice.~~]

[~~G~~ F] . Mass appraisals.

In developing and reporting a mass appraisal for ad valorem tax purposes, a licensee shall comply with the requirements of Standard VI of the Uniform Standards of Professional Appraisal Practice [in the 1990 edition or the edition in effect at the time of the reports' preparation] .

[~~H~~ G] . Record keeping requirements.

1. A licensee or registrant of the Real Estate Appraiser Board shall, upon request or demand, promptly produce to the board or any of its agents any document, book, or record in a licensee's possession concerning any appraisal which the licensee performed, or for which the licensee is required to maintain records for inspection and copying by the board or its agents. These records shall be made available at the licensee's place of business during regular business hours.

2. Upon the completion of an assignment, a licensee or registrant shall return to the rightful owner, upon demand, any document or instrument which the licensee possesses.

[~~I~~ H] . Disclosure requirements.

A licensee appraising property in which he, any member of his family, his firm, any member of his firm, or any entity in which he has an ownership interest, has any interest shall disclose, in writing, to any client such interest in the property and his status as a real estate appraiser licensed in the Commonwealth of Virginia. As used in the context of this regulation, "any interest" includes but is not limited to an ownership interest in the property to be appraised or in an adjacent property or involvement in the transaction, such as deciding whether to extend credit to be secured by such property.

[~~J~~ I] . Competency.

A licensee shall abide by the Competency Provision as stated in the Ethics Provision of the Uniform Standards of Professional Appraisal Practice [in the 1990 edition or the edition in effect at the time of the reports' preparation] .

[~~K~~ J] . Unworthiness.

1. A licensee shall act as a certified general real

estate appraiser, certified residential real estate appraiser or licensed residential real estate appraiser in such a manner as to safeguard the interests of the public, and shall not engage in improper, fraudulent, or dishonest conduct.

2. A licensee may not have been convicted, found guilty or pled guilty, regardless of adjudication, in any jurisdiction of the United States of a misdemeanor involving moral turpitude or of any felony there being no appeal pending therefrom or the time for appeal having elapsed. Any plea of nolo contendere shall be considered a conviction for the purposes of this subdivision. The record of a conviction certified or authenticated in such form as to be admissible in evidence of the laws of the jurisdiction where convicted shall be admissible as prima facie evidence of such guilt.

3. A licensee shall inform the board in writing within 30 days of pleading guilty or nolo contendere or being convicted or found guilty, regardless of adjudication, of any felony or of a misdemeanor involving moral turpitude.

4. A licensee may not have had a license or certification as a real estate appraiser which was suspended, revoked, or surrendered in connection with a disciplinary action or which has been the subject of discipline in any jurisdiction.

5. A licensee shall inform the board in writing within 30 days of the suspension, revocation or surrender of an appraiser license or certification in connection with a disciplinary action in any other jurisdiction, and a licensee shall inform the board in writing within 30 days of any appraiser license or certification which has been the subject of discipline in any jurisdiction.

§ 4.4. Standards of conduct for certified appraiser education instructors.

A. Instructors shall [~~*maintain*~~ *develop*] *a record for each student which shall included the student's name and address, the course name, the course hours and dates given, and the date the course was passed.* [*This record shall be retained by the course provider.*]

B. The instructor shall not solicit information from any person for the purpose of discovering past licensing examination questions or questions which may be used in future licensing examinations.

C. The instructor shall not distribute to any person copies of license examination questions, or otherwise communicate to any person license examination questions, without receiving the prior written approval of the copyright owner to distribute or communicate those questions.

D. The instructor shall not, through an agent or otherwise, advertise its services in a fraudulent, deceptive or misrepresentative manner.

E. Instructors shall not take any appraiser licensing examination for any purpose other than to obtain a license as a real estate appraiser.

PART V.
EDUCATIONAL OFFERINGS.

§ 5.1. Requirement for the approval of appraisal educational offerings.

Pursuant to the mandate of Title 11 of the Federal Financial Institutions Reform, Recovery and Enforcement Act of 1989, § 54.1-2013 of the Code of Virginia, and the qualifications criteria set forth by the Appraisal Qualifications Board of the Appraisal Foundation, all educational offerings submitted for prelicensure and continuing education credit shall be approved by the board. Although educational offerings which have been approved by the Appraisal Foundation's Educational Offering Review Panel may be considered to have met the standards for approval set forth in these regulations, all educational offerings must be approved by the board.

§ 5.2. Standards for the approval of appraisal educational offerings for prelicensure credit.

A. Content.

1. Prior to licensure, the applicant shall have successfully completed coverage of the Uniform Standards of Professional Appraisal Practice either as a portion of a qualified course of at least 15 classroom hours, or in a single, qualified course of at least 15 classroom hours. After July 1, 1992, applicants shall have successfully completed a 15 classroom hour course in the Uniform Standards of Professional Appraisal Practice.

2. While various appraisal courses may be credited toward the classroom requirement specified for each level of licensure, all applicants for licensure as a licensed residential or a certified residential real estate appraiser must demonstrate that their course work included coverage of all the topics listed below.

Appraisal standards and ethics
Influences on real estate value
Legal considerations in appraisal
Types of value
Land economic principles
Real estate markets and analysis
Valuation process
Property description and analysis
Highest and best use analysis
Appraisal statistical concepts
Sales comparison approach
Site valuation

Cost approach
Income approach
Valuation of partial interests

3. All appraisal and appraisal-related offerings presented for prelicensure credit must have a final, written examination.

4. Credit toward the classroom hour requirement to satisfy the educational requirement prior to licensure shall be granted only where the length of the educational offering is at least 15 classroom hours.

B. Instruction.

With the exception of courses taught at accredited colleges, universities, junior and community colleges, or adult distributive or marketing education programs, all other prelicensure educational offerings given after April 1, 1992, must be taught by instructors certified by the board.

§ 5.3. Standards for the approval of appraisal educational offerings for continuing education credit.

A. Content.

1. The content of courses, seminars, workshops or conferences which may be accepted for continuing education credit includes, but is not limited to those topics listed in § 5.2 A 2 and below.

Ad valorem taxation
Arbitrations
Business courses related to the practice of real estate appraisal
Construction estimating
Ethics and Uniform Standards of Professional Appraisal Practice
Land use planning, zoning, and taxation
Property development
Real estate appraisal (valuations/evaluations)
Real estate financing and investment
Real estate law
Real estate related computer applications
Real estate securities and syndication
Real property exchange

2. Courses, seminars, workshops or conferences submitted for continuing education credit must indicate that the licensee participated in an educational program that maintained and increased his knowledge, skill and competency in real estate appraisal.

3. Credit toward the classroom hour requirement to satisfy the continuing education requirements shall be granted only where the length of the educational offering is at least two hours and the licensee participated in the full length of the program.

4. As outlined in Part III of these regulations all certified general real estate appraisers, certified residential real estate appraisers, and licensed residential real estate appraisers shall complete 20 classroom hours prior to the renewal of any license. Three classroom hours shall cover recent developments in federal, state and local real estate appraisal law and regulation.

B. Instruction.

Although continuing education offerings are not required to be taught by board certified instructors, these offerings must meet the standards set forth in § 5.3 A of these regulations.

§ 5.4. Procedures for awarding prelicense and continuing education credits.

A. Course credits shall be awarded only once for courses having substantially equivalent content.

B. Proof of completion of such course, seminar, workshop or conference may be in the form of a transcript, certificate, letter of completion or in any such written form as may be required by the board. All courses, seminars and workshops submitted for prelicensure and continuing education credit must indicate the number of classroom hours.

C. Information which may be requested by the board in order to further evaluate course content includes, but is not limited to, course descriptions, syllabi or textbook references.

D. All transcripts, certificates, letters of completion or similar documents submitted to verify completion of seminars, workshops or conferences for continuing education credit must indicate successful completion of the course, seminar, workshop or conference. Applicants must furnish written proof of having received a passing grade in all prelicensure and continuing education courses submitted.

E. Credit may be awarded for prelicensure courses completed by challenge examination without classroom attendance, if such credit was granted by the course provider prior to July 1, 1990, and provided that the board is satisfied with the quality of the challenge examination that was administered by the course provider.

F. All courses seminars, workshops, or conferences, submitted for satisfaction of continuing education requirements must be satisfactory to the board.

G. Correspondence courses, video and remote TV educational offerings may be acceptable to meet the classroom hour requirements for prelicensure and continuing education courses provided each course or offering is approved by the board and has been presented

by an accredited college, university, junior or community college; the student passes a written examination administered at a location by an official approved by the college or university; the subject matter was appraisal related; and that the course or offering is a minimum of 15 classroom hours in length.

[*H. A teacher of appraisal courses may receive either education credit for the classroom hour(s) taught or experience credit for the classroom hour(s) taught, but not both. These credits shall be awarded only once for courses having substantially equivalent content.*]

§ 5.5. Course approval fees.

Course Approval Fee $200

§ 5.6. Re-approval of courses required.

Approval letters issued under these regulations for educational offerings shall expire two years from the last day of the month in which they were issued, as indicated in the approval letter.

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Footnotes

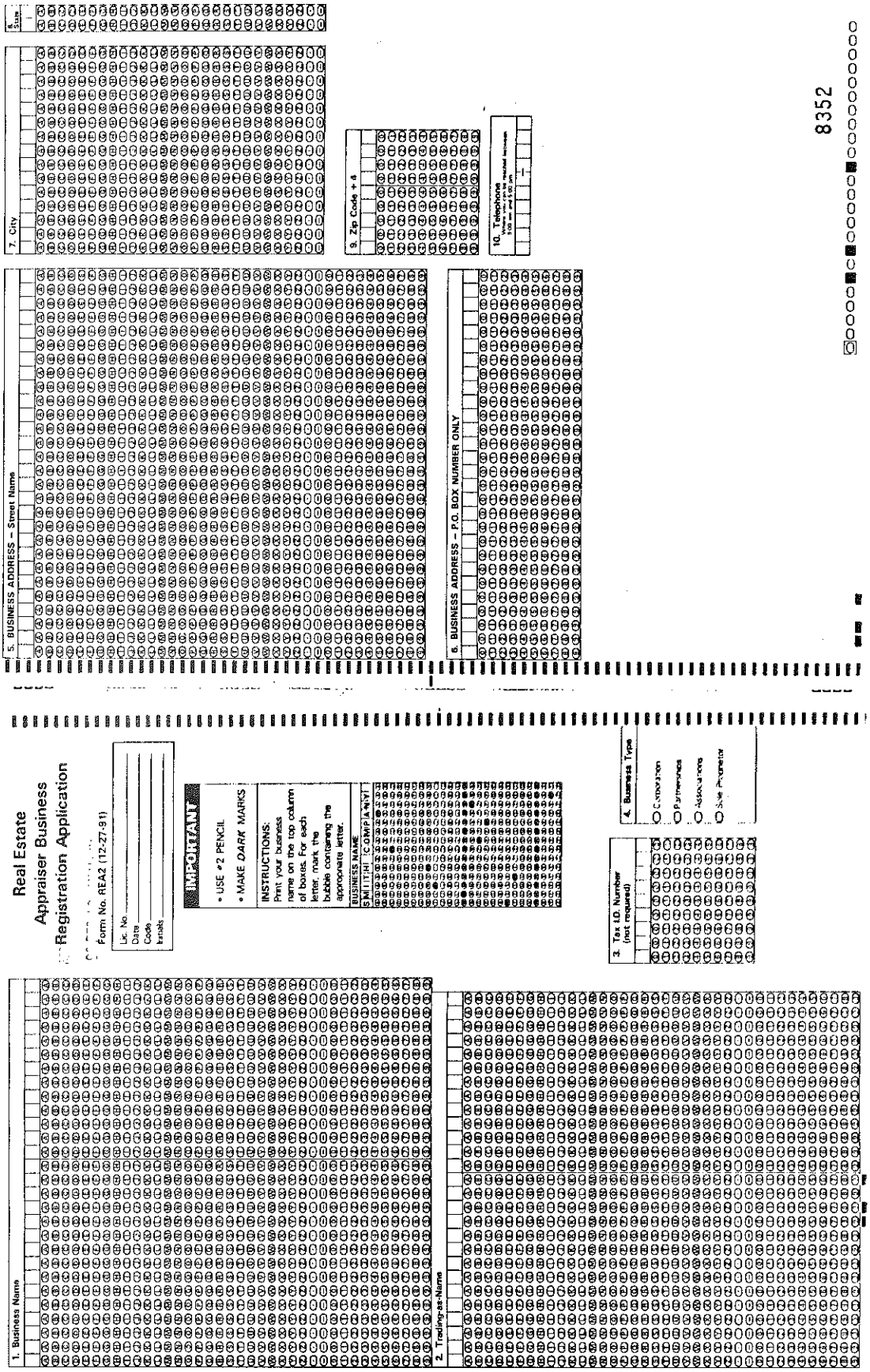
[1] The Uniform Standards of Professional Appraisal Practice ("USPAP") Copyright (c) 1987, 1990 are published by the Appraisal Foundation. All rights reserved. Copies of the Uniform Standards of Professional Appraisal Practice are available from the Appraisal Foundation, 1029 Vermont Avenue, NW, Suite 900, Washington D.C. 20005. The cost is $25.

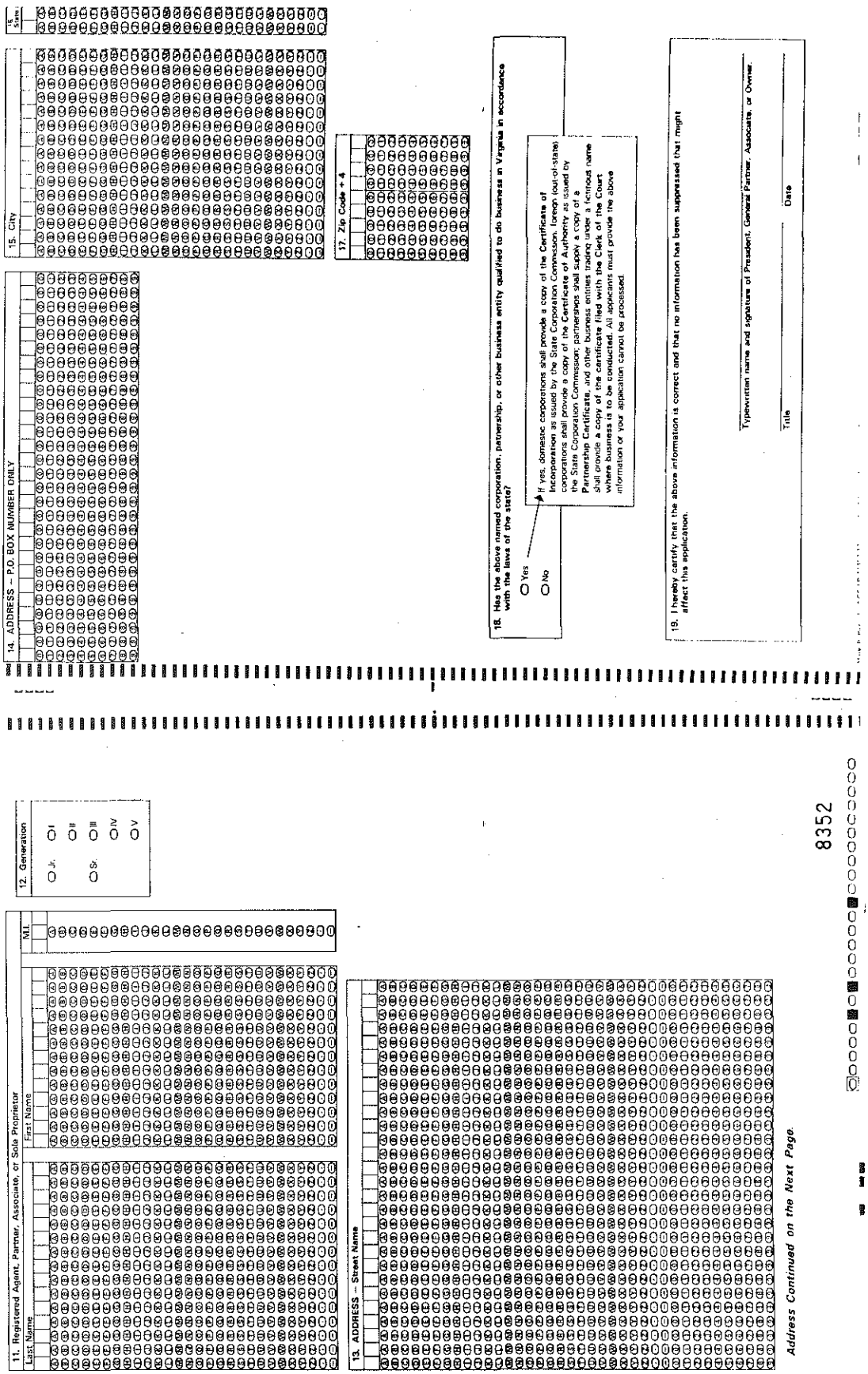
Some of the provisions contained in the Uniform Standards of Professional Appraisal Practice are inapplicable to real estate appraisals, and therefore are not applicable to Virginia Appraiser Board licensees. For example, the USPAP includes standards for the performance of personal property appraisals and a license is not required to perform such appraisals.

[2] The board shall not be responsible for the licensee's/registrant's failure to receive notices, communications and correspondence caused by the licensee's/registrant's failure to promptly notify the board of any change of address.

[3] The board shall not be responsible for the licensee's/registrant's failure to receive notices, communications and correspondence caused by the licensee's/registrant's failure to promptly notify the board of any change of name.

[4] Application of the Departure Provision of USPAP is not allowed for all federally related transactions requiring the services of an appraiser.


Real Estate
Appraiser Business
Registration Application
Form No. REA2 (12-27-91)
Lic. No
Date
Code
Initials
IMPORTANT
• USE #2 PENCIL
• MAKE DARK MARKS
INSTRUCTIONS:
Print your business name on the top column of boxes. For each letter, mark the bubble containing the appropriate letter.
BUSINESS NAME
SMITH'S COMPANY
1. Business Name
2. Trading-as-Name
3. Tax I.D. Number (not required)
4. Business Type
Corporation
Partnership
Association
Sole Proprietor
5. BUSINESS ADDRESS – Street Name
6. BUSINESS ADDRESS – P.O. BOX NUMBER ONLY
7. City
8. State
9. Zip Code + 4
10. Telephone
8352


15. State
15. City
17. Zip Code + 4
14. ADDRESS – P.O. BOX NUMBER ONLY
18. Has the above named corporation, partnership, or other business entity qualified to do business in Virginia in accordance with the laws of the state?
Yes
No
If yes, domestic corporations shall provide a copy of the Certificate of Incorporation as issued by the State Corporation Commission; foreign (non-Virginia) corporations shall provide a copy of the Certificate of Authority as issued by the State Corporation Commission; partnerships shall supply a copy of a Partnership Certificate; and other business entities having used a fictitious name shall provide a copy of the certificate filed with the Clerk of the Court where business is to be conducted. All applicants must provide the above information or your application cannot be processed.
19. I hereby certify that the above information is correct and that no information has been suppressed that might affect this application.
Typewritten name and signature of President, General Partner, Associate, or Owner
Title
Date
12. Generation
Jr.
Sr.
I
II
III
IV
V
11. Registered Agent, Partner, Associate, or Sole Proprietor
Last Name
First Name
M.I.
13. ADDRESS – Street Name
8352
Address Continued on the Next Page.

COURSE IDENTIFICATION FORM

NAME ______________________________

ADDRESS ______________________________

SOCIAL SECURITY NUMBER (Not required) ____________________

TYPE OF LICENSE: ____LICENSED RESIDENTIAL ____CERTIFIED GENERAL

____TEMPORARY LICENSED RESIDENTIAL ____TEMPORARY CERTIFIED GENERAL

COURSE IDENTIFICATION FORM

Course Title/Number	
Name of Provider	
Address of Provider	
Classification of Provider	
Location of Course	
Beginning Date	
Completion Date	
Classroom Hours	

**Evidence of passing grade, i.e. transcript, certificate of completion, etc., should be attached

COURSE IDENTIFICATION FORM

Course Title/Number	
Name of Provider	
Address of Provider	
Classification of Provider	
Location of Course	
Beginning Date	
Completion Date	
Classroom Hours	

**Evidence of passing grade, i.e. transcript, certificate of completion, etc., should be attached

COURSE IDENTIFICATION FORM

Course Title/Number	
Name of Provider	
Address of Provider	
Classification of Provider	
Location of Course	
Beginning Date	
Completion Date	
Classroom Hours	

**Evidence of passing grade, i.e. transcript, certificate of completion, etc., should be attached

COURSE IDENTIFICATION FORM

NAME ______________________________

ADDRESS ______________________________

SOCIAL SECURITY NUMBER (Not required) ____________________

TYPE OF LICENSE: ____LICENSED RESIDENTIAL ____CERTIFIED GENERAL

____TEMPORARY LICENSED RESIDENTIAL ____TEMPORARY CERTIFIED GENERAL

COURSE IDENTIFICATION FORM

Course Title/Number	
Name of Provider	
Address of Provider	
Classification of Provider	
Location of Course	
Beginning Date	
Completion Date	
Classroom Hours	

**Evidence of passing grade, i.e. transcript, certificate of completion, etc., should be attached

COURSE IDENTIFICATION FORM

Course Title/Number	
Name of Provider	
Address of Provider	
Classification of Provider	
Location of Course	
Beginning Date	
Completion Date	
Classroom Hours	

**Evidence of passing grade, i.e. transcript, certificate of completion, etc., should be attached

COURSE IDENTIFICATION FORM

Course Title/Number	
Name of Provider	
Address of Provider	
Classification of Provider	
Location of Course	
Beginning Date	
Completion Date	
Classroom Hours	

**Evidence of passing grade, i.e. transcript, certificate of completion, etc., should be attached

Real Estate Appraiser Board Experience Log

Name: ____________________

Social Security Number: (not required) ____________________

Page ______ of ______

TYPE OF LICENSE (mark one)
- Certified General
- Licensed Residential
- Certified Residential

YEAR	ASSIGNMENT IDENTIFICATION	TYPE OF PROPERTY	RANGE OF VALUE	TYPE OF INVOLVEMENT	HOURS ON ASSIGNMENT	FOR REAB USE ONLY
1 19___		1 7 2 8 3 9 4 10 5 11 6 12	1 2 3 4 5	Fee/Staff Appraiser: Sole appraiser, Co-signer; Ad valorem; Reviewer; Real Estate counseling; Teaching	100 200 300 400 500 600 700 800 900 / 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9	
2 19___		1 7 2 8 3 9 4 10 5 11 6 12	1 2 3 4 5	Fee/Staff Appraiser: Sole appraiser, Co-signer; Ad valorem; Reviewer; Real Estate counseling; Teaching	100 200 300 400 500 600 700 800 900 / 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9	
3 19___		1 7 2 8 3 9 4 10 5 11 6 12	1 2 3 4 5	Fee/Staff Appraiser: Sole appraiser, Co-signer; Ad valorem; Reviewer; Real Estate counseling; Teaching	100 200 300 400 500 600 700 800 900 / 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9	
4 19___		1 7 2 8 3 9 4 10 5 11 6 12	1 2 3 4 5	Fee/Staff Appraiser: Sole appraiser, Co-signer; Ad valorem; Reviewer; Real Estate counseling; Teaching	100 200 300 400 500 600 700 800 900 / 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9	
5 19___		1 7 2 8 3 9 4 10 5 11 6 12	1 2 3 4 5	Fee/Staff Appraiser: Sole appraiser, Co-signer; Ad valorem; Reviewer; Real Estate counseling; Teaching	100 200 300 400 500 600 700 800 900 / 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9	
6 19___		1 7 2 8 3 9 4 10 5 11 6 12	1 2 3 4 5	Fee/Staff Appraiser: Sole appraiser, Co-signer; Ad valorem; Reviewer; Real Estate counseling; Teaching	100 200 300 400 500 600 700 800 900 / 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9	
7 19___		1 7 2 8 3 9 4 10 5 11 6 12	1 2 3 4 5	Fee/Staff Appraiser: Sole appraiser, Co-signer; Ad valorem; Reviewer; Real Estate counseling; Teaching	100 200 300 400 500 600 700 800 900 / 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9	
8 19___		1 7 2 8 3 9 4 10 5 11 6 12	1 2 3 4 5	Fee/Staff Appraiser: Sole appraiser, Co-signer; Ad valorem; Reviewer; Real Estate counseling; Teaching	100 200 300 400 500 600 700 800 900 / 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9	
9 19___		1 7 2 8 3 9 4 10 5 11 6 12	1 2 3 4 5	Fee/Staff Appraiser: Sole appraiser, Co-signer; Ad valorem; Reviewer; Real Estate counseling; Teaching	100 200 300 400 500 600 700 800 900 / 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9	
10 19___		1 7 2 8 3 9 4 10 5 11 6 12	1 2 3 4 5	Fee/Staff Appraiser: Sole appraiser, Co-signer; Ad valorem; Reviewer; Real Estate counseling; Teaching	100 200 300 400 500 600 700 800 900 / 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9	

Trans-Reflex by NCS EP 41455:32 Printed in U.S.A.

C O U R S E T I T L E / N U M B E R - S U B J E C T F O R M

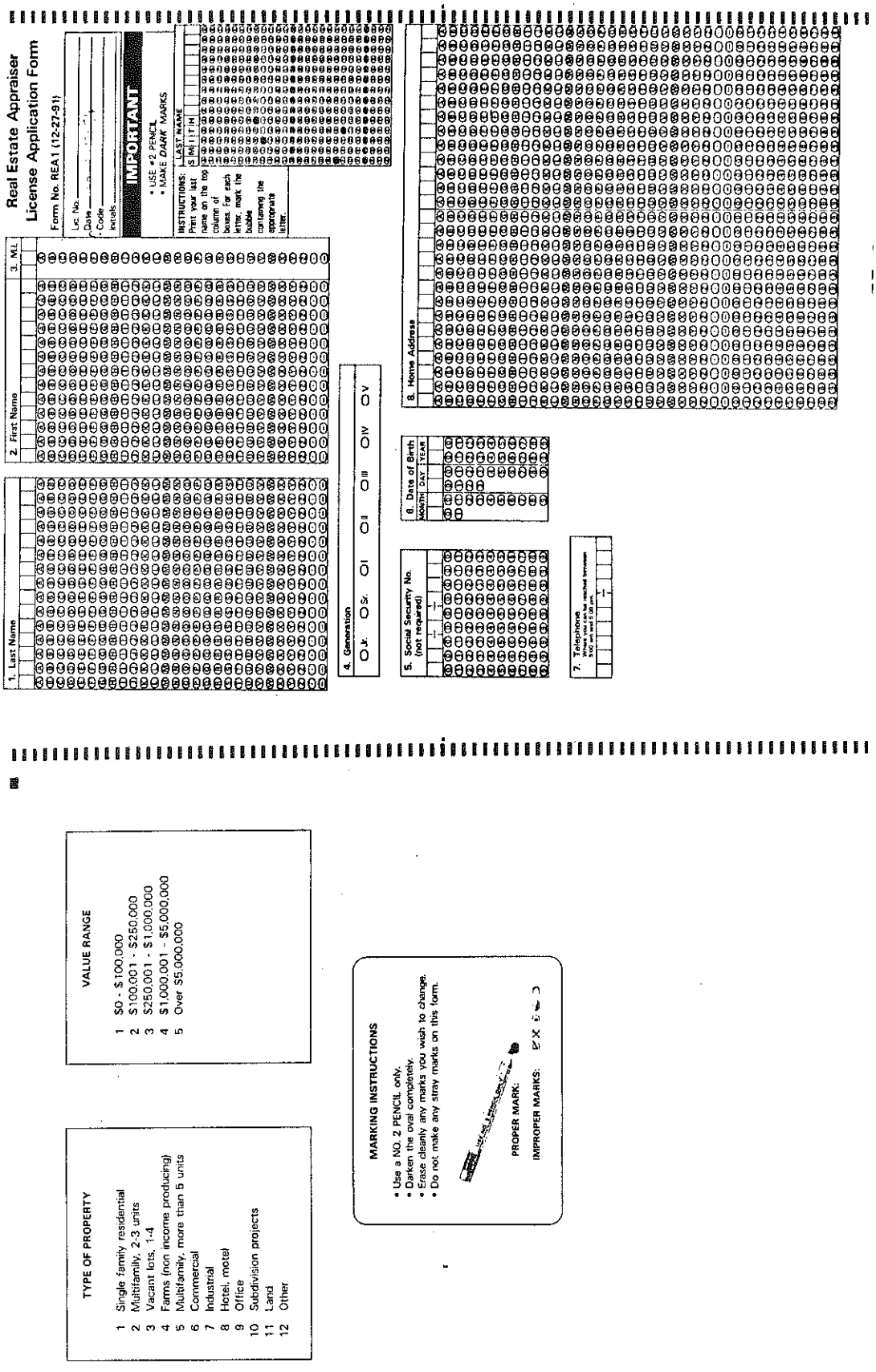
NAME ____________________

ADDRESS ____________________

SOCIAL SECURITY NUMBER ____________________

TYPE OF APPRAISER LICENSE: ___LICENSED RESIDENTIAL ___CERTIFIED GENERAL ___TEMPORARY LICENSED RESIDENTIAL ___ TEMPORARY CERTIFIED GENERAL

COURSE TITLE/NUMBER	REQUIRED APPRAISAL SUBJECTS														
	Influences on real estate value	Legal considerations in appraisal	Types of value	Land economic principles	Real estate markets and analysis	Valuation process	Property description	Highest and best use analysis	Appraisal math & statistical concepts	Sales comparison approach	Site valuation	Cost approach	Income approach	Valuation of partial interests	Appraisal standards and ethics


Real Estate Appraiser
License Application Form
Form No. REA1 (12-27-91)
IMPORTANT
• USE #2 PENCIL
• MAKE DARK MARKS
1. Last Name
2. First Name
3. M.I.
4. Generation
Jr. Sr. I II III IV V
5. Social Security No. (not required)
6. Date of Birth
MONTH DAY YEAR
7. Telephone
8. Home Address
TYPE OF PROPERTY
1 Single family residential
2 Multifamily, 2-3 units
3 Vacant lots, 1-4
4 Farms (non income producing)
5 Multifamily, more than 5 units
6 Commercial
7 Industrial
8 Hotel, motel
9 Office
10 Subdivision projects
11 Land
12 Other
VALUE RANGE
1 $0 - $100,000
2 $100,001 - $250,000
3 $250,001 - $1,000,000
4 $1,000,001 - $5,000,000
5 Over $5,000,000
MARKING INSTRUCTIONS
• Use a NO. 2 PENCIL only.
• Darken the oval completely.
• Erase cleanly any marks you wish to change.
• Do not make any stray marks on this form.
PROPER MARK:
IMPROPER MARKS:

9. ADDRESS – P.O. BOX NUMBER ONLY

10. City

11. State

12. Zip Code + 4

13. Application Type

- Original
- Reciprocal

14. License Type

- Certified General
- Certified Residential
- Licensed Residential
- Temporary Certified General
- Temporary Certified Residential
- Temporary Licensed Residential

15. If you are applying for a temporary license, identify the specific assignment below by type and location.

15a. Project Termination Date (MONTH DAY YEAR)

16. Have you had a real estate appraiser license or certification which was suspended, revoked, or surrendered in connection with a disciplinary action or which has been the subject of discipline in any jurisdiction? If yes, see page two of the instructions accompanying this application.

- Yes
- No

17. Have you ever been convicted, found guilty or plead guilty, regardless of adjudication, in any jurisdiction of a misdemeanor involving moral turpitude or of any felony? If yes, see page two of the instructions accompanying this application.

- Yes
- No

03897

18. Have you ever been issued a real estate appraiser license or certification in any other jurisdiction(s)?

- Yes If yes, please name those jurisdictions below:
- No

19. Have you ever been issued a real estate appraiser license in Virginia?

- Yes If yes, please give date(s) and license number(s) below:
- No

20. All applicants must complete this section:

I hereby certify that I have attained the number of years and hours of experience as a real estate appraiser as defined in the regulations of the Real Estate Appraiser Board for the type of license for which I am applying. I understand that the Real Estate Appraiser Board may request proof of this experience in the form of written reports or file memoranda which shall be made available to the Board upon request.

I also hereby certify that I have met the educational requirements as set forth in the Real Estate Appraiser Board regulations for the type of license for which I am applying. I understand that in order to receive credit for this education I must present official transcripts, certificates of completion or certified true copies of such as set forth in regulation.

Further, if my address listed on this application or at any time in the future is not within the state of Virginia, I do hereby irrevocably consent that suits and legal actions may be commenced against me in the proper courts of the state of Virginia in accordance with the provisions of Chapter 20, Title 54.1, Section 54.1-2019 of the Code of Virginia.

I hereby certify by my signature that the statements contained in this application are true, that I have not suppressed any information that might affect this application, and that I have read and I understand the Real Estate Appraiser Board Regulations, the Uniform Standards of Professional Appraisal Practice, & Virginia license laws and this statement.

Signature of applicant

Date

03897

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

Title of Regulation: **VR 615-45-1. Child Protective Services Central Registry Information.**

Statutory Authority: § 63.1-248.1 et seq. of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

These regulations establish criteria for determining in which cases identifying information on individuals involved in child abuse and neglect should be entered into the central registry. The regulations further establish the time frames for retention of such identifying information in the registry. Section 63.1-248.8 of the Code of Virginia requires that the State Board of Social Services promulgate these regulations.

VR 615-45-1. Child Protective Services Central Registry Information.

PART I.
DEFINITIONS.

§ 1.1. The following words and terms when used in conjunction with this regulation shall have the following meaning, unless the context clearly indicates otherwise:

"Central registry" means the name index of individuals involved in child abuse and neglect reports maintained by the Virginia Department of Social Services.

"Child protective services" means the identification, receipt and immediate investigation of complaints and reports of child abuse and neglect for children under 18 years of age. It also includes documenting, arranging for, ~~and~~ *or* providing social casework and other services for the child, his family, and the alleged abuser.

"Complaint" means a valid report of suspected child abuse/neglect which ~~must~~ *shall* be investigated by the local department of social services.

"Founded" means that a review of all the facts shows clear and convincing evidence that child abuse or neglect ~~exists~~ *has occurred* .

"Identifying information" means name, race, sex, and date of birth of the subject.

"Investigating agency" means the local department of social services responsible for conducting investigations of child abuse/neglect complaints pursuant to § 63.1-248.6 of the Code of Virginia.

"Reason to suspect" means that a review of the facts shows no clear and convincing evidence that child abuse and neglect ~~exists~~ *has occurred* . However, the ~~child's~~ situation gives the worker reason to believe that abuse or neglect ~~may have~~ *has* occurred.

"Unfounded" means that a review of the facts shows no reason to believe that abuse or neglect occurred.

PART II.
POLICY.

~~§ 2.1. Determination of risk.~~

~~The investigating agency determines risk by completing a thorough assessment of factual information available to the investigating agency as it pertains to the complaint situation. The assessment includes information about the abuse/neglect incident, the care-taker, the child, the family and any other special circumstances to determine what level of risk the situation poses to the child or to other children.~~

~~§ 2.2. Levels of risk.~~

~~The three levels of risk are:~~

~~1. High risk.~~

~~The worker's assessment of risk-related factors indicates a likelihood that the child is in jeopardy of abuse/neglect, and that intervention is necessary in order to protect the child or other children.~~

~~2. Moderate risk.~~

~~The worker's assessment of risk-related factors indicates that the child or other children are in possible jeopardy, but that a positive change in the situation is likely to occur with minimal intervention.~~

~~3. No reasonably assessable risk.~~

~~The worker's assessment of risk-related factors indicates that the situation can and will be changed, that no additional intervention is necessary and that the child or other children are at no reasonably assessable risk or abuse/neglect.~~

~~§ 2.3. Maintenance of identifying information.~~

~~Identifying information in reports of child abuse and neglect shall be maintained in the central registry as follows:~~

~~1. Seven years for a complaint determined by the investigating agency to be founded or reason to suspect and high risk, except sexual complaints.~~

~~2. Thirty years for a sexual abuse complaint determined to be founded or reason to suspect and high risk.~~

~~3. Ten years for a sexual abuse complaint determined to be founded or reason to suspect and moderate risk. (All sexual abuse complaints that are founded or reason to suspect and are not high risk shall be entered as moderate risk.)~~

§ 2.1. Levels of founded cases.

The three levels of founded cases are:

[*A.*] *Level 1.*

This level includes those injuries/conditions, real or threatened, that result in or [~~*could*~~ *were likely to*] *have resulted in serious harm to a child.*

[*B.*] *Level 2.*

This level includes those injuries/conditions, real or threatened, that result in or [~~*could*~~ *were likely to*] *have resulted in* [*moderate*] *harm to a child.*

[*C.*] *Level 3.*

This level includes those injuries/conditions, real or threatened, that result in minimal harm to a child.

§ 2.2. Maintenance of identifying information.

Identifying information in reports of child abuse and neglect shall be maintained in the central registry as follows:

1. Eighteen years past the date of the complaint for all complaints determined by the investigating agency to be founded, Level 1.

2. Seven years past the date of the complaint for all complaints determined by the investigating agency to be founded, Level 2.

3. Three years past the date of the complaint for all complaints determined by the investigating agency to be founded, Level 3.

4. One year past the date of the complaint for all complaints determined by the investigating agency to be reason to suspect.

If an individual is involved in [~~*multiple complaints*~~ *more than one complaint*] *, the information from all complaints will be maintained until the last deletion date has been reached.*

STATE WATER CONTROL BOARD

Title of Regulation: **VR 680-21-00. Water Quality Standards. (VR 680-21-01, VR 680-21-02, VR 680-21-03, VR 680-21-07, VR 680-21-08)**

Statutory Authority: § 62.1-44.15(3a) of the Code of Virginia and § 303(c)(1) of the federal Clean Water Act.

Effective Dates: February 7, 1992, through February 6, 1993.

Preamble:

The purpose of the amendments to the water quality standards regulation VR 680-21 is to bring Virginia into compliance with the Clean Water Act Section 303(c)(2) (B) requirement that states must adopt water quality standards for section 307(a) toxic pollutants. In addition to establishing for statewide application these numerical toxics standards for the protection of aquatic life and human health, other changes facilitate implementation of these toxics standards and provide for variances and site specific modifications to these standards.

The emergency regulation involves a comprehensive rewrite of the Water Quality Standards to address the potential impact of toxic substances in the Commonwealth's surface waters. The amendments to the standards regulation add a new section, VR 680-21-01.14 (Standards for Surface Water) which include 41 numerical standards for the protection of aquatic life and 66 numerical standards for the protection of human health. In addition, this new section includes a narrative definition of acute and chronic toxicity, an allowance for employing new scientific information in establishing effluent limits for those pollutants not included in this section, definitions of saltwater and freshwater for application of the numerical standards, and allowances to derive site specific modifications and variances to the standards. Other amendments provide clarification and support implementation of these standards. In VR 680-21-01.2 (General Standard) a reference to bioaccumulation was added, a clarification was added that all beneficial uses attained by November 28, 1975 are protected and the mixing zone section was rewritten. Also in VR 680-21-01.4 (Standards Application: Stream Flow) stream flow requirements were expanded and all references to Outstanding State Resource Waters in VR 680-21-07.2 (Outstanding State Resource Waters) and VR 680-21-08.2 (River Basin Section Tables - Classification Column) were deleted. Also deleted were VR 680-21-01.10 (Mercury in Fresh Water), VR 680-21-02.3 (Surface Water Standards for Surface Public Water Supplies), and VR 680-21-02 (Water Quality Criteria); these sections will be superseded by the addition of section VR 680-21-01.14. The emergency regulation will result in a comprehensive rewrite of the Water Quality Standards to address the potential impact of toxic substances in the Commonwealth's surface waters.

In addition to revisions for control of toxic pollutants, we amended the antidegradation policy section of the regulation to bring it into conformance with the federal water quality standards regulation. Since our last triennial review of the water quality standards regulation, EPA has informed us that our antidegradation policy does not completely conform with the federal regulations so this rulemaking also amends the antidegradation policy.

Nature of the Emergency:

The need to process these changes as an emergency regulation rather than through the normal Administrative Process Act route is based upon a recent action taken by the Environmental Protection Agency (EPA). EPA published in the Federal Register on November 19, 1991, a proposed rulemaking entitled "Amendments to the Water Quality Standard Regulation to Establish the Numeric Criteria for Priority Toxic Pollutants Necessary to Bring All States Into Compliance with Section 303(c)(2)(B)." If the states have not adopted water quality standards for toxic pollutants by the February 19, 1992, effective date of the final rulemaking for this federal amendment, the EPA national toxics standards will apply to Virginia and 22 other states and territories not in compliance. Virginia's proposed final rulemaking will not be effective under the normal Administrative Process Act regulatory development procedures until late May of 1992, so the national toxics standards would be imposed on the Commonwealth unless the amendments to VR 680-21 are processed as an emergency rule.

EPA is proposing to adopt only numeric criteria with minimal implementation information. Contrary to Virginia's proposed final rulemaking, the proposed federal rule will not contain mixing zone requirements or site specific modifications and variance options. The federal rulemaking would lack the detailed supporting narrative standards needed by a state to effectively implement a water quality based toxic control program. The emergency rulemaking allows the Commonwealth to continue to administer the standards program and toxics management process at the state level rather than allow EPA to impose a set of standards which cannot be properly managed in the Commonwealth.

Necessity for Action:

Although this rulemaking will significantly impact the regulated community, inclusion of the implementation language and provisions for site specific modifications and variances in the emergency regulation will provide the flexibility in regulating these discharges which is missing from the federal rulemaking. This

allows Virginia to continue to administer the water quality standards and toxic control program at the state level.

Summary:

This regulation establishes water quality standards for control of toxic pollutants in Virginia waters and therefore will significantly reduce or eliminate the potential impact of the proposed federal rulemaking by allowing the State Water Control Board to comply with the Clear Water Act Section 303(c)(2)(B) requirements act prior to the federal rulemaking effective date of February 19, 1992.

This emergency regulation will be enforced under the applicable statutes and will remain in force and effect for one year from the effective date, unless sooner modified or vacated or superseded by permanent regulations adopted pursuant to the Administrative Process Act.

The State Water Control Board will receive, consider, and respond to petitions by any interested persons at any time for the reconsideration or revision of this regulation.

It is so ordered.

BY:
/s/ Richard N. Burton
Executive Director
DATE: January 28, 1992

APPROVED BY:
/s/ Elizabeth N. Haskell
Secretary of Natural Resources
DATE: January 31, 1992

APPROVED BY:
/s/ Lawrence Douglas Wilder
Governor of the Commonwealth
DATE: February 5, 1992

FILED WITH:
/s/ Joan W. Smith
Registrar of Regulations
DATE: February 7, 1992

VR 680-21-01. Surface Water Standards with General, Statewide Application.

VR 680-21-01.2 General Standard.

A. All state waters shall be maintained at such quality as will ~~permit~~ *protect* all reasonable, beneficial uses *attained on or after November 28, 1975* and will support the propagation and growth of all aquatic life, including game fish, which might reasonably be expected to inhabit them. Reasonable beneficial uses include, but are not limited to, recreational uses, e.g. swimming and boating; and production of edible and marketable natural resources, e.g., fish and shellfish.

B. All State waters shall be free from substances attributable to sewage, industrial waste, or other waste in concentrations, amounts, or combinations which contravene established standards or interfere directly or indirectly with reasonable, beneficial uses of such water or which are inimical or harmful to human, animal, plant, or aquatic life. Specific substances to be controlled include, but are not limited to: floating debris, oil, scum, and other floating materials; toxic substances *(including those which bioaccumulate)* ; substances that produce color, tastes, turbidity, odors, or settle to form sludge deposits,- ; and substances which nourish undesirable or nuisance aquatic plant life. Effluents which tend to raise the temperature of the receiving water will also be controlled.

~~C. Zones for mixing wastes with receiving waters shall be determined on a case-by-case basis; shall be kept as small as practical; shall not be used for, or considered as, a substitute for minimum treatment technology required by the Clean Water Act and other applicable State and Federal laws; shall be implemented, to the greatest extent practicable, in accordance with the provisions of subsections A and B hereof, and shall not contain toxic substances in acutely toxic concentrations. An area of initial dilution may be allowed. This area of initial dilution will be determined on a case-by-case basis and shall not at any time exceed the lethal concentration for appropriate representative species for time periods of exposures likely to be encountered by that species and likely to cause acute effects. Mixing within these zones shall be as quick as practical and may require the installation and use of devices which ensure that waste is mixed with the allocated receiving waters in the smallest practical area. The need for such devices shall be determined on a case-by-case basis. The boundaries of these zones of admixture shall also be such as to provide a suitable passageway for fish and other aquatic organisms. In an area where more than one discharge occurs and several mixing zones are close together, these mixing zones shall be so situated that this passageway is continuous.~~

C. Mixing Zones.

1. Where necessary to attain or maintain the use designated for a surface water by these water quality standards, the Board may establish a mixing zone applicable to the non-thermal constituents of the point source discharge. No mixing zone established by the Board shall:

a. Interfere with passing or drifting aquatic organisms;

b. Cause acute lethality to passing or drifting aquatic organisms;

c. Be used for, or considered as, a substitute for minimum treatment technology required by the

Clean Water Act and other applicable State and Federal laws.

d. Constitute more than one-half of the width of the receiving watercourse nor constitute more than one-third of the area of any cross section of the receiving watercourse.

e. Extend downstream at any time a distance more than five times the width of the receiving watercourse at the point of discharge.

2. An allocated impact zone may be allowed within a mixing zone. This zone is the area of initial dilution of the effluent with the receiving water where the concentration of the effluent will be its greatest in the water column. Mixing within these allocated impact zones shall be as quick as practical and shall be sized to prevent lethality to passing aquatic organisms.

3. Mixing zones shall be determined such that acute standards are met outside the allocated impact zone and chronic standards are met at the edge of the mixing zone (see VR 680-21-01.14.A and B).

4. The Board may waive the requirements of paragraphs C.1.d and C.1.e. if a discharger provides an acceptable demonstration of:

a. Information defining the actual boundaries of the mixing zone in question; and

b. Information and data proving no violation of paragraphs C.1.a, C.1.b and C.1.c by the mixing zone in question.

5. The size of a thermal mixing zone shall be determined on a case by case basis. This determination shall be based upon a sound rationale and be supported by substantial biological, chemical, physical, and engineering evidence and analysis. Any such determination shall show to the Board's satisfaction that no adverse changes in the protection and propagation of balanced indigenous populations of fish, aquatic life, and wildlife may reasonably be expected to occur. A satisfactory showing made in conformance with Section 316(a) of the Clean Water Act shall be deemed as compliance with the requirements of this paragraph.

6. Notwithstanding the above, no new or expanded mixing zone shall:

a. Be allowed in waters listed in VR 680-21-01.3.C.3;

b. Be allowed in waters defined in VR 680-21-01.3.B for new or increased discharges unless the requirements outlined in the "Guidelines for Implementation" section of VR 680-21-01.3.B are satisfied.

7. All mixing zones shall be implemented in accordance with the provisions of subsections A and B (General Standard) above.

VR 680-21-01.3. ~~Anti-degradation~~ *Antidegradation Policy.*

A. ~~High Quality Waters.~~ *Existing instream water uses and the level of water quality necessary to protect the existing uses shall be maintained and protected.*

B. Waters whose existing quality is better than the established standards as of the date on which such standards become effective will be maintained at ~~high~~ *the existing* quality; provided that the Board has the power to authorize any project or development, which would constitute a new or an increased discharge of effluent to high quality water, when it has been affirmatively demonstrated that a change is justifiable to provide necessary economic or social development *in the area in which the waters are located;* and provided, further, that the necessary degree of waste treatment to maintain high water quality will be required where physically and economically feasible. Present and anticipated use of such waters will be preserved and protected. (Section 62.1-44.4 of the State Water Control Law.)

1. Guidelines for Implementation

~~Existing instream beneficial water uses will be maintained and protected, and actions that would interfere with or become injurious to existing uses should not be undertaken.~~

a. A new or increased discharge is defined as a newly constructed facility or an existing facility which requests a significant increase in its volume or loading of one or more of the constituents listed in VR 680-21-01.14.B.

b. In considering whether a possible *significant* change *in water quality* is justifiable to provide necessary economic or social development, the Board will provide notice and opportunity for a public hearing so that interested persons will have an opportunity to present information *and the Board will satisfy the requirement of intergovernmental coordination as part of the Commonwealth's Continuing Planning Process .*

c. Upon a finding that such change is justifiable, the change nevertheless, must not result in violation of those water quality characteristics necessary to attain the national water quality goal of protection and propagation of fish, shellfish, and wildlife, and recreation in and on the water. Further, if a change is considered justifiable, it must not result in any significant loss of marketability *or recreational* use of fish, shellfish or other marine resources, and all practical measures should be taken to eliminate or minimize the impact on water quality.

d. When degradation or lower water quality is allowed, ~~the owner shall nevertheless employ all cost effective and reasonable best management practices for nonpoint source control~~ *the Board shall assure that there shall be achieved the highest statutory and regulatory requirements applicable to all new and existing point sources to the water body and all cost-effective and reasonable best management practices for nonpoint source control which are under the jurisdiction of the Board.*

2. Any determinations concerning thermal discharge limitations made under Section 316(a) of the Clean Water Act will be considered to be in compliance with the ~~anti-degradation~~ *antidegradation* policy.

~~B. High Quality State Resource Waters.~~

~~Where high quality waters constitute an outstanding resource, such as waters of national and state parks and wildlife refuges and waters of exceptional recreational or ecological significance, that water quality shall be maintained and protected to prevent permanent or long-term degradation or impairment of beneficial uses of the water. When proposing a designation of any waters as outstanding resource waters, under this section, the Board shall convene a public hearing to receive data, views, and argument on the proposal.~~

C. Surface waters, or portions thereof, which are not significantly impacted by human activities and which provide exceptional environmental settings and either exceptional aquatic communities or exceptional recreational opportunities may be designated and protected as described in VR 680-21-01.3.C.1, 2 and 3.

1. Designation Procedures.

Designations shall be adopted in accordance with the provisions of the Administrative Process Act and the Board's Public Participation Guidelines. As part of the process, the Board shall, when considering regulatory action to designate any waters under this section, take all reasonable steps to notify potentially impacted parties, including local governments, of the Board's intent and the estimated impacts of any possible designation.

2. Guidelines for Implementation.

a. The quality of waters designated in VR 680-21-01.3.C.3 shall be maintained and protected to prevent permanent or long-term degradation or impairment.

b. No new, additional, or increased discharge of sewage, industrial wastes or other pollution into waters designated in VR 680-21-01.3.C.3 shall be allowed.

c. Nonpermitted activities causing temporary sources of pollution, which are under the jurisdiction of the Board, may be allowed in waters designated in VR 680-21-01.3.C.3 even if degradation may be expected to temporarily occur as long as after a minimal period of time the waters are returned or restored to conditions equal to or better than those existing just prior to the temporary source of pollution.

3. Reserved for Future Designations of waters defined in VR 680-21-01.3.C.

VR 680-21-01.4. Standards Application: Stream Flow.

A. Stream Flow.

1. Stream Standards for protection from acute effects on aquatic life shall apply whenever flows are equal to, or greater than, the lowest flow which, on a statistical basis, would occur for a 1-day-period once every 10 years.

2. Stream Standards *for protection from chronic effects on aquatic life and applicable standards in VR 680-21-01.5* shall apply whenever flows are equal to, or greater than, the lowest flow which, on a statistical basis, would occur for a 7-consecutive-day period once every 10 years.

3. Stream Standards for protection of human health from carcinogenic effects (as shown in VR 680-21-01.14.B) shall apply whenever flows are equal to, or greater than, the harmonic mean flow.

4. Stream Standards for protection of human health from noncarcinogenic effects (as shown in VR 680-21-01.14.B) shall apply whenever flows are equal to, or greater than, the lowest flow which, on a statistical basis, would occur for a 30-consecutive-day period once every 5 years.

B. The flows listed above in VR 680-21-04.A.1 and 2 are used to determine compliance with the water quality standards unless other methods which are statistically valid are employed which can be shown to protect aquatic organisms.

C. Manmade alterations in stream flow shall not contravene reasonable, beneficial uses including protection of the propagation and growth of aquatic life.

~~**VR 680-21-01.10. Mercury in Fresh Water.**~~

~~A. Standard.~~

~~0.05 ug/l(ppb) total recoverable mercury in fresh water.~~

~~0.01 ug/l (ppb) methyl mercury in fresh water.~~

~~B. Policy.~~

~~1. The Board, pursuant to Section 62.1-44.15(3)(a) of~~

~~the Code of Virginia (1950), as amended, hereby sets forth its policy that, with respect to any State waters which the water quality standard for total recoverable mercury and/or methyl mercury is exceeded, the Board shall identify the point and nonpoint sources of mercury contamination and institute appropriate abatement action against such sources to reduce the level of mercury in such State waters to a concentration less than or equal to the Water Quality Standard. Such abatement action shall include the submittal, by the owner of the source, of a plan and schedule for the reduction of such mercury contamination and an evaluation of the potential for environmental cleanup with a plan and schedule for said cleanup as appropriate.~~

~~2. The Board, pursuant to Section 62.1-44.15(3)(a) of the Code of Virginia (1950), as amended, hereby sets forth its policy that the level of methyl mercury in edible fish tissue in fresh water, as an arithmetic mean of a representative sampling of the fish population tested by or at the direction of the Board, shall not exceed concentration of 750 ng/g (ppb). A representative sampling shall consist of individuals of at least two species representing two trophic levels including a predator species, chosen at the direction of the Board. The edible tissue of the individual fish shall be analyzed and, wherever practicable, when more than one location is sampled the same species shall be collected at all locations.~~

~~With respect to any State waters in which the foregoing concentration is exceeded, the Board shall identify the point and nonpoint sources of mercury contamination and institute abatement action against such sources, as appropriate, reduce the level of methyl mercury in edible fish tissue in such State waters, as an arithmetic mean of a representative sampling of the fish population tested by or at the direction of the Board, to a concentration not exceeding 750 ng/g (ppb). Such abatement action shall include the submittal, by the owner of the source, of a plan and schedule for the reduction of such mercury contamination and an evaluation of the potential for environmental cleanup with a plan and schedule for said cleanup, as appropriate.~~

~~3. Further, the Board, pursuant to Section 62.1-44.15(3)(a) of the Code of Virginia (1950), as amended, hereby sets forth its policy that a concentration of total mercury in the freshwater river sediments in excess of 300 nanograms per gram (parts per billion-ppb) shall be an index of potential mercury contamination. Wherever this level is exceeded, the staff shall determine mercury levels in edible fish tissue and the water column and take appropriate action pursuant to Sections A and B of this policy.~~

~~4. Compliance with any Order issued by the Board to any such owner for cause involving mercury shall constitute "appropriate abatement action" under the terms of this policy for the duration of such Order.~~

~~5. Notwithstanding the above, pursuant to Section 62.144.4 of the Code of Virginia, in waters in which the mercury concentrations are below this standard or any level enumerated in this policy, the Board may initiate action under this policy to ensure that State waters are maintained at, or returned to, the quality existing at the time of adoption of this standard.~~

VR 680-21-01.14. Standards for Surface Water.

A. Instream water quality conditions shall not be acutely or chronically toxic. The following are definitions of acute and chronic toxicity conditions.

Acute Toxicity means an adverse effect that usually occurs shortly after the introduction of a pollutant. Lethality to an organism is the usual measure of acute toxicity. Where death is not easily detected immobilization is considered equivalent to death.

Chronic Toxicity means an adverse effect that is irreversible or progressive or occurs because the rate of injury is greater than the rate of repair during prolonged exposure to a pollutant. This includes low level, long-term effects such as reduction in growth or reproduction.

B. The following table is a list of numerical water quality standards for specific parameters.

1. For those waters with multiple designated beneficial uses, the most stringent standards in the following table shall apply.

2. When information has become available from the Environmental Protection Agency to calculate additional aquatic life or human health standards not contained in the table the Board may employ these values in establishing effluent limitations or other limitations pursuant to the General Standard in VR 680-21-01.2 necessary to protect the beneficial uses until the Board has completed the regulatory standards adoption process.

VR680-21-01.14.B continued...

Table of Parameters

	AQUATIC LIFE				HUMAN HEALTH	
	FRESHWATER		SALTWATER		PUBLIC WATER	ALL OTHER
SUBSTANCE[1]	ACUTE[2] ug/L	CHRONIC[3] ug/L	ACUTE[2] ug/L	CHRONIC[3] ug/L	SUPPLIES[4] ug/L	SURFACE WATERS[5] ug/L
Aldrin c	3.0	0.3	1.3	0.13	0.0013	0.0014
Ammonia	See Table 1	See Table 2	See Tables 3 and 4			
Anthracene					9,600	110,000
Arsenic					50	
Arsenic III	360	190	69	36		
Barium					2,000	
Benzene c					12	710
Benzo(a)anthracene c					0.028	0.311
Benzo(b)fluoranthene c					0.028	0.311
Benzo(k)fluoranthene c					0.028	0.311
Benzo(a)pyrene c					0.028	0.311
Bromoform c					44	3,600
Cadmium	$e^{(1.128[\ln(\text{hardness}^*)]-3.828)}$	$e^{(0.7852[\ln(\text{hardness}^*)]-3.490)}$	43	9.3	16	170
Carbon Tetrachloride c					2.5	45
Chlordane c	2.4	0.0043	.09	0.0040	0.0058	0.0059
Chloride	860,000	230,000			250,000**	
Chlorine	See VR680-21-01.11					
Chlorodibromomethane					690	57,000

VR680-21-01.14.8 continued...

	AQUATIC LIFE				HUMAN HEALTH	
	FRESHWATER		SALTWATER		PUBLIC WATER	ALL OTHER
SUBSTANCE[1]	ACUTE[2] ug/L	CHRONIC[3] ug/L	ACUTE[2] ug/L	CHRONIC[3] ug/L	SUPPLIES[4] ug/L	SURFACE WATERS[5] ug/L
Chloroform c					57	4,700
Chloromethane c					57	4,700
Chlorpyrifos	0.083	0.041	0.011	0.0056		
Chromium III	$e^{(0.8190[\ln(\text{hardness}^*)]+3.688)}$	$e^{(0.8190[\ln(\text{hardness}^*)]+1.561)}$			33,000	670,000
Chromium VI	16	11	1,100	50	170	3,400
Chrysene c					0.028	0.311
Copper	$e^{(0.9422[\ln(\text{hardness}^*)]-1.464)}$	$e^{(0.8545[\ln(\text{hardness}^*)]-1.465)}$	2.9	2.9	1,300	
Cyanide	22	5.2	1.0	1.0	700	215,000
DDT c	1.1	0.0010	0.13	0.0010	0.0059	0.0059
Demeton		0.1		0.1		
Dibenz(a,h)anthracene c					0.028	0.311
Dichloromethane c					47	16,000
1,2-Dichlorobenzene					2,700	17,000
1,3-Dichlorobenzene					400	2,600
1,4-Dichlorobenzene					400	2,600
Dichlorobromomethane c					3	220
1,2-Dichloroethane c					3.8	990
(2,4-dichlorophenoxy) acetic acid (2,4-D)					71	

VR680-21-01.14.B continued...

	AQUATIC LIFE				HUMAN HEALTH	
	FRESHWATER		SALTWATER		PUBLIC WATER	ALL OTHER
SUBSTANCE[1]	ACUTE[2] ug/L	CHRONIC[3] ug/L	ACUTE[2] ug/L	CHRONIC[3] ug/L	SUPPLIES[4] ug/L	SURFACE WATERS[5] ug/L
Dieldrin c	2.5	0.0019	0.71	0.0019	0.0014	0.0014
Di-2-Ethylhexyl Phthalate c					18	59
2,4-Dinitrotoluene c					1.1	91
Dioxin	See VR680-21-01.15					
Dissolved Oxygen	See VR680-21-01.5					
Endosulfan	0.22	0.056	0.034	0.0087	0.93	2.0
Endrin	0.18	0.0023	0.037	0.0023	0.76	0.81
Ethylbenzene					3,100	29,000
Fluoranthene					300	370
Fluorene					1,300	14,000
Foaming agents (measured as methylene blue active substances)					500**	
Guthion		0.01		0.01		
Heptachlor c	0.52	0.0038	0.053	0.0036	0.0021	0.0021
Hexachlorocyclohexane (Lindane)	2.0	0.080	0.16	0.01	7	25
Hydrogen Sulfide		2.0		2.0		
Indeno(1,2,3-cd)pyrene c					0.028	0.311
Iron (soluble)					300**	
Isophorone					6,900	490,000

VR680-21-01.14.B continued..

	AQUATIC LIFE				HUMAN HEALTH	
	FRESHWATER		SALTWATER		PUBLIC WATER	ALL OTHER
SUBSTANCE[1]	ACUTE[2] ug/L	CHRONIC[3] ug/L	ACUTE[2] ug/L	CHRONIC[3] ug/L	SUPPLIES[4] ug/L	SURFACE WATERS[5] ug/L
Kepone		zero		zero		
Lead	$e^{(1.273[\ln(\text{hardness}^*)]-1.460)}$	$e^{(1.273[\ln(\text{hardness}^*)]-4.705)}$	220	8.5	15	
Malathion		0.1		0.1		
Manganese (soluble)					50**	
Mercury[6]	2.4	0.012	2.1	0.025	0.144	0.146
Methoxyclor		0.03		0.03	40	
Mirex		zero		zero		
Monochlorobenzene					680	21,000
Nickel	$e^{(0.8460[\ln(\text{hardness}^*)]+3.3612)}$	$e^{(0.8460[\ln(\text{hardness}^*)]+1.1645)}$	75	8.3	607	4,583
Nitrate (as N)					10,000	
Parathion	0.065	0.013				
PCB-1242 c		0.014		0.030	0.00044	0.00045
PCB-1254 c		0.014		0.030	0.00044	0.00045
PCB-1221 c		0.014		0.030	0.00044	0.00045
PCB-1232 c		0.014		0.030	0.00044	0.00045
PCB-1248 c		0.014		0.030	0.00044	0.00045
PCB-1260 c		0.014		0.030	0.00044	0.00045
PCB-1016 c		0.014		0.030	0.00044	0.00045

VR680-21-01.14.B continued...

	AQUATIC LIFE				HUMAN HEALTH	
	FRESHWATER		SALTWATER		PUBLIC WATER	ALL OTHER
SUBSTANCE[1]	ACUTE[2] ug/L	CHRONIC[3] ug/L	ACUTE[4] ug/L	CHRONIC[3] ug/L	SUPPLIES[4] ug/L	SURFACE WATERS[5] ug/L
Pentachlorophenol c	e(1.005(pH)-4.830)	e(1.005(pH)-5.290)	13	7.9	2.8	82
pH	See VR680-21-01.5					
Phenol					21,000	4,600,000
Phosphorus (Elemental)				0.10		
Pyrene					960	11,000
Radioactivity	See VR680-21-01.12					
Selenium	20	5.0	300	71	172	11,200
Silver	e(1.72[ln(hardness)]-6.52)		2.3			
Sulfate					250,000**	
Temperature	See VR680-21-01.5					
Tetrachloroethylene					318	3,519
Toluene					6,800	200,000
Total dissolved solids					500,000**	
Toxaphene[6] c	0.73	0.0002	0.21	0.0002	0.0073	0.0075
Trichloroethylene c					27	807
2,4,6-Trichlorophenol c					21	65
[2-(2,4,5-Trichlorophenoxy) propionic acid) (Silvex)					50	

VR680-21-01,14.8 continued...

	AQUATIC LIFE				HUMAN HEALTH	
	FRESHWATER		SALTWATER		PUBLIC WATER	ALL OTHER
SUBSTANCE[1]	ACUTE[2] ug/L	CHRONIC[3] ug/L	ACUTE[2] ug/L	CHRONIC[3] ug/L	SUPPLIES[4] ug/L	SURFACE WATERS[5] ug/L
Tributyltin	See VR680-21-01.13					
Vinyl Chloride c					20	5,250
Zinc	(0.8473[ln(hardness*)]+0.8604) e	(0.8473[ln(hardness*)]+0.7614) e	95	86	5,000**	

[1] = Unless specifically listed above, all metals shall be measured as dissolved.
[2] = One hour average concentration not to be exceeded more than once every three years.
[3] = Four day average concentration not to be exceeded more than once every three years.
[4] = Unless otherwise noted, these standards have been calculated to protect human health from toxic effects through drinking water and fish consumption.
[5] = Unless otherwise noted, these standards have been calculated to protect human health from toxic effects through fish consumption.
[6] = Chronic aquatic life values have been calculated to protect wildlife from harmful effects through ingestion of contaminated tissue. However, the standard will also protect aquatic life from toxic effects.
* = Hardness as calcium carbonate mg/L $CaCO_3$
** = To maintain acceptable taste, odor or aesthetic quality of drinking water.
c = Known or suspected carcinogen, human health standards are for a risk level of 10^{-5}.

VR680-21-01.14.8 Continued....

TABLE 1***

A. Acute Ammonia Standard for Freshwater: Coldwater Habitats; Trout or Other Sensitive Coldwater Species Present

Total Ammonia (mg/liter)****

Temperature (°C)

pH	0 C	5 C	10 C	15 C	20 C	25 C	30 C
6.50	35	33	31	30	29	20	14.3
6.75	32	30	28	27	27	18.6	13.2
7.00	28	26	25	24	23	16.4	11.6
7.25	23	22	20	19.7	19.2	13.4	9.5
7.50	17.4	16.3	15.5	14.9	14.6	10.2	7.3
7.75	12.2	11.4	10.9	10.5	10.3	7.2	5.2
8.00	8.0	7.5	7.1	6.9	6.8	4.8	3.5
8.25	4.5	4.2	4.1	4.0	3.9	2.8	2.1
8.50	2.6	2.4	2.3	2.3	2.3	1.71	1.28
8.75	1.47	1.40	1.37	1.38	1.42	1.07	0.83
9.00	0.86	0.83	0.83	0.86	0.91	0.72	0.58

B. Acute Ammonia Standard for Freshwater: Warm Water Habitats; Trout or Other Sensitive Coldwater Species Absent

Total Ammonia (mg/liter)****

Temperature (°C)

pH	0 C	5 C	10 C	15 C	20 C	25 C	30 C
6.50	35	33	31	30	29	29	20
6.75	32	30	28	27	27	26	18.6
7.00	28	26	25	24	23	23	16.4
7.25	23	22	20	19.7	19.2	19.0	13.5
7.50	17.4	16.3	15.5	14.9	14.6	14.5	10.3
7.75	12.2	11.4	10.9	10.5	10.3	10.2	7.3
8.00	8.0	7.5	7.1	6.9	6.8	6.8	4.9
8.25	4.5	4.2	4.1	4.0	3.9	4.0	2.9
8.50	2.6	2.4	2.3	2.3	2.3	2.4	1.81
8.75	1.47	1.40	1.37	1.38	1.42	1.52	1.18
9.00	0.86	0.83	0.83	0.86	0.91	1.01	0.82

VR680-21-01.14.B Continued....

TABLE 2***

A. Chronic Ammonia Standard for Freshwater; Coldwater Habitats; Trout or Other Sensitive Coldwater Species Present

Total Ammonia (mg/liter)****

Temperature (°C)

pH	0 C	5 C	10 C	15 C	20 C	25 C	30 C
6.50	3.02	2.82	2.66	2.59	1.79	1.26	0.90
6.75	3.02	2.82	2.66	2.59	1.79	1.26	0.90
7.00	3.02	2.82	2.66	2.59	1.79	1.26	0.90
7.25	3.02	2.82	2.66	2.59	1.79	1.26	0.90
7.50	3.02	2.82	2.66	2.59	1.79	1.26	0.90
7.75	2.80	2.60	2.47	2.38	1.66	1.17	0.84
8.00	1.80	1.71	1.62	1.57	1.10	0.78	0.56
8.25	1.03	0.97	0.93	0.91	0.64	0.46	0.34
8.50	0.58	0.55	0.53	0.53	0.38	0.27	0.21
8.75	0.34	0.32	0.31	0.31	0.23	0.17	0.13
9.00	0.20	0.19	0.19	0.20	0.15	0.12	0.09

B. Chronic Ammonia Standard for Freshwater; Warm Water Habitats; Trout or Other Sensitive Coldwater Species Absent

Total Ammonia (mg/liter)****

Temperature (°C)

pH	0 C	5 C	10 C	15 C	20 C	25 C	30 C
6.50	3.02	2.82	2.66	2.59	2.53	1.78	1.27
6.75	3.02	2.82	2.66	2.59	2.53	1.78	1.27
7.00	3.02	2.82	2.66	2.59	2.53	1.78	1.27
7.25	3.02	2.82	2.66	2.59	2.53	1.78	1.27
7.50	3.02	2.82	2.66	2.59	2.53	1.78	1.27
7.75	2.80	2.60	2.47	2.38	2.35	1.65	1.18
8.00	1.82	1.71	1.62	1.57	1.55	1.10	0.79
8.25	1.03	0.97	0.93	0.91	0.90	0.65	0.47
8.50	0.58	0.55	0.53	0.53	0.53	0.39	0.29
8.75	0.34	0.32	0.31	0.31	0.32	0.24	0.19
9.00	0.20	0.19	0.19	0.20	0.21	0.16	0.13

VR680-21-01.14,8 Continued...

TABLE 3

Acute Ammonia Standard for Saltwater

Total Ammonia (mg/L)****

Temperature (°C)

pH	0 C	5 C	10 C	15 C	20 C	25 C	30 C	35 C
Salinity = 10 g/kg								
7.0	270	191	131	92	62	44	29	21
7.2	175	121	83	58	40	27	19	13
7.4	110	77	52	35	25	17	12	8.3
7.6	69	48	33	23	16	11	7.7	5.6
7.8	44	31	21	15	10	7.1	5.0	3.5
8.0	27	19	13	9.4	6.4	4.6	3.1	2.3
8.2	18	12	8.5	5.8	4.2	2.9	2.1	1.5
8.4	11	7.9	5.4	3.7	2.7	1.9	1.4	1.0
8.6	7.3	5.0	3.5	2.5	1.8	1.3	0.98	0.75
8.8	4.6	3.3	2.3	1.7	1.2	0.92	0.71	0.56
9.0	2.9	2.1	1.5	1.1	0.85	0.67	0.52	0.44

Acute Ammonia Standard for Saltwater

Total Ammonia (mg/L)****

Temperature (°C)

pH	0 C	5 C	10 C	15 C	20 C	25 C	30 C	35 C
Salinity = 20 g/kg								
7.0	291	200	137	96	64	44	31	21
7.2	183	125	87	60	42	29	20	14
7.4	116	79	54	37	27	18	12	8.7
7.6	73	50	35	23	17	11	7.9	5.6
7.8	46	31	23	15	11	7.5	5.2	3.5
8.0	29	20	14	9.8	6.7	4.8	3.3	2.3
8.2	19	13	8.9	6.2	4.4	3.1	2.1	1.6
8.4	12	8.1	5.6	4.0	2.9	2.0	1.5	1.1
8.6	7.5	5.2	3.7	2.7	1.9	1.4	1.0	0.77
8.8	4.8	3.3	2.5	1.7	1.3	0.94	0.73	0.56
9.0	3.1	2.3	1.6	1.2	0.87	0.69	0.54	0.44

VR680-21-01.14.8 Continued....

TABLE 3 Continued

Acute Ammonia Standard for Saltwater

Total Ammonia (mg/L)****

Temperature (°C)

pH	0 C	5 C	10 C	15 C	20 C	25 C	30 C	35 C
Salinity = 30 g/kg								
7.0	312	208	148	102	71	48	33	23
7.2	196	135	94	64	44	31	21	15
7.4	125	85	58	40	27	19	13	9.4
7.6	79	54	37	25	21	12	8.5	6.0
7.8	50	33	23	16	11	7.9	5.4	3.7
8.0	31	21	15	10	7.3	5.0	3.5	2.5
8.2	20	14	9.6	6.7	4.6	3.3	2.3	1.7
8.4	12.7	8.7	6.0	4.2	2.9	2.1	1.6	1.1
8.6	8.1	5.6	4.0	2.7	2.0	1.4	1.1	0.81
8.8	5.2	3.5	2.5	1.8	1.3	1.0	0.75	0.58
9.0	3.3	2.3	1.7	1.2	0.94	0.71	0.56	0.46

VR680-21-01.14.8 Continued....

TABLE 4

Chronic Ammonia Standard for Saltwater

Total Ammonia (mg/L)****

Temperature (°C)

pH	0 C	5 C	10 C	15 C	20 C	25 C	30 C	35 C
				Salinity = 10 g/kg				
7.0	41	29	20	14	9.4	6.6	4.4	3.1
7.2	26	18	12	8.7	5.9	4.1	2.8	2.0
7.4	17	12	7.8	5.3	3.7	2.6	1.8	1.2
7.6	10	7.2	5.0	3.4	2.4	1.7	1.2	0.84
7.8	6.6	4.7	3.1	2.2	1.5	1.1	0.75	0.53
8.0	4.1	2.9	2.0	1.4	0.97	0.69	0.47	0.34
8.2	2.7	1.8	1.3	0.87	0.62	0.44	0.31	0.23
8.4	1.7	1.2	0.81	0.56	0.41	0.29	0.21	0.16
8.6	1.1	0.75	0.53	0.37	0.27	0.20	0.15	0.11
8.8	0.69	0.50	0.34	0.25	0.18	0.14	0.11	0.08
9.0	0.44	0.31	0.23	0.17	0.13	0.10	0.08	0.07

TABLE 4 Continued

Chronic Ammonia Standard for Saltwater

Total Ammonia (mg/L)****

Temperature (°C)

pH	0 C	5 C	10 C	15 C	20 C	25 C	30 C	35 C
				Salinity = 20 g/kg				
7.0	44	30	21	14	9.7	6.6	4.7	3.1
7.2	27	19	13	9.0	6.2	4.4	3.0	2.1
7.4	18	12	8.1	5.6	4.1	2.7	1.9	1.3
7.6	11	7.5	5.3	3.4	2.5	1.7	1.2	0.84
7.8	6.9	4.7	3.4	2.3	1.6	1.1	0.78	0.53
8.0	4.4	3.0	2.1	1.5	1.0	0.72	0.50	0.34
8.2	2.8	1.9	1.3	0.94	0.66	0.47	0.31	0.24
8.4	1.8	1.2	0.84	0.59	0.44	0.30	0.22	0.16
8.6	1.1	0.78	0.56	0.41	0.28	0.20	0.15	0.12
8.8	0.72	0.50	0.37	0.26	0.19	0.14	0.11	0.08
9.0	0.47	0.34	0.24	0.18	0.13	0.10	0.08	0.07

VR680-21-01.14.8 Continued...

TABLE 4 Continued

Chronic Ammonia Standard for Saltwater

Total Ammonia (mg/L) ****

Temperature (°C)

pH	0 C	5 C	10 C	15 C	20 C	25 C	30 C	35 C
Salinity = 30 g/kg								
7.0	47	31	22	15	11	7.2	5.0	3.4
7.2	29	20	14	9.7	6.6	4.7	3.1	2.2
7.4	19	13	8.7	5.9	4.1	2.9	2.0	1.4
7.6	12	8.1	5.6	3.7	3.1	1.8	1.3	0.90
7.8	7.5	5.0	3.4	2.4	1.7	1.2	0.81	0.56
8.0	4.7	3.1	2.2	1.6	1.1	0.75	0.53	0.37
8.2	3.0	2.1	1.4	1.0	0.69	0.50	0.34	0.25
8.4	1.9	1.3	0.90	0.62	0.44	0.31	0.23	0.17
8.6	1.2	0.84	0.59	0.41	0.30	0.22	0.16	0.12
8.8	0.78	0.53	0.37	0.27	0.20	0.15	0.11	0.09
9.0	0.50	0.34	0.26	0.19	0.14	0.11	0.08	0.07

*** To calculate total ammonia values at different pH's and temperature values than listed in the tables 1 and 2 use the following formulas:

Formulas Used In The Calculation of Acute Criteria Values for Ammonia In Freshwater

The one hour average concentration of ammonia (in mg/L as un-ionized NH_3) can be calculated by using the following formulas.

0.52/FT/FPH/2 = acute criteria concentration

where:

FT = final temperature

$= 10^{0.03(20-TCAP)}$; TCAP< T < 30°C

$= 10^{0.03(20-T)}$; 0 < T < TCAP

TCAP = 20°C ; When trout and other sensitive coldwater species are present.

= 25°C ; When trout and other sensitive coldwater species are absent.

FPH = final pH

= 1 ; 8.0 < pH < 9.0

$= (1 + 10^{7.4-pH})/1.25$; 6.5< pH < 8.0

Conversions from un-ionized to total ammonia should be performed using the following formulas:

Total ammonia criteria = calculated un-ionized ammonia criteria (divided by) fraction of un-ionized ammonia

Where:

Fraction of un-ionized ammonia = $1/(10^{pKa-pH} + 1)$

pKa = 0.09018 + (2729.92/(273.2 + temperature °C)).

Formulas Used In The Calculation of Chronic Criteria Values for Ammonia In Freshwater

The 4-day average concentration of ammonia (in mg/L as un-ionized NH_3) can be calculated by using the following formulas.

0.80/FT/FPH/RATIO = chronic criteria concentration

where:

FT = final temperature

$= 10^{0.03(20-TCAP)}$; TCAP< T < 30°C

$= 10^{0.03(20-T)}$; 0 < T < TCAP

TCAP = 15°C ; When trout and other sensitive coldwater species are present.

VR680-21-01.14.8 Continued....

= 20°C ; When trout and other sensitive coldwater species are absent.

FPH = final pH

= 1 ; 8.0 < pH < 9.0

= $(1 + 10^{7.4-pH})/1.25$; 6.5< pH < 8.0

RATIO = 13.5 ; 7.7< pH < 9

= $20.25 \times (10^{7.7-pH})/(1 + 10^{7.4-pH})$; 6.5 < pH < 7.7

Conversions from un-ionized to total ammonia should be performed using the following formulas:

Total ammonia criteria = calculated un-ionized ammonia criteria divided by fraction of un-ionized ammonia

Where:

Fraction of un-ionized ammonia = $1/(10^{pKa-pH} + 1)$

Where pka = 0.09018 + (2729.92/(273.2 + temperature °C)).

****
To convert these values to mg/Liter N, multiply by 0.822.

C. Application of Freshwater and Saltwater Numerical Standards.

The numerical water quality standards listed in VR 680-21-01.14.B (excluding dissolved oxygen, pH, temperature and chlorine) shall be applied according to the following classes of waters (see VR 680-21-01.5), and boundary designations:

CLASS OF WATERS	*NUMERICAL STANDARD*
I, and II (Estuarine Waters)	*Saltwater standards apply*
II (Transition Zone)	*More stringent of either the freshwater or saltwater standards apply*
II (Tidal Freshwater), III, IV, V and VI	*Freshwater standards apply*

The following describes the boundary designations for Class II, (estuarine, transition zone and tidal freshwater waters) by river basin:

1. Rappahannock Basin.

Tidal freshwater is from the fall line of the Rappahannock River to Buoy 37 near Tappahannock, Virginia, including all tidal tributaries that enter the tidal freshwater Rappahannock River.

Transition Zone is from Buoy 37 to Buoy 11 near Morattico, Virginia, including all tidal tributaries that enter the transition zone of the Rappahannock River.

Estuarine waters are from Buoy 11 to the mouth of the Rappahannock River (Buoy 6), including all tidal tributaries that enter the estuarine waters of the Rappahannock River.

2. York Basin.

Tidal freshwater is from the fall line of the Mattaponi River to Clifton, Virginia and from the fall line of the Pamunkey River to Sweet Hall Landing, Virginia, including all tidal tributaries that enter the tidal freshwaters of the Mattaponi and Pamunkey Rivers.

Transition Zone of the Mattaponi River is from Clifton, Virginia to the York River and the transition zone of the Pamunkey River is from Sweet Hall Landing, Virginia to the York River. The transition zone for the York River is from West Point, Virginia to Buoy 13 near Poropotank Bay. All tidal tributaries that enter the transition zones of the Mattaponi, Pamunkey, and York Rivers are themselves in the transition zone.

Estuarine waters are from Buoy 13 to the mouth of the York River (Tue Marsh Light) including all tidal tributaries that enter the estuarine waters of the York River.

3. James Basin.

Tidal Freshwater is from the fall line of the James River to the confluence of the Chickahominy River (Buoy 70), including all tidal tributaries that enter the tidal freshwater James River.

Transition Zone is from Buoy 70 to Buoy 47 near Jamestown Island including all tidal tributaries that enter the transition zone of the James River.

Estuarine Waters are from Buoy 47 to the mouth of the James River (Buoy 25) including all tidal tributaries that enter the estuarine waters of the James River.

4. Potomac Basin.

Tidal Freshwater includes all tidal tributaries that enter the Potomac River from its fall line to Buoy 43 near Quantico, Virginia.

Transition Zone includes all tidal tributaries that enter the Potomac River from Buoy 43 to Buoy 33 near Dahlgren, Virginia.

Estuarine Waters includes all tidal tributaries that enter the Potomac River from Buoy 33 to the mouth of the Potomac River (Buoy 44B).

5. Chesapeake Bay, Atlantic Ocean, and Small Coastal Basins.

Estuarine Waters include the Atlantic Ocean tidal tributaries, and the Chesapeake Bay and its small coastal basins from the Virginia State line to the mouth of the Bay (a line from Cape Henry drawn through Buoys 3 and 8 to Fishermans Island), and its tidal tributaries, excluding the Potomac tributaries and those tributaries listed above.

6. Chowan River Basin.

Tidal freshwater includes the Northwest River and its tidal tributaries from the Virginia-North Carolina State line to the free flowing portion, the Blackwater River and its tidal tributaries from the Virginia-North Carolina State line to the end of tidal waters at approximately State Route 611 at river mile 20.90, the Nottoway River and its tidal tributaries from the Virginia-North Carolina State line to the end of tidal waters at approximately Route 674, and the North Landing River and its tidal tributaries from the Virginia-North Carolina State line to the Great Bridge Lock.

Transition zone includes Back Bay and its tributaries in the City of Virginia Beach to the Virginia-North

Carolina State line.

D. Site Specific Modifications to Numerical Water Quality Standards.

1. The Board may consider site specific modifications to numerical water quality standards in VR 680-21-01.14.B where the applicant or permittee demonstrates that the alternate numerical water quality standards are sufficient to protect all designated beneficial uses (see VR 680-21-01.1 and 2) of that particular surface water segment or body.

2. Any demonstration for a site specific human health standard shall be restricted to a reevaluation of the bioconcentration or bioaccumulation properties of the pollutant.

3. Site specific temperature requirements are found in VR 680-21-01.9.

4. Procedures for Promulgation and Review of Site Specific Modifications to Numerical Water Quality Standards Resulting from VR 680-21-01.14.D.1 and 2.

a. Proposals describing the details of the site specific study shall be submitted to the Board's staff for approval prior to commencing the study.

b. Any site specific modification shall be promulgated in accordance with the Administrative Process Act.

c. If the Board approves a site specific modification for a newly constructed facility or an existing facility which requests an increase in its volume or loading of one or more of the constituents listed in VR 680-21-01.14.B discharging to waters defined in VR 680-21-01.3.B that facility shall also be required to meet the socio-economic justification as described in VR 680-21-01.3.B.

E. Variances to Water Quality Standards.

1. Water Body Variance.

a. A water body variance may be allowed where the conditions are currently limiting attainment of a water quality standard. A variance to the water quality standard may be allowed on a case by case basis where the applicant affirmatively demonstrates that one or more of the conditions below serve as the basis for the variance:

(1) Naturally occurring pollutant concentrations prevent the attainment of the water quality standard; or

(2) Natural, ephemeral, intermittent or low flow conditions or water levels prevent the attainment of the water quality standard, unless these conditions may be compensated by the discharge of sufficient volume of effluent discharges without violating State water conservation requirements to enable water quality standards to be met; or

(3) Human caused conditions or sources of pollution prevent the attainment of the water quality standard and cannot be remedied or would cause more environmental damage to correct than to leave in place; or

(4) Dams, diversions, or other types of hydrologic modifications preclude the attainment of the water quality standard, and it is not feasible to restore the water body to its original condition or to operate such modification in a way that would result in the attainment of the water quality standard; or

(5) Physical conditions related to the natural features of the water body, such as the lack of a proper substrate, cover, flow, depth, pools, riffles, and the like, unrelated to water quality, preclude attainment of the water quality standard for the protection of aquatic life.

b. The variance shall establish the modified water quality standard as close to the underlying standard as possible.

2. Discharger Specific Variance.

a. A discharger-specific variance may be allowed on a case by case basis where a discharger can demonstrate that compliance with a water quality based permit limit is not presently feasible because immediate compliance would impose a substantial and widespread economic and social impact.

b. The variance shall establish a modified wasteload allocation (WLA) as close to the underlying WLA that will meet the water body's standard as possible and establishes that the modified WLA is applicable only to the discharger.

c. The variance shall not affect the total maximum daily load (TMDL) for the water body, effluent limitations required for other dischargers on the water body, or load allocations for nonpoint sources.

3. Variances in VR 680-21-01.14.E.1 and 2 above shall not prevent the maintenance and protection of existing uses; or exempt any discharger or activity from compliance with other appropriate technology or water quality-based limits or best management practices.

4. Procedures for Promulgation and Review of Variances to Water Quality Standards Resulting from VR 680-21-01.E.1 and 2.

a. Proposals describing the details of the variance study shall be submitted to staff for approval prior

to commencing the study.

b. Any variance shall be promulgated as a regulation in accordance with the Administrative Process Act.

c. The variance shall be reevaluated and either continued, modified, or revoked as part of each subsequent Triennial Review. At the time of Triennial Review the permittee shall make a showing that the conditions for granting the variance still apply.

d. If the Board approves a water body variance (VR 680-21-01.14.E.1) for a newly constructed facility or an existing facility which requests an increase in its volume or loading of one or more of the constituents listed in VR 680-21-01.14.B discharging to waters defined in VR 680-21-01.3.B, that facility shall also be required to meet the socio-economic justification as described in VR 680-21-01.3.B.

5. None of the variances in VR 680-21-01.14.E shall apply to the halogen ban section of the chlorine policy (VR 680-21-01.11.B.5), and to temperature (VR 680-21-01.5) if superseded by 316(a) requirements. No water body variances (VR 680-21-01.14.E.1) shall apply to the standards that are designed to protect human health from carcinogenic and non-carcinogenic toxic effects (VR 680-21-01.14.B). Discharger specific variances (VR 680-21-01.14.E.2) to standards designed to protect human health from carcinogenic and non-carcinogenic effects shall be limited to an order of magnitude increase in exposure concentration.

~~**VR 680-21-02.3. Surface Water Standards for Surface Public Water Supplies.**~~

~~In addition to other standards established for the protection of public or municipal water supplies, the following standards apply at the water intake; the standards also apply to any upstream or downstream reach specified in the appropriate river basin table.~~

~~The standards apply to both the water supply main stream and its tributaries within the designated distance.~~

~~CONSTITUENT~~	~~CONCENTRATION (MG/L)~~
~~Arsenic~~	~~0.05~~
~~Barium~~	~~1.0~~
~~Cadmium*~~	~~0.01~~
~~Chloride~~	~~250~~
~~Chromium (Total)~~	~~0.05~~
~~Copper*~~	~~1.0~~
~~Foaming agents (measured as methylene blue active substances)~~	~~0.5~~
~~Iron (soluble)~~	~~0.3~~
~~Lead~~	~~0.05~~
~~Manganese (soluble)~~	~~0.05~~
~~Mercury*~~	~~0.002~~
~~Nitrate (as N)~~	~~10~~
~~Phenols~~	~~0.001~~
~~Selenium*~~	~~0.01~~
~~Silver*~~	~~0.05~~
~~Sulfate~~	~~250~~
~~Total dissolve solids~~	~~500~~
~~Zinc*~~	~~5.0~~
~~Chlorinated Hydrocarbon Insecticides:~~	
~~Endrin*~~	~~0.0002~~
~~Lindane*~~	~~0.004~~
~~Methoxychlor*~~	~~0.1~~
~~Toxaphene*~~	~~0.005~~
~~Chlorophenoxy Herbicides:~~	
~~2,4D~~	~~0.1~~
~~Silvex~~	~~0.01~~

~~*The numeric standards for the constituents above are designed to protect public water supplies for human consumption. The limits established for those chemicals marked with an asterisk (*) may not protect aquatic life. Therefore, when a request to classify a stream as a public water supply is received, an evaluation shall be made to determine whether more stringent limits are needed for those chemicals in order to ensure protection of aquatic life.~~

~~VR 680-21-03.1. General Requirements.~~

~~Section VR 680-21-03.2 below establishes water quality criteria for certain substances in surface waters. Groundwater criteria are found in VR 680-21-04.4. One basic distinction differentiates water quality criteria from water quality standards found in VR 680-21-01 and VR 680-21-04 of these regulations. The standards are always mandatory while the criteria are not. Criteria shall be utilized as mandatory requirements when in the judgment of the Board they are necessary to ensure the protection of the beneficial uses of the water body. The agency will employ the criteria values or any others it deems appropriate in establishing effluent limitations or other limitations necessary to protect the beneficial uses. The Board may consider modifications to these criteria, on a case-by-case basis, dependent upon a site specific determination performed by the permittee which demonstrates that alternate criteria are sufficient to ensure protection of water quality.~~

VR680-21-03.2 Water Quality Criteria for Surface Water

Chronic Criteria for Protection of Aquatic Life ug/l

Substance	Value	Applicability
Aldrin	0.03	Freshwater
	0.03	Saltwater
Ammonia	SEE TABLE ATTACHED	Freshwater
Arsenic trivalent, inorganic, total recoveable	190	Freshwater
	36	Saltwater
Cadmium total recoverable	$e^{.07852-(\ln(\text{hardness}))3.490}$	Freshwater
	9.3	saltwater
Chlordane	.0043	Freshwater
	0.004	Saltwater
Chromium hexavalent, total recoverable	11	Freshwater
	50	Saltwater
trivalent, total recoverable	$e^{-0.819(\ln(\text{hardness}))+1.561}$	Freshwater
	No saltwater Value	
Coppe Copper, total recoverable	$e^{0.8545(\ln(\text{hardness}))1.465}$	Freshw
	2.9	Saltwater
Cyanide, total	5.2	Freshwater
	1.0	Saltwater
DDT	0.001	All Waters
Demeton	0.1	All Waters
Dieldrin	0.0019	All Waters
Endosulfan	0.056	Freshwater
	0.0087	Saltwater
Endrin	0.0023	All Waters
Guthion	0.01	All Waters
Heptachlor	0.0038	Freshwater
	0.0036	Saltwater
Hydrogen Sulfide	2.0	All Waters
Iron	1,000	Freshwater
	No Saltwater Value	

*Total-unless otherwise indicated

Chronic Criteria for Protection of Aquatic Life ug/l

Substance*	Value	Applicability
Kepone	Zero	All Waters
Lead, total recoverable	$e^{1.266\{\ln(\text{hardness})\}+4.661}$	Freshwater
	5.6	Saltwater
Lindane	0.080	Freshwater
	0.0016	Saltwater
Malathion	0.1	All Waters
Manganese	100	Saltwater
Mercury	0.10	Saltwater
Methoxychlor	0.03	All Waters
Mirex	Zero	All Waters
Nickel total recoverable	$e^{0.76\{\ln(\text{hardness})\}+1.06}$	Freshwater
	7.1	Saltwater
Parathion	0.04	All Waters
Phenol	1.0	All Waters
Phthalate Esters	3.0	All Waters-
Polychlorinated Biphenyls	0.014	Freshwater
	003	Saltwater
Selenium, total inorganic	35	Freshwater
	54	Salter
Silver, total recoverable	$e^{1.72\{\ln(\text{hardness})\}-6.52}$ x0.01	Freshwater
	0.023	Saltwater
Toxaphene	0.013	Freshwater
	0.0007	Saltwater
Zinc, total recoverable	47	Freshwater
	58	Saltwater

*Total unless otherwwise indicated

Ammonia Criteria

pH	0C	5 C	10 C	15 C	20 C	25 C	30 C
A. Salmonids or Other Sensitive Coldwater Species Present							
Unionized Ammonia (mg/liter NH_3)							
6.50	0.0007	0.0009	0.0013	0.0019	0.0019	0.0019	0.0019
6.75	0.0012	0.0017	0.0023	0.0033	0.0033	0.0033	0.0033
7.00	0.0021	0.0029	0.0042	0.0059	0.0059	0.0059	0.0059
7.25	0.0037	0.0052	0.0074	0.0105	0.0105	0.0105	0.0105
7.50	0.0066	0.0093	0.0132	0.0186	0.0186	0.0186	0.0186
7.75	0.0109	0.0153	0.022	0.031	0.031	0.031	0.031
8.00	0.0126	0.0177	0.025	0.035	0.035	0.035	0.035
8.25	0.0126	0.0177	0.025	0.035	0.035	0.035	0.035
8.50	0.0126	0.0177	0.025	0.035	0.035	0.035	0.035
8.75	0.0126	0.0177	0.025	0.035	0.035	0.035	0.035
9.00	0.0126	0.0177	0.025	0.035	0.035	0.035	0.035
Total Ammonia (mg/liter NH_3)							
6.50	2.5	2.4	2.2	2.2	1.49	1.04	0.73
6.75	2.5	2.4	2.2	2.2	1.49	1.04	0.73
7.00	2.5	2.4	2.2	2.2	1.49	1.04	0.74
7.25	2.5	2.4	2.2	2.2	1.50	1.04	0.74
7.50	2.5	2.4	2.2	2.2	1.50	1.05	0.74
7.75	2.3	2.2	2.1	2.0	1.40	0.99	0.71
8.00	1.53	1.44	1.37	1.33	0.93	0.66	0.47
8.25	0.87	0.82	0.78	0.76	0.54	0.39	0.28
8.50	0.49	0.47	0.45	0.44	0.32	0.23	0.17
8.75	0.28	0.27	0.26	0.27	0.19	0.15	0.11
9.00	0.16	0.16	0.16	0.16	0.13	0.10	0.08

B. Salmonids and Other Sensitive Coldwater Species Absent

Unionized Ammonia (mg/liter NH_3)

6.50	0.0007	0.0009	0.0013	0.0019	0.0026	0.0026	0.0026
6.75	0.0012	0.0017	0.0023	0.0033	0.0047	0.0047	0.0047
7.00	0.0021	0.0029	0.0042	0.0059	0.0083	0.0083	0.0083
7.25	0.0037	0.0052	0.0074	0.0105	0.0148	0.0148	0.0148
7.50	0.0066	0.0093	0.0132	0.0186	0.026	0.026	0.026
7.75	0.0109	0.0153	0.022	0.031	0.043	0.043	0.043
8.00	0.0126	0.0177	0.025	0.035	0.050	0.050	0.050
8.25	0.0126	0.0177	0.025	0.035	0.050	0.050	0.050
8.50	0.0126	0.0177	0.025	0.035	0.050	0.050	0.050
8.75	0.0126	0.0177	0.025	0.035	0.050	0.050	0.050
9.00	0.0126	0.0177	0.025	0.035	0.050	0.050	0.050

B. Salmonids and Other Sensitive Coldwater Species Absent (cont.)

Total Ammonia (mg/liter NH_3)

pH	0C	5C	10C	15C	20C	25C	30C
6.50	2.5	2.4	2.2	2.2	2.1	1.46	1.03
6.75	2.5	2.4	2.2	2.2	2.1	1.47	1.04
7.00	2.5	2.4	2.2	2.2	2.1	1.47	1.04
7.25	2.5	2.4	2.2	2.2	2.1	1.48	1.05
7.50	2.5	2.4	2.2	2.2	2.1	1.49	1.06
7.75	2.3	2.2	2.1	2.0	1.98	1.39	1.00
8.00	1.59	1.44	1.37	1.33	1.31	0.93	0.67
8.25	0.87	0.82	0.78	0.76	0.76	0.54	0.40
8.50	0.49	0.47	0.45	0.44	0.45	0.33	0.25
8.75	0.28	0.27	0.26	0.27	0.27	0.21	0.16
9.00	0.16	0.16	0.16	0.16	0.17	0.14	0.11

~~Site specific criteria development is strongly suggested at temperatures above 20°C because of the limited data available to generate the criteria recommendation, and at temperatures below 20°C because of the limited data and because small changes in the criteria may have significant impact on the level of treatment required in meeting the recommended criteria.~~

VR 680-21-07.2. ~~Outstanding State Resource Waters.~~ *Special Designations in Surface Waters.*

The following section recognizes waters which the General Assembly, Board and/or other State agencies have determined to be of special ecological or recreational significance to the State. The designation of a Scenic River and the significance of this designation are the subject of the Scenic Rivers Act (Section 10-167 et seq. of the Code of Virginia). ~~The listing of Outstanding State Resource Waters that follows constitutes those waters which the Board has designated as high quality state resource waters subject to the protections found in the anti-degradation policy in Section VR 680-21-01.3.~~

VR 680-21-08.2 Classification Column.

A. DO, pH and Temperature Standards.

The classification column defines the Class of waters to which the basin section belongs in accordance with the Class descriptions given in Section VR 680-21-01.5. Section VR 680-21-01.5 defines the State's seven classes (I - VII) and the dissolved oxygen (DO), pH and maximum temperature that apply to each class. By finding the class of waters for a basin section in the Classification Column and referring to Section VR 680-21-01.5, the DO, pH and maximum temperature standards can be found for each basin section.

B. ~~CGIF~~ *DGIF* Trout Waters.

The ~~Commission~~ *Department* of Game and Inland Fisheries ~~(CGIF)~~ *(DGIF)* has established a classification system for trout waters based on aesthetics, productivity, resident fish population and stream structure. Classes I through IV rate wild trout habitat; Classes V through VIII rate cold water habitat not suitable for wild trout but adequate for year-round hold-over of stocked trout. The ~~CGIF~~ *DGIF* classification system is included in this publication as a subclassification of the Board's trout water classes (Class V Put and Take Trout Waters and Class VI Natural Trout Waters) in the Classification Column. These subclassifications are for informational purposes only and imply no additional requirements. The ~~CGIF~~ *DGIF* subclasses are shown as subclasses i - viii in the Class Column to differentiate from the Board's Classes V and VI. ~~CGIF~~ *DGIF* trout water classifications which are not consistent with Board classifications for Put and Take Trout Waters or Natural Trout Waters are shown with a double asterisk (**) in the Classification Column. These trout waters have been identified for reevaluation by the ~~CGIF~~ *DGIF* . Those trout waters which have no ~~CGIF~~ *DGIF* classification are shown with a triple asterisk (***). The ~~CGIF~~ *DGIF* subclasses are described below. Inclusion of these subclasses will provide additional information about specific streams for permit writers and other interested persons. Trout waters classified as Classes I or II by the ~~CGIF~~ *DGIF* (shown as i or ii in this publication) are also recognized as ~~Outstanding State Resource Waters~~ in Section VR 680-21-07.2 of this publication.

a. ~~CGIF~~ *DGIF* Stream Class Descriptions - Classes are shown in small Roman numerals (i-viii) in the basin tables.

~~CGIF~~ *DGIF* STREAM CLASS DESCRIPTIONS

Wild Natural Trout Streams

Class I. Stream of outstanding natural beauty possessing wilderness or at least remote characteristics, an abundance of large deep pools, and excellent fish cover. Substrate is variable with an abundance of coarse gravel and rubble. Stream contains a good population of wild trout or has the potential for such. Would be considered an exceptional wild trout stream.

Class II. Stream contains a good wild trout population or the potential for one but is lacking in aesthetic quality, productivity, and/or in some structural characteristic. Stream maintains good water quality and temperature, maintains at least a fair summer flow, and adjacent land is not extensively developed. Stream would be considered a good wild trout stream and would represent a major portion of Virginia's wild trout waters.

Class III. Stream which contains a fair population of wild trout with carrying capacity depressed by natural factors or more commonly man-related landuse practices. Landuse activities may result in heavy siltation of the stream, destruction of banks and fish cover, water quality degradation, increased water temperature, etc. Most streams would be considered to be in the active state of degradation or recovery from degradation. Alteration in landuse practices would generally improve carrying capacity of the stream.

Class IV. Stream which contains an adequately reproducing wild trout population but has severely reduced summer flow characteristics. Fish are trapped in isolated pools where they are highly susceptible to predators and fishermen. Such streams could quickly be over-exploited and, therefore, provide difficult management problems.

Stockable Put and Take Trout Streams

Class V. Stream does not contain an adequately reproducing wild trout population nor does it have the potential for such. However, water quality is adequate, water temperature is good, and invertebrate productivity is exceptional. Pools are abundant with

good size and depth and fish cover is excellent. Stream would be good for stocked trout but may offer more potential for a fingerling stocking program.

Class VI. Stream does not contain a significant number of trout nor a significant population of warmwater gamefish. Water quality is adequate and water temperature good for summer carryover of stocked trout. Summer flow remains fair and adjacent land is not extensively developed. All streams in this class would be considered good put-n-take trout stocking water.

Class VII. Stream does not contain a significant number of trout nor a significant population of warmwater gamefish. Water quality and temperature are adequate for trout survival but productivity is marginal as are structural characteristics. Streams in this class could be included in a stocking program but they would be considered marginal and generally would not be recommended for stocking.

Class VIII. Stream does not contain a significant number of trout nor a significant population of warmwater gamefish. Water quality and temperature are adequate for trout but summer flows are very poor (less than 30% of channel). Streams in this class can provide good put-n-take trout fishing during spring and early summer but would not be recommended for summer or fall stocking.

Other. Remaining streams would be considered unsuitable for any type of trout fishery. Streams would be considered unsuitable under any of the following conditions:

(a) summer temperatures unsuitable for trout survival.

(b) stream contains a significant population of warmwater gamefish

(c) insufficient flow

(d) intolerable water quality

BUREAU OF INSURANCE

February 12, 1992

ADMINISTRATIVE LETTER 1992-5

To: All Insurers, Health Services Plans, and Health Maintenance Organizations Licensed to Write Accident and Sickness Insurance in Virginia

Re: Virginia Insurance Regulation No. 38: Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers

On July 5, 1991 the State Corporation Commission of Virginia adopted Insurance Regulation No. 38 pursuant to § 38.2-3419.1 of the Code of Virginia. A copy of this regulation was forwarded to all affected insurers, health services plans, and health maintenance organizations the week of July 8, 1991. Regulation No. 38 became effective October 1, 1991 and requires all insurers, health services plans, and health maintenance organizations issuing policies of accident and sickness insurance or subscription contracts in Virginia to report cost and utilization data relating to mandated benefits and mandated providers to the Bureau of Insurance annually by May 1.

Companies that meet any one of the exemption criteria contained in Section 4.B. of the regulation for a given reporting period will not be required to file a full report for that period. Each company claiming an exemption for a given reporting period must, however, complete and file the first page of form MB-1 as contained in Appendix B of the regulation. A copy of Form MB-1 is attached for your convenience.

Companies that are required to comply with the reporting requirements of Regulation No. 38 for 1991 are reminded that the 1991 reporting period extends from October 1, to December 31. In subsequent years the reporting period will extend from January 1, to December 31. This initial abbreviated reporting period is permitted as a consequence of the October 1, 1991 effective date of Regulation No. 38.

Reports filed in compliance with this regulation must be in the format contained in Form MB-1. Companies filing full reports are encouraged to submit them on computer diskettes issued by the Bureau of Insurance. However, companies may submit their reports in paper form, if typed. Handwritten reports will not be accepted. Each company wishing to file its report on diskette should complete and return the attached Diskette and File Structure Layout Request Form. Diskettes supplied by the Bureau of Insurance will contain Form MB-1 and the required data entry system. Detailed instructions will also be provided. Companies wishing to submit their reports in ASCII format should use the Diskette and File Structure Request Form to request the required file structure layout. Reports filed in this manner will only be accepted if they are in the form prescribed by the Bureau of Insurance.

Companies are reminded that Regulation No. 38 contains instructions and reference materials which define the data required to complete Form MB-1. A list of additional instructions is attached to provide further clarification.

Should you have any questions, please direct them to:

J. Hil Richardson, Jr.
Senior Insurance Analyst
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23209
Telephone No. (804) 371-0388

Section 38.2-218 of the Code of Virginia provides that any person who knowingly or willfully violates any provision of the insurance laws shall be punished for each violation by a penalty of not more than $5,000. Failure to file a substantially complete and accurate report or exemption request pursuant to the provisions of Regulation No. 38 by the due date may be considered a willful violation and may subject the company to an appropriate penalty.

/s/ Steven T. Foster
Commissioner of Insurance

DISKETTE AND FILE STRUCTURE LAYOUT REQUEST FORM

Catherine S. West
Microcomputer Systems Coordinator
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23209

RE: Administrative Letter 1992-5
Annual Report of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia and Regulation No. 38

Dear Ms. West:

We would like to submit the above-referenced report by May 1, 1992:

[ ] on computer diskette using the entry system and diskette to be supplied by the Bureau of Insurance (requiring an IBM or IBM compatible personal computer with DOS and a minimum of 640K of memory). Please forward a:

[ ] 3.5" high density (1.4M) diskette
[ ] 5.25" high density (1.2M) diskette

containing Form MB-1 and the required entry system and detailed instructions to my attention as indicated below.

[ ] in ASCII text format on computer diskette or tape. Please forward the required file structure layout and detailed instructions to my attention as indicated below.

Name: _____

Title: _____

Company: _____

NAIC Number: _____ Group NAIC Number: _____

Mailing Address: _____

_____

_____

Phone Number: _____ Date: _____

Form MB-1 Supplemental Instructions

1. All questions referring to annual or yearly figures should be interpreted to mean the period October 1, through December 31, 1991 for reports due May 1, 1992. In subsequent years, beginning with the 1992 reporting period, those questions will refer to the full calendar year.

2. Companies are reminded that claims information can be reported on either an "incurred claims" or "paid claims" basis. One basis must be used consistently throughout the report, however. Companies filing on diskettes provided by the Bureau of Insurance will be prompted to indicate on what basis the reported claims data were collected. Companies filing on paper and using an "incurred claims" basis should so note at the top of page 2 of Form MB-1. The Bureau of Insurance will assume that paper reports not containing such a notation were prepared with data collected on a "paid claims" basis.

3. In Part A: Benefit Worksheet #1 - Individual (page 2) the line labeled Obstetrical Services should be ignored and has been stricken on the copy of Form MB-1 attached to Administrative Letter 1992-5. Diskettes distributed by the Bureau of Insurance do not contain data entry blanks for this line.

4. In Part A: Benefit Worksheet #1 - Individual (page 2), column "d - Number of Contracts," companies should report the number of individual contracts which contain the benefits listed. For example, benefits which are mandated offers may be present in fewer contracts than mandated coverages.

5. In Part B: Benefit Worksheet #2 - Group (page 3), column "d - Number of Contracts," companies should report the number of group certificates which contain the benefits listed. Therefore, column "e - Claim Cost per Contract" requires a cost per certificate figure. It is understood that the number of group certificates can change frequently, but every effort should be made to estimate the average number in force during the reporting period.

6. In Part A and Part B, (pages 2-5) column "f - Annual Administrative Cost" should only include fourth-quarter 1991 administrative costs (not start-up costs, unless those costs were incurred during the reporting period).

7. Column "g - Percent of Total Health Claims Paid" figures should be calculated using a base of total individual policy claims for Part A: Benefit Worksheet #1 - Individual (page 2) and for Part B: Provider Worksheet #1 - Individual (page 4) and a base of total group contract claims for Part

A: Benefit Worksheet #2 - Group (page 3) and Part B: Provider Worksheet #2 - Group (page 5). Claims information should be limited to claims on policies or contracts issued or issued for delivery in the Commonwealth of Virginia and subject to Virginia mandated benefit and provider statutes.

8. In Part C (page 6), blanks directly to the right of the Mental, Emotional and Nervous Disorders and Alcohol and Drug Dependence headings which were originally intended for total premium figures should be ignored and have been stricken on the copy of Form MB-1 attached to Administrative Letter 1992-5. Separate inpatient and outpatient figures are required for both benefit categories, however, and should be recorded in the appropriate blanks. Diskettes distributed by the Bureau of Insurance do not contain the stricken blanks.

9. In Part C (page 7), question #4, the premium for a policy with mandates should include all mandated offerings in addition to mandated coverages and mandated providers.

10. Symbols such as "N/A" should not be used in these reports. If a particular question or group of questions are not applicable to a company, then the corresponding blanks should be left empty (an answer of "0" will be given a numeric value of zero). All empty blanks should be explained in a cover letter accompanying the report filing.

Form MB-1

Annual Report of Cost and Utilization Data
Relating to Mandated Benefits and Mandated Providers
Pursuant to §38.2-3419.1 of the Code of Virginia

Reporting Year_____

Company Name _____

Group Name _____

Mailing Address _____

_____

NAIC#_____ Group NAIC #_____

Name of Person Completing Report_____

Title_____

Direct Telephone #_____

Mailing Address_____

_____

Total accident and sickness premiums written in Virginia:

in the year_____ the amount of $ _____

Is the reporting company a cooperative nonprofit life benefit company or mutual assessment life, accident and sickness insurer?

[ ] Yes [ ] No

Does this company solely issue policies not subject to the mandated benefits and mandated provider requirements of §§38.2-3408 through 38.2-3419 and 38.2-4221 of the Code of Virginia?

[ ] Yes [ ] No

Does this company claim an exemption under Section 4 of Regulation No. 38 for this reporting year?

[ ] Yes, and filing only this page. [ ] No, and filing a complete report.

Signature_____ Date_____

Part A: Benefit Worksheet # 1 – Individual

* Benefit	a Number of Visits	b Number of Days	c Total Claims Payments	d Number of Contracts	e Claim Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims Paid
Dependent Children Coverage							
Doctor to Include Dentist							
Newborn Children							
Inpatient Mental / Emotional / Nervous							
~~Obstetrical Services~~							
Pregnancy from Rape / Incest							
Mammography							
Child Health Supervision							

* include information and amounts paid on hospital bills and other providers
a : number of provider and physician visits
b : number of days in facility (if applicable)
c : total of claims paid for this mandate
d : number of contracts in force in Virginia
e : cost per contract = column c divided by column d
f : the administrative cost of complying with this mandate during the reporting year
g : claims paid for this benefit as a percentage of the total amount of health claims paid for Virginia policyholders by this company

Benefit Worksheet # 2 – Group

* Benefit	a Number of Visits	b Number of Days	c Total Claims Payments	d Number of Contracts	e Claim Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims Paid
Dependent Children Coverage							
Doctor to Include Dentist							
Newborn Children							
Mental / Emotional / Nervous:							
Inpatient							
Outpatient							
Alcohol and Drug Dependence:							
Inpatient							
Outpatient							
Obstetrical Services							
Pregnancy from Rape / Incest							
Mammography							
Child Health Supervision							

* include information and amounts paid on hospital bills and other providers [for all health care expenses incurred because of this mandate]
a : number of provider and physician visits
b : number of days in facility (if applicable)
c : total of claims paid for this mandate
d : number of certificates in Virginia [with this coverage]
e : cost per contract = column c divided by column d
f : the administrative cost of complying with this mandate during the reporting year
g : claims paid for this benefit as a percentage of the total amount of [all] health claims paid for Virginia policyholders by this company

Part B: Provider Worksheet # 1 – Individual

Provider	a Number of Visits	b Total Claims Payments	c Cost Per Visit	d Number of Contracts	e Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims Paid
Chiropractor							
Optometrist							
Optician							
Psychologist							
Clinical Social Worker							
Podiatrist							
Professional Counselor							
Physical Therapist							
Clinical Nurse Specialist							
Audiologist							
Speech Pathologist							

a : number of visits to this provider group for which claims were paid in Virginia
b : total dollar amount of claims paid to this provider group in Virginia
c : cost per visit = column b divided by column a
d : number of contracts in force in Virginia
e : cost per contract = column b divided by column d
f : the annual administrative cost associated with compliance with this mandate
g : claims paid for services administered by this provider group as a percentage of the total amount of health claims paid for Virginia policyholders by this company

Provider Worksheet # 2 – Group

Provider	a Number of Visits	b Total Claims Payments	c Cost Per Visit	d Number of Contracts	e Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims Paid
Chiropractor							
Optometrist							
Optician							
Psychologist							
Clinical Social Worker							
Podiatrist							
Professional Counselor							
Physical Therapist							
Clinical Nurse Specialist							
Audiologist							
Speech Pathologist							

a : number of visits to this provider group for which claims were paid in Virginia
b : total dollar amount of claims paid to this provider group in Virginia
c : cost per visit = column b divided by column a
d : number of certificates in Virginia
e : cost per contract = column b divided by column d
f : the annual administrative cost associated with compliance with this mandate
g : claims paid for services administered by this provider group as a percentage of the total amount of health claims paid for Virginia policyholders by this company

Part C

1. Please use what you consider to be your standard policy to answer this question. For the individual policy used as your base calculations in the question below:
- o What is the deductible?_____
- o What is the coinsurance?_____
- o What is the individual/employee out-of-pocket maximum? _____

For the group policy used as your base calculation in the question below:
- o What is the deductible?_____
- o What is the coinsurance?_____
- o What is the individual/employee out-of-pocket maximum? _____

For your health insurance in Virginia, what is the total annual premium including mandates, and what amount is added to the annual premium of each type policy for each mandate listed?

Please indicate where coverage under your policy exceeds Virginia's mandates.

	Individual Policy		Group Certificates	
	Single	Family	Single	Family
Total Annual Policy Premium	____	____	____	____
Premium for:				
Dependent Children Coverage		____		____
Doctor to Include Dentist	____	____	____	____
Newborn Children	____	____	____	____
Mental/Emotional/Nervous (Mental Disabilities) Inpatient	____	____	____	____
* Outpatient			____	____
*Alcohol and Drug Dependence			____	____
Inpatient			____	____
Outpatient			____	____
*Obstetrical Services			____	____
Pregnancy from Rape or Incest	____	____	____	____
*Mammography	____	____	____	____
*Child Health Supervision	____	____	____	____

* Denotes mandated offering

Chiropractor	____	____	____	____
Optometrist	____	____	____	____
Optician	____	____	____	____
Psychologist	____	____	____	____
Clinical Social Worker	____	____	____	____
Podiatrist	____	____	____	____
Professional Counselor	____	____	____	____
Physical Therapist	____	____	____	____
Clinical Nurse Specialist	____	____	____	____
Audiologist	____	____	____	____
Speech Pathologist	____	____	____	____

2. What is the number of individual policies and/or group certificates issued by your Company in 1991 in Virginia?

	Single	Family
Individual	_____	_____
Group	_____	_____

3. What is the number of individual policies and/or group certificates in force for your company as of December 31, 1991 in Virginia?

	Single	Family
Individual	_____	_____
Group	_____	_____

4. What would be the annual premium for an individual policy with no mandated benefits or mandated providers for a 30 year old male in the Richmond area in your standard premium class? What would be the cost for a policy for the same individual with present mandates? (Assume coverage including $250 deductible, $1,000 stop-loss limit, 80% co-insurance factor, $250,000 policy maximum.) If you do not issue a policy of this type, please provide the premium for a 30 year old male in your standard premium class for the policy that you offer that is most similar to the one described and summarize the differences from the described policy.

Without Mandates $_____

With Mandates $_____

Part D: Utilization and Expenditures for Selected Procedures by Provider Type

Select Procedure Codes are listed here to obtain information about utilization and costs for specific types of services. Please identify expenditures and only visits for the Procedure Codes indicated. Other claims should not be included here.

1. **Procedure Code 90015**
Office Visit, Intermediate Service to New Patient

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Clinical Social Worker			
Physical Therapist			
Podiatrist			
Profesional Counselor			
Psychologist			
Physician			

2. **Procedure Code 90844**
Medical Psychotherapy, 45 to 50 Minute Session

	Number of Visits	Claims Payments	Cost Per Visit
Clinical Nurse Specialist			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist			
Physician			

3. **Procedure Code 90853**
Group Medical Psychotherapy

	Number of Visits	Claims Payments	Cost Per Visit
Clinical Nurse Specialist			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist			
Physician			

Differences in Policy _____

_____

_____

5. Do you add an amount to the annual premium of a group certificate to cover the cost of conversion to an individual policy? Yes_____ No _____

If yes, what is the average dollar amount:

Single _____ Family _____

If no, is that cost covered in the annual premium of the individual policy? Yes____No____

4. Procedure Code 92507
Speech, Language or Hearing

	Number of Visits	Claims Payments	Cost Per Visit
Audiologist			
Clinical Social Worker			
Physical Therapist			
Professional Counselor			
Speech Pathologist			
Physician			

5. Procedure Code 97110
Physical Medicine Treatment, 30 Minutes, Therapeutic Exercise

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			
Speech Pathologist			

6. Procedure Code 97124
Physical Medicine Treatment, Massage

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			

7. Procedure Code 97128
Physical Medicine Treatment, Ultrasound

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			

8. Procedure Code 92352
Fitting of Spectacle Prosthesis for Aphakia

	Number of Visits	Claims Payments	Cost Per Visit
Ophthalmolgist			
Optician			
Optometrist			
Physician			

9. Procedure Code 11765
Excision of Ingrown Toenail

	Number of Visits	Claims Payments	Cost Per Visit
Physician			
Podiatrist			

AT RICHMOND, FEBRUARY 3, 1992

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

v. .. CASE NO. INS910239

Ex Parte: In the matter of
adopting Rules Governing
Long-Term Care Insurance

CORRECTING ORDER

WHEREAS, by order entered herein November 27, 1991, the Commission adopted a regulation entitled "Rules Governing Long-Term Care Insurance"; and

WHEREAS, the regulation attached to the Commission's aforesaid order contained four typographical errors which resulted from reformatting the pages of the regulation;

THEREFORE, IT IS ORDERED that the following corrections shall be made to the Commission's "Rules Governing Long-Term Care Insurance":

(1) Page 20, delete the first line: "though your policy had never been in force. After the application has been";

(2) Page 20, add as the last line: "and protection, you should be aware of and seriously consider certain factors which";

(3) Page 25, add as the first three lines: "benefits shall be determined in accordance with § 38.2-3130 paragraph 7. Claim reserves must also be established in the case when such policy or rider is in claim status. Reserves for policies and riders subject to this subsection should be based on"; and

(4) Page 34, delete the first three lines: "(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change."

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to Joan M. Gardner, Esquire, Blue Cross & Blue Shield of Virginia, P.O. Box 27401, Richmond, Virginia 23279; Mary Griffin, Esquire, Consumers Union, Suite 520, 2001 S Street, N.W., Washington D.C. 20009; Gary Cole, Counsel, Transport Life Insurance Company, 714 Main Street, Fort Worth, Texas 76102; Marian Dolliver-Altman, First Financial Services of Virginia, Suite 201, 1500 Forest Avenue, Richmond, Virginia 23229; and the Bureau of Insurance in care of Deputy Commissioner Gerald A. Milsky, who shall forthwith give further notice of the corrections to the Commission's "Rules Governing Long-Term Care Insurance" by mailing a copy of this order to all insurers licensed to sell long-term care insurance in the Commonwealth of Virginia.

DIRECTOR'S ORDER NUMBER FIVE (92)

VIRGINIA'S TWENTY-THIRD INSTANT GAME LOTTERY; "SUNKEN TREASURE," FINAL RULES FOR GAME OPERATION.

In accordance with the authority granted by Section 58.1-4006A of the Code of Virginia, I hereby promulgate the final rules for game operation in Virginia's twenty-third instant game lottery, "Sunken Treasure." These rules amplify and conform to the duly adopted State Lottery Board regulations for the conduct of instant game lotteries.

The rules are available for inspection and copying during normal business hours at the State Lottery Department headquarters, 2201 West Broad Street, Richmond, Virginia, and at each of the State Lottery Department regional offices. A copy may be requested by mail by writing to: Marketing Division, State Lottery Department, P. O. Box 4689, Richmond, Virginia 23220.

This Director's Order becomes effective on the date of its signing and shall remain in full force and effect unless amended or rescinded by further Director's Order.

/s/ Kenneth W. Thorson
Director
February 10, 1992

DEPARTMENT OF MINES, MINERALS AND ENERGY

The Department of Mines, Minerals and Energy has consolidated its request for information forms from various divisions into one agency-wide form. The new form, DMME-IR-1 (Feb. 92) entitled "Request for Information" replaces forms DMLR-PS-038, DM-IR-01, and DMM-114.

Commonwealth of Virginia
Department of Mines, Minerals and Energy

REQUEST FOR INFORMATION

DATE: _____ NAME: (Please Print) _____

REPRESENTATIVE OF COMPANY/ORGANIZATION: _____

_____

COMPANY AND PERMIT, MINE INDEX, WELL OR FILE NUMBER ON WHICH INFORMATION IS REQUESTED:

_____

_____

_____

TYPE OF INFORMATION NEEDED (PLEASE BE AS SPECIFIC AS POSSIBLE):

_____

_____

_____

_____

_____

SIGNATURE: _____

ADDRESS: _____

_____

TELEPHONE: _____

FOR OFFICE USE ONLY:

COMPLETED BY: _____ DATE: _____

DMME-IR-1
FEB. 92

GOVERNOR'S COMMENTS ON PROPOSED REGULATIONS

(Required by § 9-6.12:9.1 of the Code of Virginia)

BOARD OF MEDICINE

Title of Regulation: **VR 465-05-01. Regulations Governing the Practice of Physicians' Assistants.**

Governor's Comment:

I concur with the form and content of this proposal. My final approval will be contingent upon a review of the public's comments.

/s/ Lawrence Douglas Wilder
Governor
Date: February 23, 1992

DEPARTMENT OF TAXATION

Title of Regulation: **VR 630-10-74.1. Nonprescription Drugs and Proprietary Medicines.**

Governor's Comment:

Pending public comment, I concur with the regulation as proposed.

/s/ Lawrence Douglas Wilder
Governor
Date: February 11, 1992

Symbol Key †
† Indicates entries since last publication of the Virginia Register

GENERAL NOTICES

NOTICE

Notices of Intended Regulatory Action are published as a separate section at the beginning of each issue of the Virginia Register.

DEPARTMENT OF WASTE MANAGEMENT

Public Notice

Designation of Regional Solid Waste Management Planning Area

In accordance with the provision of § 10.1-1411 of the Code of Virginia, and Part V, Regulations for the Development of Solid Waste Management Plans, VR 672-50-01, the Director of the Department of Waste Management intends to designate a solid waste management region for the local governments of the County of Amherst and the Town of Amherst. The County of Amherst will be designated contact for development and/or implementation of a regional solid waste management plan and programs for the recycling of solid waste generated within the designated region.

A petition has been received by the Department of Waste Management for the designation on behalf of the local governments.

Anyone wishing to comment on the designation of this region should respond in writing by 5 p.m. on March 30, 1992 to Ms. Cheryl Cashman, Legislative Liaison, Department of Waste Management, 11th Floor, Monroe Building, 101 North 14th Street, Richmond, VA 23219. FAX 804-225-3753 or 804-371-8737/TDD ☎

Immediately following the closing date for comments, the Director of the Department of Waste Management will notify the affected local governments of its approval as a region or of the need to hold a public hearing on designation.

Any questions concerning this notice should be directed to Ms. Cheryl Cashman, Legislative Liaison, at (804) 225-2667.

Public Notice

Designation of Regional Solid Waste Management Planning Area

In accordance with the provision of § 10.1-1411 of the Code of Virginia, and Part V, Regulations for the Development of Solid Waste Management Plans, VR 672-50-01, the Director of the Department of Waste Management intends to designate a solid waste management region for the local governments of the Counties of Accomack and Northampton and the Towns of Accomac, Belle Haven, Bloxom, Cape Charles, Cheriton, Chinocoteague, Eastville, Exmore, Hallwood, Keller, Melfa, Nassawaddox, Onancock, Onley, Painter, Parksley, Saxis, Tangier, and Wachpreague. The Accomack-Northampton Solid Waste Management Committee will be designated contact for development and/or implementation of a regional solid waste management plan and programs for the recycling of solid waste generated within the designated region.

A petition has been received by the Department of Waste Management for the designation on behalf of the local governments.

Anyone wishing to comment on the designation of this region should respond in writing by 5 p.m. on March 30, 1992 to Ms. Cheryl Cashman, Legislative Liaison, Department of Waste Management, 11th Floor, Monroe Building, 101 North 14th Street, Richmond, VA 23219. FAX 804-225-3753 or 804-371-8737/TDD ☎

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Any questions concerning this notice should be directed to Ms. Cheryl Cashman, Legislative Liaison, at (804) 225-2667.

Public Notice

Designation of Regional Solid Waste Management Planning Area

In accordance with the provision of § 10.1-1411 of the Code of Virginia, and Part V, Regulations for the Development of Solid Waste Management Plans, VR 672-50-01, the Director of the Department of Waste Management intends to designate a solid waste management region for the local governments of the County of Franklin and the Towns of Rocky Mount and Boones Mill. The County of Franklin will be designated contact for development and/or implementation of a regional solid waste management plan and programs for the recycling of solid waste generated within the

designated region.

A petition has been received by the Department of Waste Management for the designation on behalf of the local governments.

Anyone wishing to comment on the designation of this region should respond in writing by 5 p.m. on March 30, 1992 to Ms. Cheryl Cashman, Legislative Liaison, Department of Waste Management, 11th Floor, Monroe Building, 101 North 14th Street, Richmond, VA 23219. FAX 804-225-3753 or 804-371-8737/TDD ☎

Immediately following the closing date for comments, the Director of the Department of Waste Management will notify the affected local governments of its approval as a region or of the need to hold a public hearing on designation.

Any questions concerning this notice should be directed to Ms. Cheryl Cashman, Legislative Liaison, at (804) 225-2667.

Public Notice

Designation of Regional Solid Waste Management Planning Area

In accordance with the provision of § 10.1-1411 of the Code of Virginia, and Part V, Regulations for the Development of Solid Waste Management Plans, VR 672-50-01, the Director of the Department of Waste Management intends to designate a solid waste management region for the local governments of the County of Grayson, City of Galax and the Towns of Independence, Troutdale, and Fries. The County of Grayson will be designated contact for development and/or implementation of a regional solid waste management plan and programs for the recycling of solid waste generated within the designated region.

A petition has been received by the Department of Waste Management for the designation on behalf of the local governments.

Anyone wishing to comment on the designation of this region should respond in writing by 5 p.m. on March 30, 1992 to Ms. Cheryl Cashman, Legislative Liaison, Department of Waste Management, 11th Floor, Monroe Building, 101 North 14th Street, Richmond, VA 23219. FAX 804-225-3753 or 804-371-8737/TDD ☎

Immediately following the closing date for comments, the Director of the Department of Waste Management will notify the affected local governments of its approval as a region or of the need to hold a public hearing on designation.

Any questions concerning this notice should be directed to Ms. Cheryl Cashman, Legislative Liaison, at (804) 225-2667.

Public Notice

Designation of Regional Solid Waste Management Planning Area

In accordance with the provision of § 10.1-1411 of the Code of Virginia, and Part V, Regulations for the Development of Solid Waste Management Plans, VR 672-50-01, the Director of the Department of Waste Management intends to designate a solid waste management region for the local governments of the County of Henry, the City of Martinsville and the Town of Ridgeway. The County of Henry will be designated contact for development and/or implemetation of a regional solid waste management plan and programs for the recycling of solid waste generated within the designated region.

A petition has been received by the Department of Waste Management for the designation on behalf of the local governments.

Anyone wishing to comment on the designation of this region should respond in writing by 5 p.m. on March 30, 1992 to Ms. Cheryl Cashman, Legislative Liaison, Department of Waste Management, 11th Floor, Monroe Building, 101 North 14th Street, Richmond, VA 23219. FAX 804-225-3753 or 804-371-8737/TDD ☎

Immediately following the closing date for comments, the Director of the Department of Waste Management will notify the affected local governments of its approval as a region or of the need to hold a public hearing on designation.

Any questions concerning this notice should be directed to Ms. Cheryl Cashman, Legislative Liaison, at (804) 225-2667.

Public Notice

Designation of Regional Solid Waste Management Planning Area

In accordance with the provision of § 10.1-1411 of the Code of Virginia, and Part V, Regulations for the Development of Solid Waste Management Plans, VR 672-50-01, the Director of the Department of Waste Management intends to designate a solid waste management region for the local governments of the County of Highland and the Town of Monterey. The County of Highland will be designated contact for development and/or implementation of a regional solid waste management plan and programs for the recycling of solid waste generated within the designated region.

A petition has been received by the Department of Waste Management for the designation on behalf of the local governments.

Anyone wishing to comment on the designation of this region should respond in writing by 5 p.m. on March 30, 1992 to Ms. Cheryl Cashman, Legislative Liaison, Department of Waste Management, 11th Floor, Monroe Building, 101 North 14th Street, Richmond, VA 23219. FAX

804-225-3753 or 804-371-8737/TDD ☎

Immediately following the closing date for comments, the Director of the Department of Waste Management will notify the affected local governments of its approval as a region or of the need to hold a public hearing on designation.

Any questions concerning this notice should be directed to Ms. Cheryl Cashman, Legislative Liaison, at (804) 225-2667.

Public Notice

Designation of Regional Solid Waste Management Planning Area

In accordance with the provision of § 10.1-1411 of the Code of Virginia, and Part V, Regulations for the Development of Solid Waste Management Plans, VR 672-50-01, the Director of the Department of Waste Management intends to designate a solid waste management region for the local governments of the County of Rockbridge, the Cities of Lexington and Buena Vista, and the Towns of Glasgow and Goshen. The County of Rockbridge will be designated contact for development and/or implementation of a regional solid waste management plan and programs for the recycling of solid waste generated within the designated region.

A petition has been received by the Department of Waste Management for the designation on behalf of the local governments.

Anyone wishing to comment on the designation of this region should respond in writing by 5 p.m. on March 30, 1992 to Ms. Cheryl Cashman, Legislative Liaison, Department of Waste Management, 11th Floor, Monroe Building, 101 North 14th Street, Richmond, VA 23219. FAX 804-225-3753 or 804-371-8737/TDD ☎

Immediately following the closing date for comments, the Director of the Department of Waste Management will notify the affected local governments of its approval as a region or of the need to hold a public hearing on designation.

Any questions concerning this notice should be directed to Ms. Cheryl Cashman, Legislative Liaison, at (804) 225-2667.

STATE WATER CONTROL BOARD

† Notice to the Public

Deadline Extended for Public Comment on Proposed Regulatory Actions

On December 30, 1991, the State Water Control Board released three proposed regulatory actions for public comment. Notices of public comment period for these regulatory actions were published in the Virginia Register and various newspapers across the Commonwealth on December 30, 1991. However, one newspaper notice was not published until January 9, 1992. Therefore, in order to ensure that all interested persons are afforded the same opportunity to submit their comments, notice is hereby given that the deadline for receipt of public comments has been extended to 4 p.m. on Tuesday, March 10, 1992.

This extension applies to the public comment periods on:

VR 680-21-00 Water Quality Standards (standards for toxics, for statewide application, for protection of aquatic life and human health to comply with § 303 (c)(2)(B) of the Clean Water Act)

VR 680-21-00 Water Quality Standards (site specific modification to the numerical water quality criteria for copper in the Clinch River between Carbo and St. Paul)

VR 680-14-09 Virginia Pollutant Discharge Elimination System (VPDES) General Permit for Domestic Sewage Discharges of Less Than or Equal to 1,000 Gallons

If you have any questions regarding this extension, please contact Mrs. Cindy Berndt, Policy and Planning Supervisor, State Water Control Board, P.O. Box 11143, Richmond, VA 23230, telephone (804) 527-5158.

VIRGINIA CODE COMMISSION

NOTICE TO STATE AGENCIES

Change of Address: Our new mailing address is: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219. You may FAX in your notice; however, we ask that you do not follow-up with a mailed copy. Our FAX number is: 371-0169.

FORMS FOR FILING MATERIAL ON DATES FOR PUBLICATION IN THE VIRGINIA REGISTER OF REGULATIONS

All agencies are required to use the appropriate forms when furnishing material and dates for publication in the Virginia Register of Regulations. The forms are supplied by the office of the Registrar of Regulations. If you do not have any forms or you need additional forms, please contact: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

FORMS:

NOTICE of INTENDED REGULATORY ACTION - RR01
NOTICE of COMMENT PERIOD - RR02
PROPOSED (Transmittal Sheet) - RR03
FINAL (Transmittal Sheet) - RR04
EMERGENCY (Transmittal Sheet) - RR05

NOTICE of MEETING - RR06
AGENCY RESPONSE TO LEGISLATIVE OR GUBERNATORIAL OBJECTIONS - RR08
DEPARTMENT of PLANNING AND BUDGET (Transmittal Sheet) - DPBRR09

Copies of the Virginia Register Form, Style and Procedure Manual may also be obtained at the above address.

ERRATA

BOARD FOR CONTRACTORS

Title of Regulation: **VR 220-02-2. Rules and Regulations of the Board for Contractors.**

Publication: 8:10 VA.R. 1498-1508 February 10, 1992.

Correction to Proposed Regulation:

Page 1501, § 2.1 E, line 4, change "office" to "officer."

Page 1504, § 4.1 B 3, change "approved" to "provided."

Page 1507, § 5.2 15, fourth line, change "designed" to "designated."

Page 1507, § 5.2 16, fifth line, change "member" to "members."

Page 1507, § 5.2 19 c, first line, change the first "is" to "it."

CALENDAR OF EVENTS

Symbols Key
† Indicates entries since last publication of the Virginia Register
♿ Location accessible to handicapped
☎ Telecommunications Device for Deaf (TDD)/Voice Designation

NOTICE

Only those meetings which are filed with the Registrar of Regulations by the filing deadline noted at the beginning of this publication are listed. Since some meetings are called on short notice, please be aware that this listing of meetings may be incomplete. Also, all meetings are subject to cancellation and the Virginia Register deadline may preclude a notice of such cancellation.

For additional information on open meetings and public hearings held by the Standing Committees of the Legislature during the interim, please call Legislative Information at (804) 786-6530.

VIRGINIA CODE COMMISSION

EXECUTIVE

Long-Term Care Ombudsman Program Advisory Council

March 26, 1992 - 9 a.m. – Open Meeting
Richmond Memorial Hospital, Laburnum Conference Room, 1300 Westbrook Avenue, Richmond, Virginia. ♿

Deborah Little from the Department of Health will discuss licensure and certification of nursing facilities and OBRA implementation in Virginia. Business will include finalizing plans for the development of a citizen advocacy network.

Contact: Ms. Virginia Dize, State Ombudsman, Virginia Department for the Aging, 700 E. Franklin Street, 10th Floor, Richmond, VA 23219, telephone (804) 225-2271/TDD ☎ or toll-free 1-800-552-3402.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Pesticide Control Board

† **April 16, 1992 - 10 a.m.** – Open Meeting
† **April 17, 1992 - 9 a.m.** – Open Meeting
The Community Cultural Center, Northern Virginia Community College, 8333 Little River Turnpike, Annandale, Virginia. ♿

During the general business meeting, the board will conduct a forum, during which the public may comment on the residential use of pesticides. Beginning at 9 a.m. the public will also have an opportunity to comment on matters not on the board's agenda. Portions of the meeting may be held in closed session pursuant to § 2.1-344 of the Code of Virginia.

Contact: Dr. Marvin A. Lawson, Program Manager, Office of Pesticide Management, Virginia Department of Agriculture and Consumer Services, P.O. Box 1163, Room 403, Richmond, VA 23209, telephone (804) 371-6558.

Virginia Sweet Potato Board

March 11, 1992 - 7:30 p.m. – Open Meeting
Eastern Shore Agriculture Experiment Station, Route 1, Box 133, Research Drive, Painter, Virginia. ♿

A meeting to discuss marketing, promotion, research and education programs for the state's sweet potato industry and to develop the board's annual budget. At the conclusion of other business, the board will entertain public comments for a period not to exceed 30 minutes.

Contact: J. William Mapp, Program Director, Box 26, Onley, VA 23418, telephone (804) 787-5867.

Virginia Winegrowers Advisory Board

April 6, 1992 - 10 a.m. – Open Meeting
Virginia Agricultural Experiment Station, 2500 Valley Avenue, Winchester, Virginia.

The board will (i) hear reports from Committee Chairs and Project Monitors; (ii) review old and new business; and (iii) hear and vote on new proposals for the 1992-1993 fiscal year.

Contact: Annette C. Ringwood, Wine Marketing Specialist, 1100 Bank Street, Suite 1010, Richmond, VA 23219, telephone (804) 371-7685.

STATE AIR POLLUTION CONTROL BOARD

† **April 8, 1992 - 10 a.m.** – Open Meeting
State Capitol Building, House Room 1, Richmond, Virginia.

A public meeting to receive input on the development of proposed amendments to Regulations for the Control and Abatement of Air Pollution.

Contact: Karen G. Sabasteanski, Policy Analyst, Division of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240, telephone (804) 786-2378.

ALCOHOLIC BEVERAGE CONTROL BOARD

March 16, 1992 - 9:30 a.m. – Open Meeting
March 30, 1992 - 9:30 a.m. – Open Meeting
2901 Hermitage Road, Richmond, Virginia. ♿

A meeting to receive and discuss reports and activities from staff members. Other matters not yet determined.

Contact: Robert N. Swinson, Secretary to the Board, 2901 Hermitage Road, P.O. Box 27491, Richmond, VA 23261, telephone (804) 367-0616.

ARCHITECTS, LAND SURVEYORS, PROFESSIONAL ENGINEERS AND LANDSCAPE ARCHITECTS, BOARD FOR

March 19, 1992 - 9 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting to (i) approve minutes from November 21, 1991, meeting; (ii) review correspondence; and (iii) review enforcement files.

Contact: Willie Fobbs, III, Assistant Director, Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-8514.

Board for Interior Designers

March 27, 1992 - 9 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting to (i) approve minutes from January 10, 1992, meeting; (ii) review correspondence; and (iii) review applications.

Contact: Willie Fobbs, III, Assistant Director, Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-8514.

Board for Land Surveyors

March 20, 1992 - 9 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting to (i) approve minutes from January 9, 1992, meeting; (ii) review correspondence; and (iii) review enforcement files.

Contact: Willie Fobbs, III, Assistant Director, Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-8514.

ASAP POLICY BOARD - VALLEY

March 9, 1992 - 8:30 a.m. – Open Meeting
Augusta County School Board Office, Fishersville, Virginia. ♿

A regular meeting to conduct business pertaining to (i) court referrals; (ii) financial report; (iii) director's report; and (iv) statistical reports.

Contact: Mrs. Rhoda G. York, Executive Director, 2 Holiday Court, Staunton, VA 24401, telephone (703) 886-5616 or in Waynesboro (703) 943-4405.

AUCTIONEERS BOARD

† **March 10, 1992 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting to conduct regulatory review and other matters which require board action.

Contact: Mr. Geralde W. Morgan, Administrator, Department of Commerce, 3600 West Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8534.

STATE BUILDING CODE TECHNICAL REVIEW BOARD

† **March 27, 1992 - 10 a.m.** – Open Meeting
Virginia Housing Development Authority, 601 Belvidere Street, Second Conference Room , First Floor, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to (i) consider requests for interpretation of the Virginia Uniform Statewide Building Code; (ii) consider appeals from the rulings of local appeal boards regarding application of the Virginia Uniform Statewide Building Code; and (iii) approve minutes of previous meeting.

Contact: Jack A. Proctor, 205 North Fourth Street, Richmond, VA 23219, telephone (804) 371-7772.

CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

March 26, 1992 - 10 a.m. – Open Meeting
State Water Control Board, Conference Room, Innsbrook Corporate Center, 4900 Cox Road, Glen Allen, Virginia. ♿ (Interpreter for deaf provided upon request)

The board will conduct general business, including review of local Chesapeake Bay Preservation Area programs. Public comment will be heard early in the meeting. A tentative agenda will be available from the Chesapeake Bay Local Assistance Department by March 19, 1992.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Central Area Review Committee

March 9, 1992 - 10 a.m. – Open Meeting
March 23, 1992 - 10 a.m. – Open Meeting
General Assembly Building, Senate Room B, 9th and Broad Streets, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area Programs for the Central Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Northern Area Review Committee

March 11, 1992 - 10 a.m. – Open Meeting
March 25, 1992 - 10 a.m. – Open Meeting
Council on the Environment, Conference Room, 9th Street Office Building, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area Programs for the Northern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Regulatory Review Committee and Program Study Group

March 18, 1992 - 10 a.m. – Open Meeting
Monroe Building, Meeting Room E, 101 North 14th Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will consider issues relating to Chesapeake Bay Preservation Area Designation and Management Regulations, VR 173-02-01. No public comment will be taken.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Southern Area Review Committee

March 18, 1992 - 10 a.m. – Open Meeting
Council on the Environment, Conference Room, 9th Street Office Building, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area Programs for the Southern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

COUNCIL ON CHILD DAY CARE AND EARLY CHILDHOOD PROGRAMS

March 17, 1992 - 2 p.m. – Public Hearing
March 17, 1992 - 7 p.m. – Public Hearing
Pearl Sample Elementary School, Culpeper County Public Schools, Intersection of Routes 15 and 29, Culpeper, Virginia. ♿ (Interpreter for deaf provided upon request)

March 24, 1992 - 2 p.m. – Public Hearing
March 24, 1992 - 7 p.m. – Public Hearing
Wytheville Community College, Grayson Commons, Wytheville, Virginia. ♿ (Interpreter for deaf provided upon request)

A public hearing on child care and development block grant. Public comments will be received.

Contact: Margaret A. Smith, Acting Director, Virginia Council on Child Day Care and Early Childhood Programs,

Suite 1116, Washington Building, 1100 Bank Street, Richmond, VA 23219, telephone (804) 371-8603.

CHILD DAY-CARE COUNCIL

March 11, 1992 - 8 a.m. – Open Meeting
Koger Executive Center, West End, Blair Building, Conference Room, 2nd Floor, 1604 Santa Rosa Road, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to discuss legislation affecting child care centers, camps, school age programs, and preschool/nursery schools.

† **March 12, 1992 - 9 a.m.** – Open Meeting
Koger Executive Center, West End, Blair Building, Conference Rooms A and B, 8007 Discovery Drive, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to discuss issues, concerns and programs that impact child care centers, camps, school age programs, and preschool/nursery schools. The public comment period is 1 p.m.

Contact: Peggy Friedenberg, Legislative Analyst, Office of Governmental Affairs, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

INTERDEPARTMENTAL REGULATION OF RESIDENTIAL FACILITIES FOR CHILDREN

Coordinating Committee

March 20, 1992 - 8:30 a.m. – Open Meeting
Office of Coordinator, Interdepartmental Regulation, 1603 Santa Rosa Road, Tyler Building, Suite 208, Richmond, Virginia. ♿

A meeting to consider such administrative and policy issues as may be presented to the committee. A period for public comment is provided at each meeting.

Contact: John J. Allen, Jr., Coordinator, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-7124.

STATE BOARD FOR COMMUNITY COLLEGES

† **March 25, 1992 - Time to be determined** – Open Meeting
Patrick Henry Community College, Martinsville, Virginia.

A state board committee meeting.

† **March 26, 1992 - 9 a.m.** – Open Meeting
Patrick Henry Community College, Martinsville, Virginia.

A regularly scheduled state board meeting. Agenda available by March 9, 1992.

Contact: Joy Graham, Assistant Chancellor, Public Affairs, Virginia Community College System, 101 North 14th Street, Richmond, VA 23219, telephone (804) 225-2126 or (804) 371-8504/TDD ☎

COMPENSATION BOARD

March 26, 1992 - 5 p.m. – Open Meeting
Ninth Street Office Building, Room 913/913A, 9th Floor, 202 North Ninth Street, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

A routine meeting to conduct business.

Contact: Bruce W. Haynes, Executive Secretary, P.O. Box 3-F, Richmond, VA 23206-0686, telephone (804) 786-3886.

DEPARTMENT OF CONSERVATION AND RECREATION

Falls of the James Scenic River Advisory Board

March 20, 1992 - Noon – Open Meeting
Planning Commission Conference Room, Fifth Floor, City Hall, Richmond, Virginia.

A meeting to review river issues and programs.

Contact: Richard G. Gibbons, Environmental Program Manager, Department of Conservation and Recreation, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-4132 or (804) 786-2121/TDD ☎

BOARD FOR CONTRACTORS

April 10, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Contractors intends to amend regulations entitled: **VR 220-01-2. Board for Contractors Licensing Regulations.** These amendments are proposed to enhance the administration of the board's regulations, thereby promoting public health, safety and welfare, as well as benefiting consumers and licensed/registered contractors.

Contact: Florence R. Brassier, Assistant Director, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-8557.

Recovery Fund Committee

March 26, 1992 - 9 a.m. – Open Meeting
3600 West Broad Street, Richmond, Virginia.

A meeting to consider claims filed against the Virginia Contractor Transaction Recovery Fund. This meeting will be open to the public; however, a portion of the discussion may be conducted in Executive Session.

Contact: Vickie Brock, Recovery Fund Administrator, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-2394.

BOARD OF CORRECTIONS

March 11, 1992 - 10 a.m. – Open Meeting
6900 Atmore Drive, Board of Corrections Board Room, Richmond, Virginia.

A regular monthly meeting to consider such matters as may be presented to the board.

Contact: Mrs. Vivian Toler, Secretary to the Board, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3235.

Liaison Committee

March 12, 1992 - 9:30 a.m. – Open Meeting
6900 Atmore Drive, Board of Corrections Board Room, Richmond, Virginia.

A meeting to address and discuss criminal justice issues.

Contact: Mrs. Vivian Toler, Secretary to the Board, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3235.

BOARD FOR COSMETOLOGY

† **March 9, 1992 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

A general business meeting.

Contact: Demetra Y. Kontos, Assistant Director, Board for Cosmetology, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-2175.

Committee on Criminal Justice Information Systems

† **March 26, 1992 - 10 a.m.** – Open Meeting
Governor's Cabinet Conference Room, 6th Floor, Ninth Street Office Building, 9th and Grace Streets, Richmond, Virginia.

A meeting to discuss projects and business of the committee.

Contact: Paula J. Scott, Executive Assistant, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-4000.

DEPARTMENT OF CRIMINAL JUSTICE SERVICES (BOARD OF)

April 1, 1992 - 9 a.m. – Public Hearing
General Assembly Building, House Room D, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Criminal Justice Services Board intends to amend regulations entitled: **VR 240-01-2. Rules Relating to Compulsory In-Service Training Standards for Law-Enforcement Officers, Jailors or Custodial Officers, Courtroom Security Officers, Process Service Officers and Officers of the Department of Corrections Institutional Services.** The proposed amendments mandate in-service training requirements for those criminal justice officers specified in the title of the regulation.

Statutory Authority: § 9-170 of the Code of Virginia.

Written comments may be submitted until March 12, 1992.

Contact: L.T. Eckenrode, Division Director, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-4000.

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April 1, 1992 - 9 a.m. – Public Hearing
General Assembly Building, House Room D, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Criminal Justice Services Board intends to amend regulations entitled: **VR 240-01-12. Rules Relating to Certification of Criminal Justice Instructors.** These proposed amendments set forth mandated training requirements for certification of Criminal Justice Instructors.

Statutory Authority: § 9-170 of the Code of Virginia.

Written comments may be submitted until March 12, 1992.

Contact: L.T. Eckenrode, Division Director, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-8475.

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April 1, 1992 - 2:30 p.m. – Public Hearing
General Assembly Building, House Room D, Richmond,

Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Criminal Justice Services Board intends to adopt regulations entitled: **VR 240-04-2. Rules Relating to the Forfeited Drug Asset Sharing Program.** The purpose of the proposed regulation is to regulate the administration of the Forfeited Drug Asset Sharing Program.

Statutory Authority: §§ 19.2-386.4, 19.2-386.10 and 19.2-386.14 of the Code of Virginia.

Written comments may be submitted until February 28, 1992.

Contact: Paula J. Scott, Executive Assistant, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-8730.

Committee on Criminal Justice Information Systems

† **March 26, 1992 - 10 a.m.** – Open Meeting
Governor's Cabinet Conference Room, 6th Floor, Ninth Street Office Building, 9th and Grace Streets, Richmond, Virginia. &

A meeting to discuss projects and business of the committee.

Contact: Paula J. Scott, Executive Assistant, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-4000.

Criminal History Records Improvement Task Force

† **March 17, 1992 - 10 a.m.** – Open Meeting
State Police Training Academy. &

A meeting to continue an assessment of and planning for improvements to criminal history records in the Commonwealth.

Contact: Paula J. Scott, Executive Assistant, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-4000.

Virginia Juvenile Justice and Delinquency Prevention Advisory Committee

† **March 18, 1992 - 10 a.m.** – Open Meeting
State Capitol, Senate Room 4, Richmond, Virginia. &

A meeting to discuss matters relating to the prevention and treatment of juvenile delinquency and the administration of juvenile justice in the Commonwealth.

Contact: Paula J. Scott, Executive Assistant, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-4000.

STATE EDUCATION ASSISTANCE AUTHORITY

Board of Directors

March 12, 1992 - 10 a.m. – Open Meeting
411 East Franklin Street, Second Floor Boardroom, Richmond, Virginia. &

A general business meeting.

Contact: Catherine E. Fields, Administrative Assistant, One Franklin Square, 411 East Franklin Street, Suite 300, Richmond, VA 23219, telephone (804) 775-4648, toll-free 1-800-792-LOAN or SCATS (804) 786-2035.

DEPARTMENT OF EDUCATION (STATE BOARD OF)

April 24, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Education intends to **repeal** existing regulations entitled **VR 270-02-0000. Teacher Certification Regulations,** and to **adopt new** regulations entitled: **VR 270-01-0000:1. Regulations Governing the Licensure of School Personnel.** These regulations provide a basis for the licensure of school personnel including teachers, administrators, and support personnel.

NOTICE

Public hearings were scheduled in four locations statewide for February 20, 1992, four days prior to the publication of the regulations in the Virginia Register. A snow date has been set for March 5 (except in Manassas where the snow date is set for March 4).

Although initially, the hearings were inadvertently scheduled for the earlier dates, it appears that there will be significant comment from the public relative to the requirements. Department staff will need the additional time to analyze the comments and to make any necessary revisions to the proposed regulations. Written comments will be accepted through April 24, 1992.

The following steps have been (or will be in the very near future) taken to make the public aware of the public hearings:

1. Approximately 800 copies of the proposed regulations and hearing notices have been mailed to appropriate stakeholders in local school divisions, certain private schools, colleges and universities, and professional organizations. Staff feels that we have successfully identified and reached the vast manority of stakeholders.

2. The Board of Education will issue a statewide press

release to the media announcing the date and details of the hearings.

3. Information regarding the hearings will be posted on VaPEN, Virginia's Educational Computer Network. This will be available to all users nationwide who have access to the network. This will include teachers and administrators in most local school divisions and Virginia colleges and universities, as well as many of the same population nationwide.

4. Word-of-mouth announcements have been made from individuals who are members of professional organizations. These individuals include staff of the department who are members of the organizations and/or staff who have met with the organizations since the date was set back in November, 1991.

If there is sufficient opposition to any of the proposals or substantial revision to them, the Board of Education may hold a second public hearing prior to the formal adoption of the regulations.

Statutory Authority: §§ 22.1-16 and 22.1-298 of the Code of Virginia.

Written comments may be submitted until April 24, 1992.

Contact: Charles W. Finley, Associate, School Accreditation, Department of Education, P.O. Box 6-Q, Richmond, VA 23216-2060, telephone (804) 225-2747 or toll-free 1-800-292-3820.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

March 10, 1992 - 10 a.m. – Open Meeting
April 14, 1992 - 10 a.m. – Open Meeting
Monroe Building, Council Conference Room, 9th Floor, Monroe Building, Richmond, Virginia. ♿

A general business meeting. For more information contact the Council.

Contact: Anne Pratt, Associate Director, 101 North Fourteenth Street, 9th Floor, Monroe Building, Richmond, VA 23219, telephone (804) 225-2629.

LOCAL EMERGENCY PLANNING COMMITTEE - CITY OF ALEXANDRIA

† **March 11, 1992 - 6 p.m.** – Open Meeting
Alexandria Police Department, 2003 Mill Road, Alexandria, Virginia. ♿

An open meeting with committee members and facility emergency coordinators to conduct business in accordance with SARA Title III, Emergency Planning and Community Right-to-Know Act of 1986.

Contact: Charles W. McRorie, Emergency Preparedness Coordinator, 900 Second Street, Alexandria, VA 22312, telephone (703) 838-3825 or (703) 838-5056/TDD ☎

LOCAL EMERGENCY PLANNING COMMITTEE - ARLINGTON COUNTY/CITY OF FALLS CHURCH

† **March 25, 1992 - 5 p.m.** – Open Meeting
Fire Station #1, 500 South Glebe Road, Arlington, Virginia. ♿ (Interpreter for deaf provided if requested)

An open meeting to discuss the Superfund Amendments and Reauthorization Act (SARA) requirements for hazardous materials.

Contact: Thomas M. Hawkins, Jr., Chairman, 2100 Clarendon Boulevard, Suite 400, Fire Department Administration, Arlington, VA 22201, telephone (703) 358-3365 or (703) 558-2096/TDD ☎

LOCAL EMERGENCY PLANNING COMMITTEE - CHESTERFIELD COUNTY

April 2, 1992 - 5:30 p.m. – Open Meeting
† **May 7, 1992 - 5:30 p.m.** – Open Meeting
Chesterfield County Administration Building, 10001 Ironbridge Road, Chesterfield, Virginia. ♿

A meeting to meet requirements of Superfund Amendment and Reauthorization Act of 1986.

Contact: Linda G. Furr, Assistant Emergency Services, Chesterfield Fire Department, P.O. Box 40, Chesterfield, VA 23832, telephone (804) 748-1236.

LOCAL EMERGENCY PLANNING COMMITTEE - FAIRFAX COUNTY, THE CITY OF FAIRFAX, AND THE TOWNS OF HERNDON AND VIENNA

March 12, 1992 - 10 a.m. – Open Meeting
John C. Wood Municipal Center, 3730 Old Lee Highway, Fairfax, Virginia. ♿

A general meeting.

Contact: David Duncan, 4031 University Drive, Fairfax, VA 22030, telephone (703) 246-3967.

LOCAL EMERGENCY PLANNING COMMITTEE - GLOUCESTER

April 22, 1992 - 6:30 p.m. – Open Meeting
Gloucester Administration Building, Conference Room, Gloucester, Virginia. ♿ (Interpreter for deaf provided if requested)

A quarterly meeting to include a briefing on the DES,

Zelda Hurricane Exercise, a report from the By-Laws Committee and approval of the final draft of LEPC Hazardous Materials Plan Update.

Contact: Georgette N. Hurley, Assistant County Administrator, P.O. Box 329, Gloucester, VA 23061, telephone (804) 693-4042.

LOCAL EMERGENCY PLANNING COMMITTEE - COUNTY OF MONTGOMERY/TOWN OF BLACKSBURG

† **March 10, 1992 - 3 p.m.** – Open Meeting

Montgomery County Courthouse, 3rd Floor, Board of Supervisors Room, Christiansburg, Virginia. ♿

A meeting to discuss the development of a Hazardous Materials Emergency Response Plan for Montgomery County and the Town of Blacksburg.

Contact: Steve Via, New River Valley Planning District Commission, P.O. Box 3726, Radford, VA 24143, telephone (703) 639-9313 or SCATS (804) 676-4012.

LOCAL EMERGENCY PLANNING COMMITTEE - CITY OF PORTSMOUTH

March 11, 1992 - 9 a.m. – Open Meeting

St. Julian's Annex, Building 307, Victory Boulevard at Magazine Road, Portsmouth, Virginia.

A general meeting.

Contact: Karen Karpowski, Portsmouth Fire Department, 361 Effingham Street, Portsmouth, VA 23704-2337, telephone (804) 393-8765.

LOCAL EMERGENCY PLANNING COMMITTEE - PRINCE WILLIAM COUNTY, MANASSAS CITY, AND MANASSAS PARK CITY

March 16, 1992 - 1:30 p.m. – Open Meeting

1 County Complex Court, Potomac Conference Room, Prince William, Virginia. ♿

A multi-jurisdictional local emergency planning committee to discuss issues related to hazardous substances in the jurisdictions. SARA Title III provisions and responsibilities for hazardous material emergency response planning.

Contact: John E. Medici, Hazardous Materials Officer, 1 County Complex Court, Internal Zip MC470, Prince William, VA 22192, telephone (703) 792-6800.

LOCAL EMERGENCY PLANNING COMMITTEE - WINCHESTER

March 11, 1992 - 3 p.m. – Open Meeting
Winchester/Frederick Economic Development Commission, 12 Rouss Avenue, Meeting Room, Winchester, Virginia.

A general meeting.

Contact: L.A. Miller, Fire Chief, Winchester Fire and Rescue Department, 126 North Cameron Street, Winchester, VA 22601, telephone (703) 662-2298.

VIRGINIA EMPLOYMENT COMMISSION

Advisory Board

March 11, 1992 - 1 p.m. – Open Meeting
March 12, 1992 - 8:30 a.m. – Open Meeting
Virginia Employment Commission, 100 Carpenter Drive, Suite 105-A, Sterling, Virginia. ♿ (Interpreter for deaf provided if requested)

A regular meeting.

Contact: Ralph G. Cantrell, Commissioner, Virginia Employment Commission, 703 E. Main Street, Richmond, VA 23219, telephone (804) 786-3001 or (804) 371-8050/TDD ☎

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

April 27, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Funeral Directors and Embalmers intends to amend regulations entitled: **VR 320-01-2. Regulations of the Board of Funeral Directors and Embalmers.** The amendments are designed to delete the requirements for the funeral services trainee program that are now incorporated into VR 320-01-4.

Statutory Authority: §§ 54.1-2400, 54.1-2803 (10), and 54.1-2820 of the Code of Virginia.

Written comments may be submitted until April 27, 1992.

Contact: Meredyth P. Partridge, Executive Director, Board of Funeral Directors and Embalmers, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9907.

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April 27, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1

of the Code of Virginia that the Board of Funeral Directors and Embalmers intends to amend regulations entitled: **VR 320-01-3. Regulations for Preneed Funeral Planning.** The amendments are designed to bring current regulations into compliance with 1991 legislation requiring insurance policies and annuity contracts which fund preneed contracts to offer a minimum rate of return.

Statutory Authority: §§ 54.1-2400, 54.1-2803 (10), and 54.1-2820 of the Code of Virginia.

Written comments may be submitted until April 27, 1992.

Contact: Meredyth P. Partridge, Executive Director, Board of Funeral Directors and Embalmers, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9907.

GOVERNOR'S COUNCIL ON ALCOHOL AND DRUG ABUSE

† **March 27, 1992 - 3 p.m.** – Open Meeting
Virginia Beach Resort Hotel and Conference Center, 2800 Shore Drive, Virginia Beach, Virginia.

A meeting to discuss proposed study of grain alcohol.

Contact: Amy M. Curtis, Staff Assistant, Governor's Drug Policy Office, P.O. Box 1475, Richmond, VA 23212, telephone (804) 786-2211 or (804) 371-8015/TDD ☎

GOVERNOR'S JOB TRAINING COORDINATING COUNCIL

† **March 16, 1992 - 10:30 a.m.** – Open Meeting
The Hyatt Richmond at Brookfield, 6624 West Broad Street, Richmond, Virginia. ♿

A general meeting.

Contact: Abria M. Singleton, Executive Secretary, 4615 W. Broad Street, The Commonwealth Building, Third Floor, Richmond, VA 23230, telephone (804) 367-9816.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

March 30, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Health intends to amend regulations entitled: **VR 355-28-300. Rules and Regulations of the Board of Health, Commonwealth of Virginia, for the Immunization of School Children.** The proposed amendments will make the regulations consistent with the current recommendations of the U.S. Public Health Service.

Statutory Authority: §§ 22.1-271.1, 22.1-272.1, 32.1-46 and 32.1-12 of the Code of Virginia.

NOTE: CHANGE IN WRITTEN COMMENT DATE
Written comments may be submitted until March 30, 1992, to A. Martin Cader, M.D., Virginia Department of Health, Division of Communicable Disease Control, P.O. Box 2448, Room 113, Richmond, VA 23218.

Contact: Marie Krauss, Executive Secretary, Virginia Department of Health, Division of Communicable Disease Control, P.O. Box 2448, Room 113, Richmond, VA 23218, telephone (804) 786-6261.

Division of Shellfish Sanitation

March 16, 1992 - 7 p.m. – Open Meeting
Eastern Shore Community College, Melfa, Virginia. ♿

A meeting to (i) discuss the shellfish sanitation program in Virginia; (ii) discuss the closure of Parker Creek, a tributary of Metompkin Bay in Accomack County; and (iii) discuss other related topics if requested.

Contact: Mary Wright, Classification Chief, 1500 East Main Street, Room 109-31, Richmond, VA 23219, telephone (804) 786-7937.

Radiation Advisory Board

† **March 24, 1992 - 9 a.m.** – Open Meeting
State Capitol, House Room 1, Richmond, Virginia.

An annual meeting to discuss radiological health issues.

Contact: Leslie P. Foldesi, Director, 1500 East Main Street, Room 104A, Richmond, VA 23219, telephone (804) 786-5932.

VIRGINIA HEALTH SERVICES COST REVIEW COUNCIL

March 15, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Health Services Cost Review Council intends to amend regulations entitled: **VR 370-01-001. Rules and Regulations of the Virginia Health Services Cost**

Review Council. The proposed amendments (i) waive the audit requirement and the imposition of a penalty if an "extenuating circumstance," such as a bankruptcy proceeding, exists; (ii) require the filing of an institution's historical and its certified audited financial statement prior to acceptance by council of the filing of a subsequent year's budget or the filing of any request for an interim rate increase; and (iii) require each individual licensed health care institution to submit filings, but that the screening process would still be applied to allow for hospital systems to be analyzed systemwide by the Virginia Hospital Rate Review Program.

Statutory Authority: §§ 9-158, 9-159 and 9-164 of the Code of Virginia.

Written comments may be submitted until March 15, 1992.

Contact: G. Edward Dalton, Deputy Director, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371/TDD ☎

† **March 23, 1992 - 7 p.m.** – Open Meeting
Washington Dulles Airport Marriott, 333 West Service Road, Chantilly, Virginia. ♿

The council will conduct its monthly meeting.

Contact: Kim Schulte Barnes, Information Officer, 805 East Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371/TDD ☎

VIRGINIA HISTORIC PRESERVATION FOUNDATION

March 11, 1992 - 9:30 a.m. – Open Meeting
State Treasurer's Office, Board Room, 3rd Floor, Monroe Building, 101 North 14th Street, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

A general business meeting.

Contact: Hugh Miller, Director or Margaret Peters, Information Director, 221 Governor Street, Richmond, VA 23219, telephone (804) 786-3143 or (804) 786-1934/TDD ☎

HOPEWELL INDUSTRIAL SAFETY COUNCIL

April 7, 1992 - 9 a.m. – Open Meeting
May 5, 1992 - 9 a.m. – Open Meeting
Hopewell Community Center, Second & City Point Road, Hopewell, Virginia. ♿ (Interpreter for deaf provided if requested)

Local Emergency Preparedness Committee meeting on Emergency Preparedness as required by SARA Title III.

Contact: Robert Brown, Emergency Services Coordinator, 300 North Main Street, Hopewell, VA 23860, telephone (804) 541-2298.

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT (BOARD OF)

March 11, 1992 - 9 a.m. – Public Hearing
Department of Housing and Community Development, Eighth Floor Conference Room, 205 North Fourth Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Housing and Community Development intends to adopt regulations entitled: **VR 394-01-107. Procedures for Allocation of Low-Income Housing Tax Credits.** These proposed regulations supersede the regulations published by the Virginia Housing Development Authority in 8:7 VA.R. 1123, December 30, 1991, which are being repealed simultaneously herewith. The proposed procedures establish the administrative framework for the allocation of Low Income Housing Tax Credits by the Department of Housing and Community Development.

Statutory Authority: §§ 36-143, 36-146 and 36-147 of the Code of Virginia; § 42 of the Internal Revenue Code; and Governor's Executive Order No. Forty (91).

Written comments may be submitted until March 11, 1992.

Contact: Graham Driver, Program Administrator, 205 North Fourth Street, Richmond, VA 23219, telephone (804) 786-7891.

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

† **March 17, 1992 - 11 a.m.** – Open Meeting
601 S. Belvidere Street, Richmond, Virginia. ♿

A regular meeting of the Board of Commissioners to (i) review and, if appropriate, approve the minutes from the prior monthly meeting; (ii) consider for approval and ratification mortgage loan commitments under its various programs; (iii) review the authority's operations for the prior month; (iv) consider and, if appropriate, approve the repeal of the Rules and Regulations for Allocation of Low-Income Housing Tax Credits; and (v) consider such other matters and take such other actions as it may deem appropriate. Various committees of the Board of Commissioners may also meet before or after the regular meeting and consider matters within their purview. The planned agenda of the meeting will be available one week prior to the date of the meeting.

Contact: J. Judson McKellar, Jr., General Counsel, Virginia Housing Development Authority, 601 S. Belvidere Street, Richmond, VA 23220, telephone (804) 782-1986.

COUNCIL ON INFORMATION MANAGEMENT

Mapping Advisory Commission

March 20, 1992 - 9 a.m. – Open Meeting
1100 Bank Street, 9th Floor Conference Room, Richmond, Virginia. ♿

A regular business meeting.

Contact: Linda Hening, Administrative Assistant, 1100 Bank Street, Suite 901, Richmond, VA 23219, telephone (804) 225-3622 or (804) 225-3624/TDD ☎

LIBRARY BOARD

March 17, 1992 - 9:30 a.m. – Open Meeting
Virginia State Library and Archives, 3rd Floor, Supreme Court Room, 11th Street at Capitol Square, Richmond, Virginia. ♿

A meeting to discuss administrative matters.

Contact: Jean H. Taylor, Secretary to State Librarian, Virginia State Library and Archives, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

STATE COUNCIL ON LOCAL DEBT

March 18, 1992 - 11 a.m. – Open Meeting
† **April 15, 1992 - 11 a.m.** – Open Meeting
101 North 14th Street, James Monroe Building, 3rd Floor, Treasury Board Conference Room, Richmond, Virginia. ♿

A regular meeting subject to cancellation unless there are action items requiring the Council's consideration. Persons interested in attending should call one week prior to meeting date to ascertain whether or not the meeting is to be held as scheduled.

Contact: Art Bowen, Senior Debt Analyst, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-4929.

COMMISSION ON LOCAL GOVERNMENT

March 24, 1992 - 10:30 a.m. – Open Meeting
Prince Edward County Board of Supervisors Meeting Room, Courthouse Building, North Main Street, Farmville, Virginia.

Oral presentations regarding petition filed by the Town of Farmville requesting approval of a voluntary settlement with the County of Prince Edward.

Persons desiring to participate in the Commission's oral presentations and requiring special accommodations or interpreter services should contact the Commission's offices by Friday, March 20, 1992.

March 24, 1992 - 7:30 p.m. – Public Hearing
Courthouse Building, North Main Street, Farmville, Virginia.

Public hearing regarding petition filed by the Town of Farmville requesting approval of a voluntary settlement with the County of Prince Edward.

Persons desiring to participate in the Commission's oral presentations and requiring special accommodations or interpreter services should contact the Commission's offices by Friday, March 20, 1992.

March 25, 1992 - 9 a.m. – Open Meeting
Site to be determined.

A regular meeting to consider such matters as may be presented.

Persons desiring to participate in the Commission's oral presentations and requiring special accomodations or interpreter services should contact the Commission's offices by Friday, March 20, 1992.

Contact: Barbara W. Bingham, Administrative Assistant, 702 Eighth Street Office Building, Richmond, VA 23219, telephone (804) 786-6508 or (804) 786-1860/TDD ☎

STATE LOTTERY BOARD

† **March 23, 1992 - 11 a.m.** – Open Meeting
State Lottery Department Regional Office, 1506 South Main Street, Farmville, Virginia. ♿

A regular monthly meeting. Business will be conducted according to items listed on the agenda which has not yet been determined. Two periods for public comment are scheduled.

Contact: Barbara L. Robertson, Lottery Staff Officer, State Lottery Department, 2210 W. Broad Street, Richmond, VA 23901, telephone (804) 367-9433.

MARINE RESOURCES COMMISSION

March 24, 1992 - 9:30 a.m. – Open Meeting
April 28, 1992 - 9:30 a.m. – Open Meeting
2600 Washington Avenue, 4th Floor, Room 403, Newport News, Virginia. ♿ (Interpreter for deaf provided upon request)

The commission will hear and decide marine environmental matters at 9:30 a.m.: permit applications for projects in wetlands, bottom lands, coastal primary sand dunes and beaches; appeals of local wetland board decisions; policy and regulatory issues.

The commission will hear and decide fishery management items at approximately 2 p.m.: regulatory proposals, fishery management plans, fishery conservation issues, licensing, shellfish leasing.

Meetings are open to the public. Testimony is taken under oath from parties addressing agenda items on permits and licensing. Public comments are taken on resource matters, regulatory issues, and items scheduled for public hearing. The commission is empowered to promulgate regulations in the areas of marine environmental management and marine fishery management.

Contact: Cathy W. Everett, Secretary to the Commission, P.O. Box 756, Room 1006, Newport News, VA 23607, telephone (804) 247-8088 or (804) 247-2292/TDD ☎

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

March 27, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **State Plan for Medical Assistance Relating to Specialized Care Services: VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality Care; VR 460-02-4.1940. Methods and Standards for Establishing Payment Rates - Long-Term Care; and VR 460-03-4.1944. Class Resource Cost Assignment, Computation of Service Intensity Index and Ceiling and Rate Adjustments to the Prospective Direct Patient Care Operating Cost Rate - Allowance for Inflation Methodology Base "Current" Operating Rate (Appendix IV to Nursing Home Payment System).** This proposal establishes existing agency policies for providing services to eligible recipients who require intensive nursing and other medical services.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m., March 27, 1992, to Mary Chiles, Manager, Division of Quality Care Assurance, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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April 10, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **State Plan for Medical Assistance Relating to Inpatient Hospital Settlement Agreement: VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care.** This regulation proposes to incorporate into the plan the provisions of the lawsuit final settlement agreement between the Commonwealth and the Virginia Hospital Association.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m., April 10, 1992, to Wm. R. Blakely, Director, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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April 10, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **State Plan for Medical Assistance Relating to Provider Disputes and Date of Acquisition. VR 460-03-4.1912. Dispute Resolution for State-Operated Providers; VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates–Other Types of Care; VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).** These amendments establish an appeal mechanism for state-owned facilities which are Medicaid providers and also define a nursing facility's date of acquisition when it is sold.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m., April 10, 1992, to Wm. R. Blakely, Director, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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† **May 8, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **State Plan for Medical Assistance Relating to Inpatient Outlier Adjustments: VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care.** These regulations propose the same outlier policy for hospital reimbursement as was contained in an earlier emergency regulation.

STATEMENT

Basis and Authority: Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance in lieu of board action pursuant to the board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:9, for this agency's promulgation of proposed regulations subject to the Department of Planning and Budget's and Governor's reviews. Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA.

Section 1902(a)(13)(A) of the Social Security Act is implemented by Title 42 of the Code of Federal Regulations Part 447 Subpart C. This section "requires that the State Plan provide for payment for hospital and long-term care facility services through the use of rates that the state finds, and makes assurances satisfactory to the secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with the state and federal laws, regulations, and quality and safety standards and assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to ..(inpatient hospital services)... of adequate quality."

Purpose: The purpose of this proposal is to promulgate permanent regulations to supersede the existing emergency regulations.

Summary and Analysis: The section of the state plan affected by this action is the Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care (Attachment 4.19A).

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) § 4604 required that state plans, which reimburse inpatient hospital services on a prospective basis, provide for an outlier adjustment payment for certain medically necessary inpatient hospital services. Specifically, these services involve exceptionally high costs or exceptionally long lengths of stay for (i) infants younger than one year of age in all hospitals, and (ii) children younger than six years of age in disproportionate share hospitals. The Plan, prior to the existing emergency regulation, provided for an outlier adjustment of exceptionally high costs for infants younger than one year of age in disproportionate share hospitals only.

Supplement 1 to Attachment 3.1 A & B (the Amount, Duration, and Scope of Services) currently provides for unlimited medically necessary days for children younger than 21 years because of the well child screening program (Early and Periodic Screening, Diagnosis, and Treatment). This language is being incorporated into Attachment 4.19 A at the direction of the Health Care Financing Administrations.

Impact: DMAS' projections for FY 92 for outlier adjustments in payment amounts to all hospitals for exceptionally high costs for infants younger than one year of age are:

	FY 92
GF	$73,103
NGF	$73,103
Total	$146,206

DMAS projections for FY 92 for outlier adjustments in payment amounts to disproportionate share hospitals for exceptionally high costs for children between one and six years of age are:

	FY 92
GF	$85,494
NGF	$85,494
Total	$170,988

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m., May 8, 1992, to Wm. R. Blakely, Director, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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† **May 8, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **State Plan for Medical Assistance Relating to Reimbursement Adjustment for Nonemergency ER Care. VR 460-02-4.1920. Methods and Standards Used for Establishing Payment Rates–Other Types of Care.** These amendments promulgate permanent

regulations to supersede emergency regulations which provide for the same policy.

STATEMENT

Basis and Authority: Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of board action pursuant to the board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:9, for this agency's promulgation of proposed regulations subject to the Department of Planning and Budget's and Governor's reviews. Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA.

Purpose: The purpose of this proposal is to promulgate permanent regulations to supersede the identical emergency regulation.

Summary and Analysis: The section of the State Plan affected by this proposed regulation is Attachment 4.19 B Methods and Standards for Establishing Payment Rates--Other Types of Care concerning adjusting the reimbursement for nonemergency services when rendered by emergency rooms (ER) and ER physicians.

Inappropriate use of the emergency room for nonemergency primary care has been a problem for hospitals, physicians, and third-party payers. Such inappropriate use results in higher medical costs, decreased efficiency of care and service delivery compared to care delivered by the patient's primary care physician, and the overcrowding of emergency room facilities.

Effective July 1, 1991 (the effective date of the emergency regulation which these identical proposed regulations would supersede), the Department of Medical Assistance Services (DMAS) began implementing a reimbursement reduction for nonemergency services provided in the emergency room setting. The reimbursement reduction is applied to both the facility fee and the physician fee. The intent of the program is to ensure nonemergency services provided in the emergency room are reimbursed at a rate approximating the reimbursement for that service had it been provided in a more appropriate setting, for example, the physician's office. The reimbursement rate may be conditional upon the review of emergency-related diagnosis or trauma diagnosis codes and the necessary documentation supporting the need for emergency services. The appropriate reimbursement rate is assigned by the Medicaid claims processing system, in conjunction with a manual review of selected claims, based upon the International Classification of Diseases, 9th Revision, Clinical Modification coding methodology (ICD-9-CM). Two categories are used: (i) pay the claim at the existing emergency rate for emergency services; (ii) pay the claim at the nonemergency rate for nonemergency services.

The reimbursement categories are based upon the ICD-9-CM diagnosis code. These codes are determined by the physician's diagnosis and assigned by the facility prior to the submission of the claim. For this program, DMAS assigned ICD-9-CM codes to two lists, one representing diagnosis codes that are true emergencies and the other, diagnosis codes that may be true emergencies if they meet certain criteria. Diagnosis codes that appear on the second list are reviewed to determine the emergency or nonemergency nature of the visit. Diagnosis codes that were not assigned to either list represent diagnoses for which the emergency room is not the most appropriate setting for care.

The review of the diagnosis codes to determine the list to which they were assigned was accomplished by a DMAS work group comprised of experienced physicians and nurse utilization review analysts. Information was obtained from other Medicaid agencies with similar programs in place. In addition, consultation and advice was sought from representatives of hospitals and emergency room physicians through the Virginia Hospital Association (VHA) and the American College of Emergency Room Physicians (ACEP).

Impact: There were 290,934 hospital emergency room claims filed in 1990, for a total payment by Medicaid of $26,349,708. Research done on the utilization of emergency rooms for nonemergency services indicates a range of 11% to 61% exists for nonemergency visits. For this program, DMAS has estimated that 40% of the emergency room visits are for nonemergency services, the percentage most commonly found in the research literature for medical assistance populations. The actual percentage of visits that will be identified as nonemergencies is difficult to determine in advance, as some percentage of the claims that are held for review will be deemed nonemergency claims. In addition, it is anticipated that the distribution of the diagnosis codes will change over time as the program remains in effect.

An all-inclusive fee for both physician and hospital emergency room payment for nonemergency services has been implemented. For all nonemergency claims for services delivered in the emergency room, DMAS pays to the hospital the lesser of the allowed amount (the all-inclusive fee) or the billed amount. All-inclusive is defined as all emergency room and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services. Lab services continue to be reimbursed under the existing system of rates. Claims identified as emergencies are reimbursed under existing rates.

For all nonemergency claims for services delivered by an emergency room physician in the emergency room setting, DMAS pays to the physician the lesser of the allowed amount (the all-inclusive fee) or the billed amount.

For physician claims identified as emergencies, reimbursement continues under the existing rates.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m., May 8, 1992, to Mike Jurgenson, Policy and Planning Supervisor, Division of Policy and Research, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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† **May 8, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **State Plan for Medical Assistance Relating to Community Mental Health/Mental Retardation Services: VR 460-03-3.1100, Narrative for the Amount, Duration and Scope of Services; VR 460-03-3.1102, Case Management Services; VR 460-03-3.1300, Standards Established and Methods Used to Assure High Quality Care; VR 460-02-4.1920, Methods and Standards for Establishing Payment Rates–Other Types of Care; and VR 460-04-8.1500, Community Mental Health and Mental Retardation Services: Amount, Duration and Scope of Services.** This proposed regulation provides for local community mental health/mental retardation services delivered through the Community Services Boards.

STATEMENT

Basis and Authority: Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance in lieu of board action pursuant to the board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:9, for this agency's promulgation of proposed regulations subject to the Department of Planning and Budget's and Governor's reviews. Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA. The Director adopted an emergency regulation for Community Mental Health/Mental Retardation Services to be effective July 1, 1991.

The U.S. Department of Health and Human Services, Health Care Financing Administration's approval of the parallel State Plan Amendment is pending completion.

The Code of Federal Regulations provides for the coverage of rehabilitative services at Title 42 CFR § 440.130(d). Rehabilitative services, under this section of the federal regulations, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

Purpose: The purpose of this proposal is to obtain federal financial participation for some current programs and services, previously funded with 100% state funds, and to meet future demand for treatment services. A technical correction is being made to include items F and G in § 1 which concerns high risk pregnant women and children.

Summary and Analysis: The 1990 Appropriations Act (Item 466) directed the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and DMAS to provide Medicaid coverage for community mental health and mental retardation services in Virginia. The purpose of this expansion of the Medicaid program is to obtain federal financial participation for some current programs and services as well as to meet future demand for treatment services. At a time of increasing fiscal constraints on state dollars, federal funding through Title XIX is the only mechanism available for addressing significant unmet service needs and continuing the Phase I Community Services initiative. In addition, this action enables the Commonwealth to make effective use of federal funds.

On October 1, 1990, Medicaid began coverage of mental health, mental retardation rehabilitation services under an emergency regulation. During subsequent months, the DMAS and DMHMRSAS received feedback and resolved implementation problems associated with the emergency regulation, as identified by the Community Services Boards (CSBs). Some of the regulation's provisions presented implementation problems which could only be resolved by substantive change to the regulation itself. Thus a second emergency regulation was implemented effective July 1, 1991.

The second emergency regulation differed from the initial regulation by including provisions proposed by the CSBs to simplify regulatory requirements imposed on the Boards, and to increase the services for which Medicaid reimbursement can be made. This proposed regulation reflects the content of the second emergency regulation.

The scope and coverage of this proposed regulation include Medicaid options for mental health and mental retardation services. The service definitions, provider requirements and qualification, and utilization review requirements included in the Plan change were developed by a task force of DMAS, DMHMRSAS, and local Community Services Board representatives.

Covered mental health services include targeted case management and rehabilitation services (e.g. emergency services, partial hospitalization/day treatment for adults, psychosocial rehabilitation for adults, therapeutic day treatment for children and adolescents).

For patients to be eligible to receive Community Mental Health services, they must meet the standard Medicaid eligibility criteria. In addition, other service-specific criteria include the following: mental health targeted case management services will be limited to adults with serious mental illness and children with serious emotional disturbances or who are at risk for serious emotional disturbance, as determined by diagnosis, level of disability, and duration of illness; eligibility for mental health rehabilitation services will be determined by specific utilization criteria.

Covered mental retardation services include targeted case management, and rehabilitation services such as day health and rehabilitation services.

Targeted case management services will be directed to those Medicaid eligibles who are mentally retarded. All of the mental retardation services will be provided based on a plan of care, developed by the case manager, which is to be approved and reviewed by DMHMRSAS staff every six months. Eligibility for mental retardation services will be determined by specific utilization criteria.

The 1988-90 Appropriations Act specifically dictated controls upon the providers who would be eligible to provide these services. These new covered services will be limited to providers who meet the specified qualifications. Programs must:

• Be in accordance with the DMHMRSAS Comprehensive State Plan, 1990-96

• Be licensed under regulations promulgated by DMHMRSAS

• Guarantee client access to emergency services on a 24-hour basis

• Demonstrate willingness and ability to serve all in need, regardless of ability to pay, or eligibility for Medicaid

• Have the necessary administrative and financial management capabilities

• Have the capacity to document individual case records to meet state and federal requirements.

Impact: This initiative is not expected to result in any new General Fund expenditures by DMAS. All new general fund dollars necessary to cover both services and growth will be transferred to DMAS by DMHMRSAS. DMAS will use the transferred general funds to draw down federal matching dollars.

The 1990 Appropriations Act designated $17,423,839 and $34,756,467 in federal match for the first and second years of the FY 91-92 biennium respectively. In addition, the Appropriations Act designated general fund dollars to transfer from community ICF/MRs to this initiative in the amounts of $787,500 and $3,150,000 for the first and second years of the biennium respectively. The remaining general fund dollars will be transferred from the DMHMRSAS budget.

All forty of the Community Services Boards will be providing these services as enrolled Medicaid providers, either directly or through contracts with medical/clinical providers, in accordance with the Virginia Comprehensive State Plan for 1990-96 for Mental Health, Mental Retardation and Substance Abuse Services.

Forms: The forms required by this agency for the administration of this new service are: the Community Services Boards provider agreement, the Practitioner Invoice, and the Practitioner Adjustment form.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m., May 8, 1992, to Ann Cook, Consultant, Division of Policy and Research, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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† **May 8, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **VR 460-03-4.1921. Pediatric and Obstetric Services Maximum Payments.** This proposed regulation conforms the plan to federal requirements of OBRA '89 § 6402 and to the American Medical Association's new coding convention for procedure codes.

STATEMENT

Basis and Authority: Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of board action pursuant to the board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:9, for this agency's promulgation of proposed regulations subject to the Department of Planning and Budget's and Governor's reviews. Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA.

Section 6402 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandated that states include the amounts of payments for certain obstetric and pediatric procedures

in their state plans. Each state establishes its own payment levels for Medicaid services; however, Medicaid regulations (42 CFR 447.204) provide that payments must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries to at least the extent that such services are available to the general population.

Purpose: The purpose of this proposal is to promulgate permanent regulations in conformance to OBRA '89 § 6402 and to new AMA procedure codes. This regulatory action makes no fee changes but merely changes the coding convention used by DMAS.

Summary and Analysis: Attachment 4.19 B of the plan contains reimbursement methodologies for all covered services except for inpatient hospital and long-term care, which are covered in other plan attachments. This amendment modifies Supplement 1 to Attachment 4.19 B, providing obstetric and pediatric payment rates, in conformance with the OBRA 89 requirement.

DMAS uses the American Medical Association's (AMA) Physicians' Current Procedural Terminology coding system for bills for physicians' services. Effective January 1, 1992, the AMA changed its coding system from one of identifying specific office visits to a system of evaluation and management codes. In order to conform its plan to the 1989 requirements of OBRA § 6402 and to accommodate the recent AMA changes, DMAS must modify the procedure codes and concomitant descriptions contained in Supplement 1 to Attachment 4.19 B.

Impact: This amendment has no fiscal impact because the formula used in establishing the rates for the new codes allow for budget neutral application of fees for the evaluation and management codes. Current policy which requires that payments for immunizations not exceed the Medicaid fee on file for the drug at the time of the service remains in effect.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m., May 8, 1992, to C. Mack Brankley, Director, Division of Client Services, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

BOARD OF MEDICINE

March 31, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled: **VR 465-09-01. Certification for Optometrists to Prescribe for and Treat Certain Diseases or Abnormal Conditions of the Human Eye and its Adnexa with Certain Therapeutic Pharmaceutical Agents.** The proposed amendments (i) delete the CPR requirements; (ii) redefine the examination format; (iii) redefine the diseases and conditions of the human eye and its adnexa; (iv) add new therapeutic agents; and (v) add a method to treat emergencies.

Statutory Authority: §§ 54.1-2400, 54.1-2957.1, 54.1-2957.2 and 54.1-2957.3 of the Code of Virginia.

Written comments may be submitted until March 31, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Dr., Richmond, VA 23229.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229, telephone (804) 662-9925.

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April 13, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled: **VR 465-05-01. Regulations Governing the Practice of Physician's Assistants.** The proposed amendment (i) establishes procedures for maintaining records of approved invasive procedures performed by the assistant; (ii) provides reports to the board upon request of the number of procedures performed and complications resulting from such procedures; (iii) establishes unprofessional conduct for failure to maintain such records; (iv) establishes that the scope of practice shall be the specialty of the supervising physician; and (v) establishes that any acute or significant finding or change of a patient's clinical status by an assistant must be reported to the supervising physician within one hour of findings.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Written comments may be submitted until April 13, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Dr., Richmond, VA 23229.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229, telephone (804) 662-9925.

Advisory Committee on Acupuncture

March 31, 1992 - 10 a.m. – Open Meeting
Department of Health Professions, Board Room 2, 1601 Rolling Hills Drive, Richmond, Virginia. &

A meeting to review public comments and prepare

regulations VR 465-11-01 for the practice of licensed acupuncturists, pursuant to § 54.1-2400 of the Code of Virginia. Public comments will not be entertained by the Advisory Committee.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Credentials Committee

April 11, 1992 - 8 a.m. – Open Meeting
Department of Health Professions, Board Room 3, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to (i) conduct general business; (ii) interview and review medical credentials of applicants applying for licensure in Virginia, in open and executive session; and (iii) discuss any other items which may come before the committee. Public comments will not be received.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Executive Committee

April 10, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, Board Room 1, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to (i) review closed cases; (ii) review cases/files requiring administrative action; (iii) adopt for final promulgation Regulations VR 465-03-01 Physical Therapy, VR 465-09-01 Optometry; (iv) review and approve for promulgation Regulations VR 465-11-01 Acupuncturists; and (v) consider any other items which may come before the committee. Public comments will not be received.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Legislative Committee

March 13, 1992 - 10 a.m. – Open Meeting
Department of Health Professions, Board Room 3, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to (i) discuss and develop a position on liposuction and blood testing by dentists; (ii) discuss use of diet medication and chelation therapy; (iii) develop regulations regarding advertising; and (iv) discuss other items which may come before the committee. The Legislative Committee will not entertain public comments.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Advisory Board on Occupational Therapy

April 16, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, Board Room 2, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to (i) review the AOTA's possible change in the accreditation of OT educational programs; (ii) review the content outlines for the AOTCB certification examination; (iii) review the reference guide for the OT Code of Ethics; (iv) review the utilization of specific modalities relating to practice; and (v) discuss other items which may come before the advisory board. Public comments will be received at the pleasure of the chairperson.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Advisory Committee on Optometry

† **April 10, 1992 - 8:30 a.m.** – Open Meeting
Department of Health Professions, Board Room 1, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to (i) review public comments to proposed amendments to regulations VR 465-09-01; (ii) make recommendations to the Board of Medicine; and (iii) discuss other items which may come before the committee. The Advisory Committee will not entertain public comments.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (STATE BOARD)

March 25, 1992 - 10 a.m. – Open Meeting
Rappahannock-Rapidan Community Services Board, Culpeper, Virginia.

A regular monthly meeting. The agenda will be published on March 18, and may be obtained by calling Jane V. Helfrich.

Tuesday: Informal Session - 8 p.m.

Wednesday: Committee Meetings - 9 a.m.

Wednesday: Regular Session - 10 a.m.

See agenda for location.

Contact: Jane V. Helfrich, Board Administrator, State

Mental Health, Mental Retardation and Substance Abuse Services Board, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3921.

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April 10, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Mental Health, Mental Retardation and Substance Abuse Services Board intends to adopt regulations entitled: **VR 470-05-01. Certification of Case Management.** These regulations establish requirements which facilities must meet in order to receive reimbursement from Medicaid for Case Management Services. The regulations require that case managers meet knowledge, skills and abilities set forth in the regulations and that facilities meet the standards established by the regulations.

Statutory Authority: §§ 37.1-10 and 37.1-179 et seq. of the Code of Virginia, and § I-92, Item 466.F.5 of the 1990-92 Appropriation Act.

Written comments may be submitted until April 10, 1992, to Ben Saunders, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23229.

Contact: Rubyjean Gould, Director of Administrative Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3915.

† **April 14, 1992 - 4 p.m.** – Public Hearing
Department of Social Services, 8007 Discovery Drive, Blair Building, 2nd Floor, Conference Room C, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

† **April 14, 1992 - 4 p.m.** – Public Hearing
Vinton Branch Library, 800 East Washington Avenue, Vinton, Virginia. ♿ (Interpreter for deaf provided upon request)

A public hearing to obtain comments on Virginia's Extended Fourth Year Grant Application for Part H of the Individuals with Disabilities Education Act (IDEA), that provides early intervention services for infants and toddlers with disabilities and their families, ages birth through 2. Written testimony will be accepted by the department until May 1, 1992.

Contact: Michael Fehl, Ed. D., Director of Children/Youth Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3710.

VIRGINIA MUSEUM OF FINE ARTS

Finance Committee

† **March 19, 1992 - Noon** – Open Meeting
The Payne Room/Members' Suite, Virginia Museum of Fine Arts, Boulevard and Grove Avenues, Richmond, Virginia. ♿

A regularly scheduled meeting to review the budget and discuss budget cuts.

Contact: Ms. Emily C. Robertson, Secretary of the Museum, Virginia Museum of Fine Arts, Boulevard and Grove Avenue, Richmond, VA 23221, telephone (804) 367-0553.

Board of Trustees

† **March 21, 1992 - 2 p.m.** – Open Meeting
The Chrysler Museum, Olney Road and Mowbray Arch, Norfolk, Virginia.

A regular board meeting to receive staff and committee reports, and to review budget.

Contact: Ms. Emily C. Robertson, Secretary of the Museum, Virginia Museum of Fine Arts, Boulevard and Grove Avenue, Richmond, VA 23221, telephone (804) 367-0553.

NORFOLK STATE UNIVERSITY

Board of Visitors

† **March 10, 1992 - 10 a.m.** – Open Meeting
The Board Room of the Harrison B. Wilson Hall Administration Building, Norfolk, Virginia. ♿

A regular meeting.

Contact: Gerald D. Tyler, Norfolk State University, 2401 Corprew Avenue, Wilson Hall-S340, Norfolk, VA 23504, telephone (804) 683-8373.

BOARD OF NURSING

March 23, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, Conference Room 1, 1601 Rolling Hills Drive, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A regular meeting to consider matters related to nursing education programs, discipline of licensees, licensure by examination and endorsement and other matters under the jurisdiction of the board.

Public comment will be received during an open forum session beginning at 11 a.m.

March 24, 1992 - 9 a.m. – Open Meeting
March 25, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, Conference Room 1, 1601 Rolling Hills Drive, Richmond, Virginia. ♿
(Interpreter for deaf provided upon request)

A regular meeting to consider matters related to nursing education programs, discipline of licensees, licensure by examination and endorsement and other matters under the jurisdiction of the board.

March 26, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, Conference Room 1, 1601 Rolling Hills Drive, Richmond, Virginia. ♿
(Interpreter for deaf provided upon request)

Formal hearings will be conducted by a quorum of the members of the board.

Contact: Corrinne F. Dorsey, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9909 or (804) 6762-7197/TDD ☎

Education Advisory Committee

March 17, 1992 - 10 a.m. – Open Meeting
Department of Health Professions, Conference Room 3, 1601 Rolling Hills Drive, Richmond, Virginia. ♿
(Interpreter for deaf provided upon request)

A regular meeting to consider matters related to educational programs approved by the Board of Nursing and make recommendations to the board as needed.

Public comment will be accepted at 1 p.m.

Contact: Corrinne F. Dorsey, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9909 or (804) 662-7197/TDD ☎

BOARDS OF NURSING AND MEDICINE

March 12, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Boards of Nursing and Medicine intend to adopt regulations entitled: **VR 465-12-1 and VR 495-03-1. Regulations for Prescriptive Authority for Nurse Practitioners.** The proposed regulations authorize limited prescriptive authority for nurse practitioners as allowed by changes in law enacted during the 1991 session of the General Assembly of Virginia.

Statutory Authority: §§ 54.1-2400 and 54.1-2757.01 of the Code of Virginia.

Written comments may be submitted until March 12, 1992.

Contact: Corrine F. Dorsey, R.N., Executive Director, Board of Nursing, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9909.

BOARD OF OPTOMETRY

† **March 11, 1992 - 8:30 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room 1, Richmond, Virginia.

8:30-9 a.m. - Board discussion.

9 a.m. - Informal conferences.

Contact: Lisa J. Russell, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-9910.

BOARD OF PHARMACY

† **March 10, 1992 - 9 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room #2, Richmond, Virginia.

Board meeting and formal hearings. Public comments will be accepted at the beginning of the meeting or any appropriate occasion during the meeting.

Contact: Scotti W. Milley, Executive Director, Virginia Board of Pharmacy, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9911.

DEPARTMENT OF STATE POLICE

† **May 8, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of State Police intends to amend regulations entitled: **VR 545-01-07. Motor Vehicle Safety Inspection Rules and Regulations.** The proposed amendment permits colored or tinted vent visors to be installed on motor vehicles, provided they do not extend more than two inches from the forward door post into the driver's viewing area.

STATEMENT

Basis: To relax regulation prohibiting tinted after-market devices that protrude into the driver viewing area.

Purpose: To permit the use of colored or tinted ventvisors that do not extend more than two inches into the driver viewing area to be used on motor vehicles in Virginia.

Substance: Testing of colored or tinted ventvisors has shown highway safety is not compromised when such

ventvisors do not extend more than two inches from the forward front door post. This amendment is permissive in nature to allow the use of devices previously prohibited.

Issues: Highway safety consideration requires the driver of a motor vehicle to have unobstructed forward and side visibility for safe vehicle operation. After-market colored or tinted ventvisors provide additional sunshading at the upper and forward edge levels of side windows. They also provide for induction of outside air into vehicles during periods of inclement weather when windows cannot be opened slightly without such protective devices that prevent rain and moisture from entering the vehicle.

Impact: This regulation will have a positive impact on after-market auto parts supplies by providing a viable market for these devices in Virginia.

Virginia's motorists will be afforded the opportunity to legally equip their vehicle with colored or tinted ventvisors.

Cost will be incurred by the department to print regulation changes.

Statutory Authority: §§ 46.2-1002, 46.2-1163 and 46.2-1165 of the Code of Virginia.

Written comments may be submitted until May 8, 1992.

Contact: Captain J. P. Henries, Safety Officer, P.O. Box C-32008, Richmond, VA 23261, telephone (804) 674-2017.

BOARD OF PROFESSIONAL COUNSELORS

Task Force on Substance Abuse

† **March 24, 1992 - Noon** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to conduct regulatory review and discuss general business regarding substance abuse counselor certification. No public comments.

Contact: Evelyn B. Brown, Executive Director or Joyce D. Williams, Administrative Assistant, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-9912.

REAL ESTATE APPRAISER BOARD

† **April 23, 1992 - 10 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

A general business meeting.

Contact: Demetra Y. Kontos, Assistant Director, Real Estate Appraiser Board, Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-2175.

REAL ESTATE BOARD

March 9, 1992 - 10 a.m. – Open Meeting
Fredericksburg Juvenile Courtroom, Fredericksburg Juvenile and Domestic Relations Court, 701 Princess Anne Street, Fredericksburg, Virginia.

The board will meet to conduct a formal hearing: File No. 91-00371, Real Estate Board v. Clayton D. Boutchyard.

† **March 10, 1992 - 10 a.m.** – Open Meeting
County Board Room, Arlington County, 2100 Claredon Boulevard, Arlington, Virginia.

The board will meet to conduct a formal hearing: File No. 91-01493, Real Estate Board v. David L. Carter.

Contact: Gayle Eubank, Hearings Coordinator, Department of Commerce, 3600 W. Broad Street, Fifth Floor, Richmond, VA 23230, telephone (804) 367-8524.

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

March 18, 1992 - 2 p.m. – Open Meeting
March 19, 1992 - 9 a.m. if necessary – Open Meeting
Holiday Inn - Culpeper, Route 29 South, Culpeper, Virginia. ♿

Work session and formal business meeting of the board.

Contact: Phyllis Sisk, Administrative Staff Specialist, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229, telephone (804) 662-9236, toll-free 1-800-552-3431 or 1-800-552-7096/TDD ☎

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April 10, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Social Services intends to amend regulations entitled: **VR 615-70-17. Child Support Enforcement Program.** The proposed amendments address four areas: (i) administrative deviation from the child support guideline/multiple family situations; (ii) default obligations; (iii) release of information to the public; and (iv) technical items.

Statutory Authority: §§ 63.1-25 and 63.1-249 through 63.1-274.10 of the Code of Virginia.

Written comments may be submitted until April 10, 1992,

to Penelope Boyd Pellow, Division of Child Support Enforcement, 8007 Discovery Drive, Richmond, VA 23229-8699.

Contact: Margaret J. Friedenberg, Legislative Analyst, Office of Governmental Affairs, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

BOARD OF SOCIAL WORK

† **March 20, 1992 - 10 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia. ♿

A meeting to (i) conduct general board business; and (ii) respond to correspondence. No public comment will be received.

Contact: Evelyn B. Brown, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9914.

BOARD OF PROFESSIONAL SOIL SCIENTISTS

† **March 23, 1992 - 10 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, 5th Floor, Richmond, Virginia. ♿

A general board meeting.

Contact: Nelle P. Hotchkiss, Assistant Director, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-8595.

DEPARTMENT OF TRANSPORTATION (COMMONWEALTH TRANSPORTATION BOARD)

March 18, 1992 - 2 p.m. – Open Meeting
Virginia Department of Transportation, Board Room, 1401 East Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

Work session of the Commonwealth Transportation Board and the Department of Transportation staff.

March 19, 1992 - 10 a.m. – Open Meeting
Virginia Department of Transportation, Board Room, 1401 East Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A monthly meeting to vote on proposals presented regarding bids, permits, additions and deletions to the highway system, and any other matters requiring board approval.

Public comment will be received at the outset of the meeting on items on the meeting agenda for which the opportunity for public comment has not been afforded the public in another forum. Remarks will be limited to five minutes. Large groups are asked to select one individual to speak for the group. The board reserves the right to amend these conditions.

Contact: John G. Milliken, Secretary of Transportation, 1491 East Broad Street, Richmond, VA 23219, telephone (804) 786-6670.

† **March 20, 1992 - 10 a.m.** – Public Hearing
Tappahannock/Essex Fire Department, Route 627 (Airport Road), Tappahannock, Virginia. ♿ (Interpreter for deaf provided upon request)

† **March 23, 1992 - 10 a.m.** – Public Hearing
Suffolk District Office, 1700 North Main Street (Route 460), Suffolk, Virginia. ♿ (Interpreter for deaf provided upon request)

† **March 24, 1992 - 10 a.m.** – Public Hearing
Salem District Office, Harrison Avenue North of Main Street and East of VA 311, Salem, Virginia. ♿ (Interpreter for deaf provided upon request)

† **March 27, 1992 - 10 a.m.** – Public Hearing
Virginia Highlands Community College, Route 372, Abingdon, Virginia. ♿ (Interpreter for deaf provided upon request)

† **March 30, 1992 - 10 a.m.** – Public Hearing
Staunton District Office, Commerce Road (Route 11 Bypass), Staunton, Virginia. ♿ (Interpreter for deaf provided upon request)

† **March 31, 1992 - 10 a.m.** – Public Hearing
Culpeper District Office, Route 15, Culpeper, Virginia. ♿ (Interpreter for deaf provided upon request)

† **April 1, 1992 - 10 a.m.** – Public Hearing
Fairfax City Hall, Fairfax, Virginia. ♿ (Interpreter for deaf provided upon request)

† **April 6, 1992 - 10 a.m.** – Public Hearing
Lynchburg District Office, Route 501, Lynchburg, Virginia. ♿ (Interpreter for deaf provided upon request)

† **April 7, 1992 - 10 a.m.** – Public Hearing
Richmond District Office, Pine Forest Drive off Route 1, Colonial Heights, Virginia. ♿ (Interpreter for deaf provided upon request)

A public hearing to receive comments on highway allocations for the coming year and on updating the Six-Year Improvement Program for the Interstate, Primary, and Urban Systems.

Contact: Mr. Albert W. Coates, Jr., Assistant Commissioner, Virginia Department of Transportation, 1401 East Broad Street, Richmond, VA 23219, telephone (804) 786-9950.

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April 13, 1992 - 9:30 a.m. – Public Hearing
Front Auditorium, Old Highway Building, 1221 East Broad Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Commonwealth Transportation Board intends to amend regulations entitled: **VR 385-01-09. Public Participation Guidelines.** The Administrative Process Act (§ 9-6.14:1 et seq.) of the Code of Virginia requires the Department of Transportation to establish guidelines under which input from the public can be gathered during the adoption of regulations subject to the Act. The amendments to the Public Participation Guidelines update references in the text which are no longer correct.

The amendments also change the requirement that a 60-day time period must elapse between notice of the public hearing and a public hearing. As proposed, the 60-day period would extend from the date of public notice to the last date given in the notice for submission of any written comment, which is the requirement of the Act itself. This change was made to reduce the amount of time before a regulation becomes effective, thereby streamlining the process.

Statutory Authority: §§ 33.1-12 and 9.6-14:1 et seq. of the Code of Virginia.

Written comments may be submitted until April 20, 1992, to Larry D. Jones, Management Services Division, Room 712, Highway Annex, Virginia Department of Transportation, 1401 E. Broad Street, Richmond, VA 23219.

Contact: David L. Roberts, Management Lead Analyst, Management Services Division, Room 712, Highway Annex, Virginia Department of Transportation, 1401 E. Broad Street, Richmond, VA 23219, telephone (804) 786-3620.

DEPARTMENT OF THE TREASURY (STATE TREASURER AND TREASURY BOARD)

March 18, 1992 - 9 a.m. – Open Meeting
† **April 15, 1992 - 9 a.m.** – Open Meeting
James Monroe Building, 101 North 14th Street, 3rd floor, Treasury Board Conference Room, Richmond, Virginia. ♿

A regular meeting.

Contact: Belinda Blanchard, Assistant Investment Officer, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-2142.

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† **May 8, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Treasurer intends to adopt regulations entitled: **VR 640-04-1. Regulations Governing Escheats.** The proposed regulations address the annual reporting requirements for local government treasurers and escheators and outline the escheator's responsibilities for the disclosures to be made at escheat auctions, the collection and remittance of sale proceeds, and the notifications to be made to defaulting purchasers. In addition, the regulations stipulate the required bonding for escheators, specify the commission basis for escheators and auctioneers as well as the reimbursable expenses of auctioneers, and outline department charges for requests for information under the Freedom of Information Act.

STATEMENT

Basis and Authority: § 55-200.1 of the Code of Virginia authorizes the State Treasurer to adopt any necessary rules and regulations in accordance with the Administrative Process Act to carry out the provisions of Chapter 10 of Title 55, known as the Escheats Generally Statute.

Purpose: The purpose of the proposed regulations is to clarify responsibilities of officials charged with administration of the statute and to ensure the compliance of all parties in accordance with the intent and application of the statute.

Substance and Issues: The proposed regulations address the annual reporting requirements for local government treasurers and escheators and outline the escheator's responsibilities for the disclosures to be made at escheat auctions, the collection and remittance of sale proceeds, and the notifications to be made to defaulting purchasers. In addition, the regulations stipulate the required bonding for escheators, specify the commission basis for escheators and auctioneers as well as the reimbursable expenses of auctioneers, and outline department charges for requests for information under the Freedom of Information Act.

Impact: These regulations impact local government officials, escheators, auctioneers, and the general public. It is anticipated that the regulations will clarify responsibilities of all parties involved in the escheat process and enhance administration and compliance with the statute.

Statutory Authority: § 55-200.1 of the Code of Virginia.

Written comments may be submitted until May 8, 1992.

Contact: Robert S. Young, Director of Financial Policy, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-3131.

UNIVERSITY OF VIRGINIA

Institute of Law, Psychiatry and Public Policy

March 12, 1992 - 9 a.m. – Open Meeting
March 13, 1992 - 9 a.m. – Open Meeting
Richmond Hyatt Hotel, Richmond, Virginia. ♿

Fifteenth annual symposium on mental health law issues including: (i) patient self-determination act; (ii) substance abuse and AIDS; (iii) management of care; (iv) child sexual abuse - changes in the statute of limitations; (v) satanism and ritualistic crime; (vi) workshops on civil commitment, ethical concerns regarding incompetent assent; and (vii) Americans with Disabilities Act.

Contact: Carolyn L. Engelhard, Administrator, Institute of Law, Psychiatry and Public Policy, University of Virginia, Box 100, Blue Ridge Hospital, Charlottesville, VA 22901, telephone (804) 924-5435 or (804) 924-HEAR/TDD ☎

VIRGINIA RACING COMMISSION

March 18, 1992 - 9:30 a.m. – Open Meeting
VSRS Building, 1200 East Main Street, Richmond, Virginia. ♿

A regular meeting including discussion of proposed regulations pertaining to the Virginia Breeders Fund and medication. There will be an opportunity for public participation.

Contact: William H. Anderson, Policy Analyst, Virginia Racing Commission, P.O. Box 1123, Richmond, VA 23208, telephone (804) 371-7363.

VIRGINIA RESOURCES AUTHORITY

March 10, 1992 - 9 a.m. – Open Meeting
† **April 14, 1992 - 9 a.m.** – Open Meeting
† **May 12, 1992 - 9 a.m.** – Open Meeting
The Mutual Building, 909 East Main Street, Suite 707, Conference Room A, Richmond, Virginia.

The board will meet to (i) approve minutes of its previous meeting; (ii) review the Authority's operations for the prior months; and (iii) consider other matters and take other actions as it may deem appropriate. The planned agenda of the meeting will be available at the offices of the Authority one week prior to the date of the meeting.

Public comments will be received at the beginning of the meeting.

Contact: Mr. Shockley D. Gardner, Jr., 909 East Main Street, Suite 707, Mutual Building, Richmond, VA 23219, telephone (804) 644-3100 or FAX number (804) 644-3109.

DEPARTMENT FOR THE VISUALLY HANDICAPPED

Advisory Committee on Services

April 4, 1992 - 10:30 a.m. – Open Meeting
Virginia Rehabilitation Center for the Blind, 401 Azalea Avenue, Richmond, Virginia. ♿ (interpreter for deaf provided upon request)

A quarterly meeting to advise the Board for the Visually Handicapped on matters related to services for blind and visually impaired citizens of the Commonwealth.

Contact: Barbara G. Tyson, Executive Secretary, 397 Azalea Avenue, Richmond, VA 23227, telephone (804) 371-3140/TDD ☎ or toll-free 1-800-622-2155.

VIRGINIA COUNCIL ON VOCATIONAL EDUCATION

† **March 25, 1992 - 1 p.m.** – Open Meeting
Sheraton Airport Inn, 4700 South Laburnum Avenue, Richmond, Virginia.

General session - Sheraton Airport Inn. Meeting with the Virginia Board of Education - James Monroe Building.

† **March 26, 1992 - 8 a.m.** – Open Meeting
Sheraton Airport Inn, 4700 South Laburnum Avenue, Richmond, Virginia.

Committee meetings. Business session.

Contact: George S. Orr, Jr., Virginia Council on Vocational Education, 7420-A Whitepine Road, Richmond, VA 23237, telephone (804) 275-6218.

VIRGINIA VOLUNTARY FORMULARY BOARD

March 18, 1992 - 10 a.m. – Public Hearing
109 Governor Street, Main Floor Conference Room, Richmond, Virginia.

A public hearing to consider the proposed adoption and issuance of revisions to the Virginia Voluntary Formulary. The proposed revisions to the Formulary add and delete drugs and drug products to the Formulary that became effective on February 15, 1991, and the most recent supplement to that Formulary. Copies of the proposed revisions to the Formulary are available for inspection at the Virginia Department of Health, Bureau of Pharmacy Services, James Madison Building, 109 Governor Street, Richmond, Virginia 23219. Written comments sent to the above address and received prior to 5 p.m. on March 18, 1992, will be made a part of the hearing record.

May 7, 1992 - 10:30 a.m. – Open Meeting
1100 Bank Street, Washington Building, 2nd Floor Board Room, Richmond, Virginia.

A meeting to consider public hearing comments and review new product data for products pertaining to the Virginia Voluntary Formulary.

Contact: James K. Thomson, Director, Bureau of Pharmacy Services, 109 Governor Street, Room B1-9, Richmond, VA 23219, telephone (804) 786-4236.

STATE WATER CONTROL BOARD

March 10, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to amend regulations entitled: **VR 680-21-00. Water Quality Standards.** The purpose of the proposal is to adopt, for statewide application, standards for toxics for protection of aquatic life and human health to comply with the Clean Water Act. The board will hold a formal hearing at a time and place to be established, if a petition for such a hearing is received and granted. Affected persons may petition for a formal hearing concerning any issue of fact directly relevent to the legal validity of the proposed action. Petitions must meet the requirements of § 1.23(b) of the board's Procedural Rule No. 1 (1980), and must be received by the contact person designated below by 4 p.m. on Thursday, January 30, 1992.

Statutory Authority: § 62.1-44.15(3a) of the Code of Virginia.

NOTE: CHANGE IN WRITTEN COMMENTS DATE
Written comments may be submitted until 4 p.m., March 10, 1992, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Jean Gregory, Office of Environmental Research and Standards, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5093.

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March 10, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to adopt regulations entitled: **VR 680-14-09. Virginia Pollutant Discharge Elimination System (VPDES) General Permit for Domestic Sewage Discharges of Less Than or Equal to 1,000 Gallons Per Day.** The purpose of the proposal is to adopt as a permanent regulation the emergency regulation which became effective July 12, 1991, authorizing the issuance of a general permit for qualifying domestic sewage discharges of less than or equal to 1,000 gallons per day.

Statutory Authority: § 62.1-44.15(10) of the Code of Virginia.

NOTE: CHANGE IN WRITTEN COMMENTS DATE
Written comments may be submitted until 4 p.m., March 10, 1992, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Richard Ayers, Office of Water Resources Management, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5059.

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March 10, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to amend regulations entitled: **VR 680-21-00. Water Quality Standards (VR 680-21-08.15 Tennessee and Big Sandy River Basin, Clinch River Subbasin and VR 680-21-07.1 Special Standards and Requirements.** The purpose of the proposed amendment is to establish a site-specific numerical water quality criterion for copper in the Clinch River between Carbo and St. Paul. The board will hold a formal hearing at a time and place to be determined, if a petition for such a hearing is received and granted. Affected persons may petition for a formal hearing concerning any issue of fact directly relevant to the legal validity of the proposed action. Petitions must meet the requirements of § 1.23(b) of the board's Procedural Rule No. 1 (1980), and must be received by the contact person designated below by 4 p.m on Thursday, January 30, 1992.

Statutory Authority: § 62.1-44.15(3a) of the Code of Virginia.

NOTE: CHANGE IN WRITTEN COMMENTS DATE
Written comments may be submitted until 4 p.m., March 10, 1992, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Jean Gregory, Office of Environmental Research and Standards, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5093.

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March 9, 1992 - 7 p.m. – Public Hearing
South Boston City Council Chambers, Yancey Street (behind the library), South Boston, Virginia.

March 10, 1992 - 7 p.m. – Public Hearing

Northampton General District Court, Business Route 13, Eastville, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to adopt regulations entitled: **VR 680-15-03. Surface Water Management Area Regulation.** The purpose of the proposed regulation is to establish the procedures and requirements to be followed in connection with establishment of surface water management areas, and the issuance of surface water withdrawal permits and certificates.

Statutory Authority: Chapter 25 (§ 62.1-242 et seq.) of Title 62.1 of the Code of Virginia.

Written comments may be submitted until 4 p.m., March 16, 1992, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Thomas Felvey, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5092.

VIRGINIA DEPARTMENT OF
YOUTH & FAMILY SERVICES
Youth Begins With You.

March 12, 992 - 10 a.m. – Open Meeting
April 9, 1992 - 10 a.m. – Open Meeting
May 14, 1992 - 10 a.m. – Open Meeting
Site to be announced. Richmond, Virginia.

A general business meeting.

Contact: Paul Steiner, Policy Coordinator, Department of Youth and Family Services, P.O. Box 3AG, Richmond, Virginia 23208-1108, telephone (804) 371-0692.

LEGISLATIVE

Notice to Subscribers

Legislative meetings held during the Session of the General Assembly are exempt from publication in The Virginia Register of Regulations. You may call Legislative Information for information on standing committee meetings. The number is (804) 786-6530.

CHRONOLOGICAL LIST

OPEN MEETINGS

March 9
ASAP Policy Board - Valley
Chesapeake Bay Local Assistance Board
- Central Area Review Committee
† Cosmetology, Board for
Real Estate Board

March 10
† Auctioneers Board
† Emergency Planning Committee, Local - County of Montgomery/Town of Blacksburg
Higher Education for Virginia, State Council of
† Norfolk State University
- Board of Visitors
† Pharmacy, Board of
† Real Estate Board
Virginia Resources Authority

March 11
Agriculture and Consumer Services, Department of
- Virginia Sweet Potato Board
Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
Child Day-Care Council
Corrections, Board of
† Emergency Planning Committee, Local - City of Alexandria
Emergency Planning Committee, Local - City of Portsmouth
Emergency Planning Committee, Local - Winchester
Employment Commission, Virginia
- Advisory Board
Historic Preservation Foundation, Virginia
† Optometry, Board of

March 12
† Child Day-Care Council
Corrections, Board of
- Liaison Committee
Education Assistance Authority, State
- Board of Directors
Emergency Planning Committee, Local - City of Fairfax, and the Towns of Herndon and Vienna.
Employment Commission, Virginia
- Advisory Board
University of Virginia
- Institute of Law, Psychiatry and Public Policy
Youth and Family Services, Board of

March 13
Medicine, Board of
- Legislative Committee
University of Virginia
- Institute of Law, Psychiatry and Public Policy

March 16
Alcoholic Beverage Control Board

Emergency Planning Committee, Local - Prince William County, Manassas City, and Manassas Park City
† Governor's Job Training Coordinating Council
Health, Department of
- Division of Shellfish Sanitation

March 17
† Criminal Justice Services, Department of
- Criminal History Records Improvement Task Force
† Housing Development Authority, Virginia
Library Board
Nursing, Board of
- Education Advisory Committee

March 18
Chesapeake Bay Local Assistance Board
- Regulatory Review Committee and Program Study Group
- Southern Area Review Committee
† Criminal Justice Services, Department of
- Virginia Juvenile Justice and Delinquency Prevention Advisory Committee
Local Debt, State Council on
Social Services, State Board of
Transportation Board, Commonwealth
Treasury Board
Virginia Racing Commission

March 19
Architects, Professional Engineers, Land Surveyors and Landscape Architects, Board for
Social Services, State Board of
Transportation Board, Commonwealth

March 20
Architects, Professional Engineers, Land Surveyors and Landscape Architects, Board for
- Board for Land Surveyors
Children, Interdepartmental Regulation of Residential Facilities for
- Coordinating Committee
Conservation and Recreation, Department of
- Falls of the James River Advisory Board
Information Management, Council on
† Social Work, Board of

March 21
† Museum of Fine Arts, Virginia
- Board of Trustees

March 23
Chesapeake Bay Local Assistance Board
- Central Area Review Committee
† Health Services Cost Review Council, Virginia
† Lottery Board, State
Nursing, Board of
† Soil Scientists, Board for Professional

March 24
† Health, Department of
- Radiation Advisory Board
Local Government, Commission on
Marine Resources Commission
Nursing, Board of
† Professional Counselors, Board of

March 25
Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
† Community Colleges, State Board for
† Emergency Planning Committee, Local - Arlington County/City of Falls Church
Local Government, Commission on
Mental Health, Mental Retardation and Substance Abuse Services Board, State
Nursing, Board of
† Vocational Education, Virginia Council on

March 26
Aging, Department for the
- Long-Term Care Ombudsman Program Advisory Council
Architects, Professional Engineers, Land Surveyors and Landscape Architects, Board for
- Board for Contractors
Chesapeake Bay Local Assistance Board
† Community Colleges, State Board for
Compensation Board
† Criminal Justice Services, Board of
- Committee on Criminal Justice Information Systems
Nursing, Board of
† Vocational Education, Virginia Council on

March 27
Architects, Professional Engineers, Land Surveyors and Landscape Architects, Board for
- Board for Interior Designers
† Building Code Technical Review Board, State
† Governor's Council in Alcohol and Drug Abuse

March 30
Alcoholic Beverage Control Board

March 31
Medicine, Board of
- Advisory Committee on Acupuncture

April 2
Emergency Planning Committee, Local - Chesterfield County

April 4
Visually Handicapped, Department for the
- Advisory Committee on Services

April 6
Agriculture and Consumer Services, Department of
- Virginia Winegrowers Advisory Board

April 7
Hopewell Industrial Safety Council

April 9
Youth and Family Services, Board of

April 10
† Medicine, Board of
- Executive Committee
- Advisory Committee on Optometry

April 11
Medicine, Board of
- Credentials Committee

April 14
Higher Education for Virginia, State Council of
† Virginia Resources Authority

April 15
† Local Debt, State Council on
† Treasury Board

April 16
† Agriculture and Consumer Services, Department of
- Pesticide Control Board
Medicine, Board of
- Advisory Board of Occupational Therapy

April 17
† Agriculture and Consumer Services, Department of
- Pesticide Control Board

April 22
Emergency Planning Committee, Local - Gloucester

April 23
† Real Estate Appraiser Board

April 28
Marine Resources Commission

May 5
Hopewell Industrial Safety Council

May 7
† Emergency Planning Committee, Local - Chesterfield County
Voluntary Formulary Board, Virginia

May 12
† Virginia Resources Authority

May 14
Youth and Family Services, Board of

PUBLIC HEARINGS

March 9
Water Control Board, State

March 10
Water Control Board, State

March 11
Housing and Community Development, Department of

March 17
Child Day Care and Early Childhood Programs, Council on

March 18
Voluntary Formulary Board, Virginia

March 20
† Transportation, Department of

March 23
† Transportation, Department of

March 24
Child Day Care and Early Childhood Programs, Council on
Local Government, Commission on
† Transportation, Department of

March 27
† Transportation, Department of

March 30
† Transportation, Department of

March 31
† Transportation, Department of

April 1
Criminal Justice Services, Department of
† Transportation, Department of

April 6
† Transportation, Department of

April 7
† Transportation, Department of

April 13
Transportation, Department of

April 14
† Mental Health, Mental Retardation and Substance Abuse Services, Department of