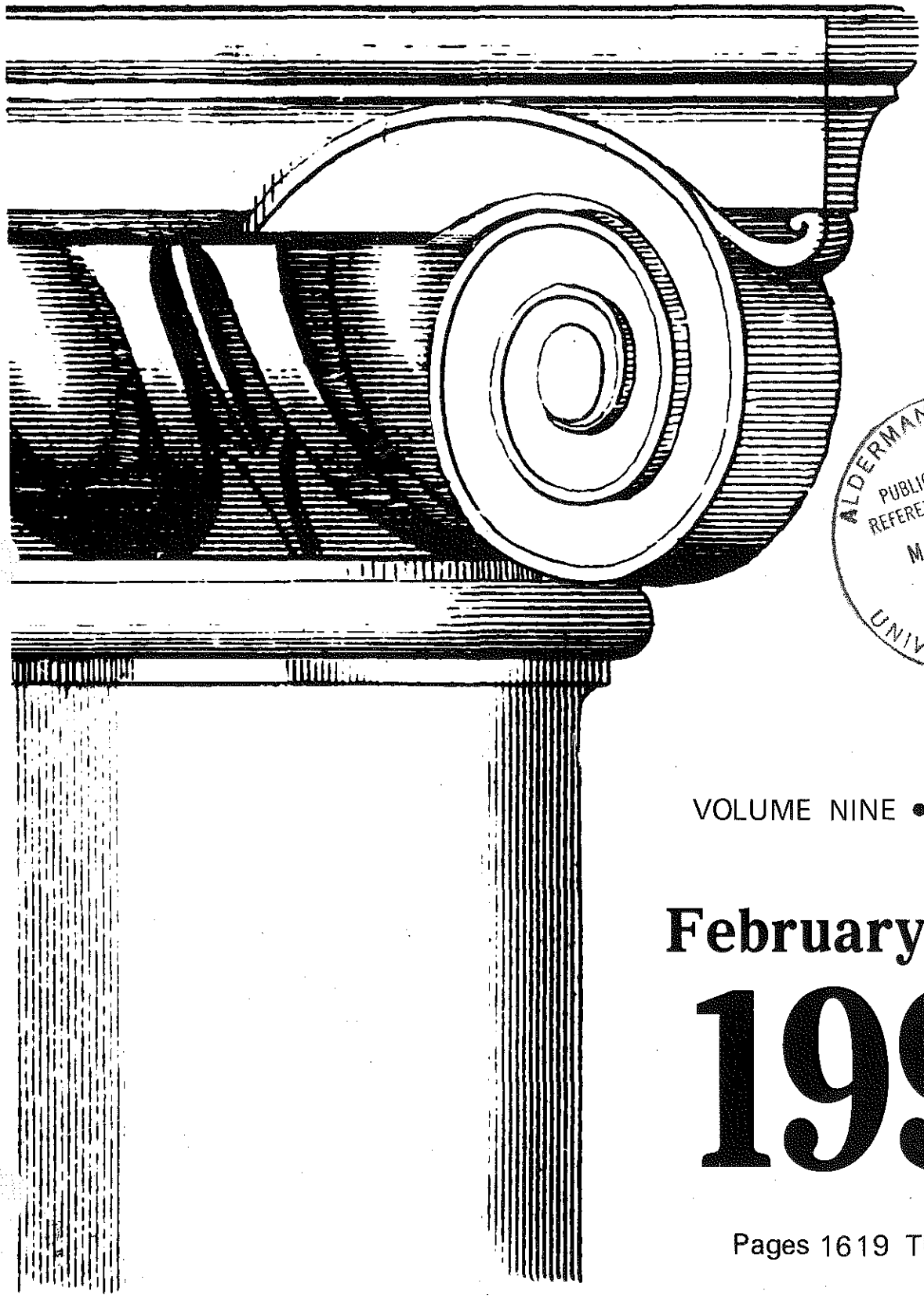
THE VIRGINIA REGISTER

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

January 1993 through April 1994

MATERIAL SUBMITTED BY Noon Wednesday	PUBLICATION DATE
Volume 9 - 1993	
Dec. 23	Jan. 11, 1993
Jan. 6	Jan 25
Jan. 20	Feb. 8
Feb. 3	Feb. 22
Feb. 17	Mar. 8
Mar. 3	Mar. 22
Mar. 17	Apr. 5
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Apr. 14	May 3
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Aug. 4	Aug. 23
Aug. 18	Sept. 6
Sept. 1	Sept. 20
Final Index - Volume 9	
Volume 10 - 1993-94	
Sept. 15	Oct. 4
Sept. 29	Oct. 18
Oct. 13	Nov. 1
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† Indicates entries since last publication of the Virginia Register

DEPARTMENT FOR THE AGING

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department for the Aging intends to consider amending regulations entitled: **VR 110-01-02. Grants to Area Agencies on Aging.** The purpose of the proposed action is to review the regulation to determine whether new regulations should be adopted, the current regulation should be amended, and sections of the current regulation should be repealed. In particular, the department is soliciting comments on its intent to (i) include services standards in regulation and (ii) clarify the circumstances under which approved Area Plans for Aging Services must be amended.

Statutory Authority: § 2.1-373(a)(7) of the Code of Virginia.

Written comments may be submitted until March 22, 1993.

Contact: J. James Cotter, Director, Division of Program Development and Management, Virginia Department for the Aging, 700 E. Franklin St., 10th Floor, Richmond, VA 23219-2327, telephone (804) 225-2271 or toll-free 1-800-552-4464.

BOARD FOR ARCHITECTS, PROFESSIONAL ENGINEERS, LAND SURVEYORS AND LANDSCAPE ARCHITECTS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board for Architects, Professional Engineers, Land Surveyors and Landscape Architects intends to consider amending regulations entitled: **VR 130-01-2. Board for Architects, Professional Engineers, Land Surveyors and Landscape Architects Rules and Regulations.** The purpose of the proposed action is to change the content of regulations to accommodate reporting requirements and other changes as needed.

Statutory Authority: § 54.1-404 of the Code of Virginia.

Written comments may be submitted until March 8, 1993.

Contact: Willie Fobbs, III, Assistant Director, Department of Commerce, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-8514.

BOARD FOR BRANCH PILOTS

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board for Branch Pilots intends to consider amending regulations entitled: **VR 535-01-01. Branch Pilot Regulations.** The purpose of the proposed action is to (i) change the requirements for license renewal; (ii) require ARPA radar training; and (iii) make other changes as needed.

Statutory Authority: § 54.1-902 of the Code of Virginia.

Written comments may be submitted until March 22, 1993.

Contact: Willie Fobbs, III, Assistant Director, Department of Commerce, 3600 W. Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 367-8514.

DEPARTMENT OF CORRECTIONS (STATE BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Corrections intends to consider promulgating regulations entitled: **VR 230-01-004. Research Regulations.** The purpose of the proposed action is to establish when and how human research may be conducted within the Department of Corrections as required in § 32.1-162.16 et seq. of the Code of Virginia.

Statutory Authority: § 53.1-5.1 of the Code of Virginia.

Written comments may be submitted until February 28, 1993, to Vivian T. Toler, Secretary to the Board, 6900 Atmore Drive, Richmond, Virginia 23225.

Contact: James S. Jones, Jr., Manager, Planning and Development, Department of Corrections, 6900 Atmore Dr., Richmond, VA 23225, telephone (804) 674-3262.

DEPARTMENT OF EDUCATION (STATE BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Education intends to consider repealing regulations entitled: **VR 270-01-0037. Regulations Governing Public School Building Construction.** The purpose of the proposed action is to repeal the existing regulations because new standards for the erection of or addition to public school buildings are being promulgated.

Statutory Authority: § 22.1-138 of the Code of Virginia.

Written comments may be submitted until March 3, 1993.

Contact: David L. Boddy, Director of Facilities, Department of Education, P.O. Box 2120, Richmond, VA 23216-2120, telephone (804) 225-2035.

DEPARTMENT OF LABOR AND INDUSTRY

† Withdrawal of Notice of Intended Regulatory Action

The Department of Labor and Industry is **WITHDRAWING** the Notice of Intended Regulatory Action for **VR 425-01-80. Virginia Hours of Work for Minors** published in 8:17 VA.R. 2723 May 18, 1992.

† Withdrawal of Notice of Intended Regulatory Action

The Department of Labor and Industry is **WITHDRAWING** the Notice of Intended Regulatory Action for **VR 425-01-81. Regulations Governing the Employment of Minors on Farms, in Gardens and in Orchards** published in 8:17 VA.R. 2723 May 18, 1992.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department of Labor and Industry intends to consider repealing regulations entitled: **VR 425-01-81. Regulations Governing the Employment of Minors on Farms, in Gardens and in Orchards.** The purpose of the proposed action is to repeal this regulation which was replaced by an emergency regulation. The emergency regulation was effective January 15, 1993. The emergency regulation which has replaced this regulation is effective for one year until January 15, 1994. Copies of the emergency regulation are available from the agency.

Statutory Authority: §§ 40.1-6(3), 40.1-100(A)(9) and 40.1-114 of the Code of Virginia.

Written comments may be submitted until March 26, 1993, to John J. Crisanti, Director, Office of Enforcement Policy, 13 South 13th Street, Richmond, Virginia 23219.

Contact: Dennis Merrill, Labor Law Director, Department of Labor and Industry, Powers-Taylor Bldg., 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-3224.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department of Labor and Industry intends to consider promulgating regulations entitled: **VR 425-01-81:1. Regulation Governing the Employment of Minors on Farms, in Gardens and in Orchards.** The purpose of the proposed action is to promulgate a new permanent regulation governing the employment of minors on farms, in gardens and in orchards to replace the emergency regulation (VR 425-01-81) which became effective January 15, 1993. The emergency regulation is effective for one year until January 15, 1994.

Statutory Authority: §§ 40.1-6(3), 40.1-100(A)(9) and 40.1-114 of the Code of Virginia.

Written comments may be submitted until March 29, 1993, to John J. Crisanti, Director, Office of Enforcement Policy, 13 South 13th Street, Richmond, Virginia 23219.

Contact: Dennis Merrill, Labor Law Director, Department of Labor and Industry, Powers-Taylor Bldg., 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-3224.

DEPARTMENT OF MEDICAL ASSISTANCE 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 Medical Assistance Services intends to consider amending regulations entitled: **VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates – Inpatient Hospital Services: Cost Report Filing and Final Settlement Filing Requirements.** The purpose of the proposed action is to promulgate regulations that require providers to submit additional financial, statistical, and structural information for the following purposes: (i) for submission of a completed cost report; and (ii) to enable DMAS to make the findings and assurances required by federal law. These regulations will also include a penalty for the failure to submit the cost report and required information in a timely manner.

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

Written comments may be submitted until February 22, 1993, to Stanley Fields, Manager, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator,

Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 371-8850.

BOARD OF MEDICINE

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines and § 54.1-2957.2 of the Code of Virginia that the Board of Medicine intends to consider amending regulations entitled: **VR 465-09-01. Certification of Optometrists to Prescribe for and Treat Certain Diseases, Including Abnormal Conditions, of the Human Eye and Its Adnexa with Certain Therapeutic Pharmaceutical Agents.** The purpose of the proposed action is to review § 4.3 of the regulations to determine whether new regulations should be adopted, the current regulations be amended and/or specific regulations be repealed in regards to certain therapeutic, pharmaceutical agents administered or prescribed by Doctors of Optometry.

A public hearing is being held, pursuant to § 54.1-2957.2 of the Code of Virginia, on March 19, 1993, at 9 a.m., at the Department of Health Professions, 6606 W. Broad St., 5th Fl., Board Room 2, Richmond, VA 23230.

Statutory Authority: §§ 54.1-2400 and 54.1-2957.2 of the Code of Virginia.

Written comments may be submitted until February 26, 1993, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717.

Contact: Eugenia K. Dorson, Deputy Executive Director, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923.

DEPARTMENT OF SOCIAL SERVICES (STATE BOARD OF)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Social Services intends to consider amending regulations entitled: **VR 615-08-1. Virginia Energy Assistance Program.** The purpose of the proposed action is to solicit input into the development of the regulations to govern the 1993-94 Energy Assistance Program. Interested parties may view the regulations governing the program at the Virginia Department of Social Services, Division of Benefit Programs, Tyler Building, 1603 Santa Rosa Road, Suite 214, Richmond, Virginia 23229-8699.

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

Written comments may be submitted until March 23, 1993, to Charlene H. Chapman, Program Manager, Division of Benefit Programs, 8007 Discovery Drive, Richmond, Virginia 23229-8699.

Contact: Peggy Friedenberg, Legislative Analyst, Department of Social Services, 8007 Discovery Dr., Richmond, VA 23229-8699, telephone (804) 662-9217.

DEPARTMENT OF TAXATION

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department of Taxation intends to consider amending regulations entitled: **VR 630-3-301 through 630-3-504. Virginia Corporate Income Tax Regulations.** The purpose of the proposed action is to update all of the corporate tax regulations by amending or repealing existing regulations and adding new regulations to clarify current departmental policy.

Statutory Authority: § 58.1-203 of the Code of Virginia.

Written comments may be submitted until March 15, 1993.

Contact: John Josephs, Senior Tax Policy Analyst, Department of Taxation, P.O. Box 1880, Richmond, VA 23282-1880, telephone (804) 367-8186.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department of Taxation intends to consider promulgating, amending, or repealing regulations entitled: **VR 630-10-1 through 630-10-113. Virginia Retail Sales and Use Tax Regulations.** The purpose of the proposed action is to update all of the retail sales and use tax regulations by amending or repealing existing regulations and adding new regulations to clarify current departmental policy.

Statutory Authority: § 58.1-203 of the Code of Virginia.

Written comments may be submitted until March 15, 1993.

Contact: Terry M. Barrett, Tax Policy Analyst, Department of Taxation, P.O. Box 1880, Richmond, VA 23282-1880, telephone (804) 367-0010.

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 HEALTH (STATE BOARD OF)

Title of Regulation: ~~VR 355-28-01~~ *VR 355-28-100* . **Regulations for Disease Reporting and Control.**

Statutory Authority: §§ 32.1-12 and 32.1-35 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted through April 23, 1993.
(See Calendar of Events section for additional information)

Summary:

The Regulations for Disease Reporting and Control explain the requirements for reporting communicable diseases, toxic substances related diseases, cancer, and memory loss disorders to the health department for the purposes of disease surveillance and control. Included are definitions of who is required to report, which diseases are reportable, and what mechanisms are available for reporting. Amendment 5 to the regulations as proposed consists of the following changes:

1. Lead poisoning in children age zero to 15 is being proposed as an addition to the list of reportable conditions. Reports of venous blood lead levels of 15 ug/dL or higher would be required to be submitted to the local health department by all reporting sources, i.e., physicians, hospital directors, and laboratory directors.

2. A new form on which information on a person having a reportable condition is being proposed to replace six different forms now in use for disease reporting. One patient would be reported per form, which would consist of three parts so that copies would be available for the reporter, the local health department, and the state health department.

3. Some minor changes are also being proposed, which include adding Escherichia coli 0157:H7 to the definition of foodborne outbreaks, to add waterborne outbreaks to the list of conditions to be reported rapidly, to allow laboratory directors to report the results of any confirmatory test for the conditions they are required to report, to bring Part V on Immunization in compliance with recent changes in the Code of Virginia, and to bring Part X, regarding reporting Memory Loss Disorders, also in accordance with changes to the Code of Virginia.

VR 355-28-100. Regulations for Disease Reporting and Control.

PART I.
DEFINITIONS.

§ 1.1. *Definitions.*

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

"Board" means the State Board of Health.

"Cancer" means all carcinomas, sarcomas, melanomas, leukemias, and lymphomas excluding localized basal and squamous cell carcinomas of the skin, except for lesions of the mucous membranes.

"Carrier" means a person who, with or without any apparent symptoms of a communicable disease, harbors a specific infectious agent and may serve as a source of infection.

"Commissioner" means the State Health Commissioner, his duly designated officer or agent.

"Communicable disease" means an illness due to an infectious agent or its toxic products which is transmitted, directly or indirectly, to a susceptible host from an infected person, animal, or arthropod or through the agency of an intermediate host or a vector or through the inanimate environment.

"Contact" means a person or animal known to have been in such association with an infected person or animal as to have had an opportunity of acquiring the infection.

"Contact tracing" means the process by which an infected person or health department employee notifies others that they may have been exposed to the infected person in a manner known to transmit the infectious agent in question.

"Department" means the State Department of Health.

"Designee" or *"designated officer or agent"* means any person, or group of persons, designated by the State Health Commissioner, to act on behalf of the commissioner or the board.

"Epidemic" means the occurrence in a community or region of cases of an illness clearly in excess of normal expectancy.

"Foodborne outbreak" means a group manifestation of illness acquired through the consumption of food or water contaminated with chemicals or an infectious agent or its toxic products. Such illnesses include but are not limited to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, Clostridium perfringens food poisoning ~~and~~ , hepatitis A , *and Escherichia coli 0157:H7* .

"Immunization" means a treatment which renders an individual less susceptible to the pathologic effects of a disease or provides a measure of protection against the disease (e.g., inoculation, vaccination).

"Independent pathology laboratory" means a nonhospital or a hospital laboratory performing surgical pathology, including fine needle aspiration biopsy and bone marrow examination services, which reports the results of such tests directly to physician offices, without reporting to a hospital or accessioning the information into a hospital tumor registry.

"Investigation" means an inquiry into the incidence, extent, source and causation of a disease occurrence.

"Isolation" means separation for the period of communicability of infected persons or animals from others in such places and under such conditions as to prevent or limit the direct or indirect transmission of an infectious agent from those infected to those who are susceptible. The means of isolation shall be the least restrictive means appropriate under the facts and circumstances as determined by the commissioner.

"Laboratory director" means any person in charge of supervising a laboratory conducting business in the Commonwealth of Virginia.

"Lead poisoning in children" means a child or children 15 years of age and younger with a confirmed venous blood level greater than or equal to 15 micrograms of lead per deciliter of whole blood (ug/dL), or such lower blood lead level as may be recommended for individual intervention by the department or the United States Department of Health and Human Services, Public Health Services, Centers for Disease Control.

"Medical care facility" means any hospital or nursing home licensed in the Commonwealth, or any hospital operated by or contracted to operate by an entity of the United States government or the Commonwealth of Virginia.

"Memory loss disorder" means any progressive dementia caused by AIDS, alcohol abuse, probable Alzheimer's disease, cerebral vascular disease, Creutzfeldt-Jakob disease, depression, head trauma, normal pressure hydrocephalus, Parkinson's disease, space-occupying lesion, toxic or metabolic disorder, or other known cause.

"Midwife" means any person who is registered as a nurse midwife by the State Board of Nursing or who possesses a midwife permit issued by the State Health Commissioner.

"Nosocomial outbreak" means any group of illnesses of common etiology occurring in patients of a medical care facility acquired by exposure of those patients to the disease agent while confined in such a facility.

"Nurse" means any person licensed as a professional nurse or as a licensed practical nurse by the Virginia State Board of Nursing.

"Period of communicability" means the time or times during which the etiologic agent may be transferred directly or indirectly from an infected person to another person, or from an infected animal to a person.

"Physician" means any person licensed to practice medicine by the Virginia State Board of Medicine.

"Quarantine" means generally, a period of detention for persons or domestic animals that may have been exposed to a reportable, contagious disease for purposes of observation or treatment.

1. Complete quarantine. The formal limitation of freedom of movement of well persons or animals exposed to a reportable disease for a period of time not longer than the longest incubation period of the disease in order to prevent effective contact with the unexposed. The means of complete quarantine shall be the least restrictive means appropriate under the facts and circumstances, as determined by the commissioner.

2. Modified quarantine. A selective, partial limitation of freedom of movement of persons or domestic animals, determined on the basis of differences in susceptibility, or danger of disease transmission. Modified quarantine is designed to meet particular situations and includes but is not limited to, the exclusion of children from school and the prohibition or restriction of those exposed to or suffering from a communicable disease from engaging in a particular occupation. The means of modified quarantine shall be the least restrictive means appropriate under the facts and circumstances, pursuant to § 3.1 E of these regulations or as determined by the commissioner.

3. Segregation. The separation for special control, or observation of one or more persons or animals from other persons or animals to facilitate control or surveillance of a reportable disease. The means of segregation shall be the least restrictive means available under the facts and circumstances, as determined by the commissioner.

"Reportable disease" means an illness due to a specific toxic substance, occupational exposure, or infectious agent, which affects a susceptible individual, either directly, as

from an infected animal or person, or indirectly through an intermediate host, vector, or the environment, as determined by the board.

"Surveillance" means the continuing scrutiny of all aspects of occurrence and spread of a disease relating to effective control of that disease. Included in the process of surveillance are the collection and evaluation of:

1. Morbidity and mortality reports.

2. Special reports of field investigations of epidemics and individual cases.

3. Isolation and identification of infectious agents by laboratories.

4. Data concerning the availability, use, and untoward side effects of the substances used in disease control.

5. Information regarding immunity levels in segments of the population.

"Toxic substance" means any substance, including any raw materials, intermediate products, catalysts, final products, or by-products of any manufacturing operation conducted in a commercial establishment, that has the capacity, through its physical, chemical or biological properties, to pose a substantial risk of death or impairment either immediately or over time, to the normal functions of humans, aquatic organisms, or any other animal but not including any pharmaceutical preparation which deliberately or inadvertently is consumed in such a way as to result in a drug overdose.

PART II.
GENERAL INFORMATION.

§ 2.1. Authority.

Chapter 2 of Title 32.1 of the Code of Virginia deals with the reporting and control of diseases. Specifically, § 32.1-35 directs the Board of Health to promulgate regulations specifying which diseases occurring in the Commonwealth are to be reportable and the method by which they are to be reported. Further, § 32.1-42 of the Code ★of Virginia authorizes the board to promulgate regulations and orders to prevent a potential emergency caused by a disease dangerous to the public health. Section 32.1-12 of the Code *of Virginia* empowers the Board of Health to adopt such regulations as are necessary to carry out provisions of laws of the Commonwealth administered by the Commissioner of the Department of Health.

§ 2.2. Purpose.

These regulations are designed to provide for the uniform reporting of diseases of public health importance occurring within the Commonwealth in order that appropriate control measures may be instituted to interrupt the transmission of disease.

§ 2.3. Administration.

A. State Board of Health.

The State Board of Health ("board") has the responsibility for promulgating regulations pertaining to the reporting and control of diseases of public health importance.

B. State Health Commissioner.

The State Health Commissioner ("commissioner") is the executive officer for the State Board of Health with the authority of the board when it is not in session, subject to the rules and regulations of and review by the board.

C. Local health director.

The local health director is responsible for the surveillance and investigation of those diseases specified by these regulations which occur in his jurisdiction. He is further responsible for reporting all such surveillance and investigations to the State Department of Health. In cooperation with the commissioner, he is responsible for instituting measures for disease control, which may include quarantine or isolation as required by the commissioner.

D. Office of Epidemiology.

The Office of Epidemiology is responsible for the statewide surveillance of those diseases specified by these regulations, for coordinating the investigation of those diseases with the local health director and ~~regional medical~~ *operations* director, and for providing direct assistance where necessary. The Director of the Office of Epidemiology acts as the commissioner's designee in reviewing reports and investigations of diseases and recommendations by local health directors for quarantine or isolation. However, authority to order quarantine or isolation resides solely with the commissioner, unless otherwise expressly provided by him.

E. Confidentiality.

All persons responsible for the administration of these regulations shall ensure that the anonymity of patients and practitioners is preserved, according to the provisions of §§ 32.1-38, 32.1-41, 32.1-71, and 32.1-71.4 of the Code of Virginia.

§ 2.4. Application of regulations.

These regulations have general application throughout the Commonwealth.

~~§ 2.5. Effective date of original regulations.~~

~~August 1, 1980.~~

~~Effective date of amendment No. 1:~~

~~August 21, 1984.~~

~~Effective date of emergency amendment of § 3.1:~~

~~January 4, 1988.~~

~~Effective date of amendment No. 2:~~

~~February 15, 1989.~~

~~Effective date of amendment No. 3.~~

~~September 14, 1989.~~

~~Effective date of amendment No. 4.~~

~~March 28, 1990.~~

~~Effective date of amendment No. 5.~~

~~November 6, 1991.~~

~~§ 2.6.~~ *§ 2.5.* Application of the Administrative Process Act.

The provisions of the Virginia Administrative Process Act, which is codified as Chapter 1.1:1 of Title 9 of the Code *of Virginia* , shall govern the adoption, amendment, modification, and revision of these regulations, and the conduct of all proceedings and appeals hereunder. All hearings on such regulations shall be conducted in accordance with § 9-6.14:7.1.

~~§ 2.7.~~ *§ 2.6.* Powers and procedures of regulations not exclusive.

The board reserves the right to authorize a procedure for enforcement of these regulations which is not inconsistent with the provisions set forth herein and the provisions of Chapter 2 of Title 32.1 of the Code *of Virginia* .

PART III.
REPORTING OF DISEASE.

§ 3.1. Reportable disease list.

The board declares the following named diseases, toxic effects, and conditions to be reportable by the persons enumerated in § 3.2:

A. List of reportable diseases:

Acquired Immunodeficiency Syndrome
Amebiasis
Anthrax
Arboviral infections
Aseptic meningitis
Bacterial meningitis (specify etiology)
Botulism
Brucellosis
Campylobacter infections (excluding C. pylori)
Chancroid
Chickenpox
Chlamydia trachomatis infections
Congenital rubella syndrome
Diphtheria
Encephalitis
primary (specify etiology)
post-infectious
Foodborne outbreaks
Giardiasis
Gonorrhea
Granuloma inguinale
Haemophilus influenzae infections invasive
Hepatitis
A
B
Non A, Non B
Unspecified
Histoplasmosis
Human immunodeficiency virus (HIV) infection
Influenza
Kawasaki Syndrome
Legionellosis
Lead poisoning in children
Leprosy
Leptospirosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
Measles (Rubeola)
Meningococcal infections
Mumps
Nosocomial outbreaks
Occupational illnesses
Ophthalmia neonatorum
Pertussis (Whooping cough)
Phenylketonuria (PKU)
Plague
Poliomyelitis
Psittacosis
Q fever
Rabies in animals
Rabies in man
Rabies treatment, post exposure
Reye syndrome
Rocky Mountain spotted fever
Rubella (German measles)
Salmonellosis
Shigellosis
Smallpox
Syphilis
Tetanus
Toxic shock syndrome
Toxic substance related illnesses
Trichinosis
Tuberculosis
Tularemia
Typhoid fever
Typhus, flea-borne
Vibrio infections including cholera
Waterborne outbreaks
Yellow fever

B. Reportable diseases requiring rapid communication.

Certain of the diseases in the list of reportable diseases, because of their extremely contagious nature or their potential for greater harm, or both, require immediate identification and control. Reporting of these diseases, listed below, shall be made by the most rapid means available, preferably that of telecommunication (e.g., telephone, telegraph, teletype, etc.) to the local health director or other professional employee of the department:

Anthrax
Botulism
Cholera
Diphtheria
Foodborne outbreaks
Haemophilus influenzae infections, invasive
Hepatitis A
Measles (Rubeola)
Meningococcal infections
Plague
Poliomyelitis
Psittacosis
Rabies in man
Smallpox
Syphilis, primary and secondary
Tuberculosis
Waterborne outbreaks
Yellow Fever

C. Diseases to be reported by number of cases.

The following disease in the list of reportable diseases shall be reported as number-of-cases only:

Influenza (by type, if available)

D. Human immunodeficiency virus (HIV) infection.

Every physician practicing in this Commonwealth shall

report to the local health department any patient of his who has tested positive for exposure to human immunodeficiency virus (HIV). Every person in charge of a medical care facility shall report the occurrence in or admission to the facility of a patient with HIV infection unless there is evidence that the occurrence has been reported by a physician. When such a report is made, it shall include the information required in § 3.2 A. Only individuals who have positive blood tests for HIV antibodies as demonstrated by at least two enzyme-linked immunosorbent assays (done in duplicate at the same time or singly at different times), and a supplemental test such as the western blot are considered to have HIV infection.

E. Toxic substances related diseases or illnesses.

Diseases or illnesses resulting from exposure to a toxic substance, shall include, but not be limited to the following:

Occupational Lung Diseases	Occupationally-Related Cancers
silicosis	mesothelioma
asbestosis	
byssinosis	

Furthermore, all toxic substances-related diseases or illnesses, including pesticide poisonings, illness or disease resulting from exposure to a radioactive substance, or any illness or disease that is indicative of an occupational health, public health, or environmental problem shall be reported.

If such disease or illness is verified, or suspected, and presents an emergency, or a serious threat to public health or safety, the report of such disease or illness shall be by rapid communication as in § 3.1 B.

F. Unusual or ill-defined diseases, illnesses, or outbreaks.

The occurrence of outbreaks or clusters of any illness which may represent an unusual or group expression of an illness which may be of public health concern shall be reported to the local health department by the most rapid means available.

G. Contact tracing.

When notified about a disease specified in § 3.1 A of the regulations, the local health department shall perform contact tracing for infectious syphilis and HIV infection, and may perform contact tracing for the other diseases if deemed necessary to protect the public health. The local health director shall have the responsibility to accomplish contact tracing by either having patients inform their potential contacts directly or through obtaining pertinent information such as names, descriptions, and addresses to enable the health department staff to inform the contacts. All contacts of HIV infection shall be afforded the opportunity for individual face-to-face disclosure of the test results and appropriate counseling. In no case shall names of informants be revealed to contacts by the health department. All information obtained shall be kept strictly confidential.

§ 3.2. Those required to report.

A. Physicians.

Each physician who treats or examines any person who is suffering from or who is suspected of having a reportable disease, or who is suspected of being a carrier of a reportable disease shall report that person's name, address, age, sex, race, name of disease diagnosed or suspected, and the date of onset of illness except that influenza should be reported by number of cases only (and type of influenza, if available). Reports are to be made to the local health department serving the jurisdiction where the physician practices. Any physician making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

Such reports shall be made on a form to be provided by the department ~~(CD-24)~~ *(Epi-1)* and shall be made within seven days unless the disease in question requires rapid reporting under § 3.1 B or § 3.1 F. ~~(Venereal diseases are reported on Form VD-35C in the manner described above.)~~

B. Directors of laboratories.

Any person who is in charge of a laboratory conducting business in the Commonwealth shall report any laboratory examination of any specimen derived from the human body which yields evidence, by the laboratory method(s) indicated *or any other confirmatory test* , of a disease listed below:

Anthrax - by culture

Campylobacter infections (excluding C. pylori) - by culture

Chlamydia trachomatis infections - by culture or antigen detection methods

Cholera - by culture
Diphtheria - by culture

Gonococcal infections - by culture or microscopic examination

Haemophilus influenzae infections - by culture or antigen detection assay of blood or cerebrospinal fluid

Hepatitis A - by serology specific for IGM antibodies

Human immunodeficiency virus (HIV) infection - by positive blood tests for HIV antibodies as demonstrated by at least two enzyme-linked immunosorbent assays (done in duplicate at the same time or singly at different times), and a supplemental test such as the western blot.

Influenza - by culture or serology

Lead poisoning in children - venous blood lead level greater than or equal to 15 ug/dL in children age 0 - 15.

Legionellosis - by culture or serology

Listeriosis - by culture

Malaria - by microscopic examination

Meningococcal infections - by culture of blood or cerebrospinal fluid

Mycobacterial diseases - by culture

Pertussis - by culture or direct fluorescent antibody test

Plague - by culture or direct fluorescent antibody test

Poliomyelitis - by culture or serology

Rabies in animals - by microscopic or immunologic examination

Salmonella infections - by culture

Shigella infections - by culture

Syphilis - by serology or dark field examination

Trichinosis - by microscopic examination of a muscle biopsy

Each report shall give the name and address of the person from whom the specimen was obtained and, when available, the person's age, race and sex. The name and address of the physician or medical facility for whom the examination was made shall also be provided. When the influenza virus is isolated, the type should be reported, if available. Reports shall be made within seven days to the local health department serving the jurisdiction in which the laboratory is located and shall be made on Form ~~CD-24.3~~ *Epi-1* or on the laboratory's own form if it includes the required information. Any person making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

Exceptions: With the exception of reporting laboratory evidence of gonococcal infections and syphilis, laboratories operating within a medical care facility shall be considered to be in compliance with the regulations when the director of that medical care facility assumes the reporting responsibility.

~~Laboratory examination results indicating gonococcal infections or syphilis shall be reported either on Form VD-36 or on Form CD-24.3 or another form acceptable to the Director of the Office of Epidemiology.~~

A laboratory may fulfill its responsibility to report mycobacterial diseases by sending a positive culture for identification or confirmation, or both, to the Virginia Division of Consolidated Laboratory Services. The culture must be identified with the patient and physician information required above.

C. Person in charge of a medical care facility.

Any person in charge of a medical care facility shall make a report to the local health department serving the jurisdiction where the facility is located of the occurrence in or admission to the facility of a patient with a reportable disease listed in § 3.1 A unless he has evidence that the occurrence has been reported by a physician. Any person making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia. The requirement to report shall include all inpatient, outpatient and emergency care departments within the medical care facility. Such report shall contain the patient's name, age, address, sex, race, name of disease being reported, the date of admission, hospital chart number, date expired (when applicable), and attending physician. Influenza should be reported by number of cases only (and type of influenza, if available). Reports shall be made within seven days unless the disease in question requires rapid reporting under § 3.1 B or § 3.1 F and shall be made on Form ~~CD-24.1~~ *Epi-1* . ~~Nosocomial outbreaks shall be reported on Form CD-24.2.~~

(Note: See § 3.2 B "Exceptions")

D. Person in charge of a school.

Any person in charge of a school shall report immediately to the local health department the presence or suspected presence in his school of children who have common symptoms suggesting an epidemic or outbreak situation. Any person so reporting shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

E. Local health directors.

The local health director shall forward within seven days to the Office of Epidemiology of the State Health Department any report of a disease or report of evidence of a disease which has been made on a resident of his jurisdiction. This report shall be by telecommunication if the disease is one requiring rapid communication, as required in § 3.1 B or § 3.1 F. All such rapid reporting shall be confirmed in writing and submitted to the Office of Epidemiology within seven days. Furthermore, the local health director shall immediately forward to the appropriate local health director any disease reports on individiuals residing in the latter's jurisdiction. The local health director shall review reports of diseases received from his jurisdiction and follow-up such reports, when indicated, with an appropriate investigation in order to evaluate the severity of the problem. He shall determine, in consultation with the ~~regional medical~~ *operations* director, the Director of the Office of Epidemiology, and the commissioner if further investigation is required and if complete or modified quarantine will be necessary.

Modified quarantine shall apply to situations in which the local health director on the scene would be best able to judge the potential threat of disease transmission. Such situations shall include, but are not limited to, the temporary exclusion of a child with a communicable disease from school and the temporary prohibition or restriction of any individual(s), exposed to or suffering from a communicable disease, from engaging in an occupation such as foodhandling that may pose a threat to the public. Modified quarantine shall also include the exclusion, under § 32.1-47 of the Code of Virginia of any unimmunized child from a school in which an outbreak, potential epidemic, or epidemic of a vaccine preventable disease has been identified. In these situations, the local health director may be authorized as the commissioner's designee to order the least restrictive means of modified quarantine.

Where modified quarantine is deemed to be insufficient and complete quarantine or isolation is necessary to protect the public health, the local health director, in consultation with the ~~regional~~ ~~medical~~ *operations* director and the Director of the Office of Epidemiology, shall recommend to the commissioner that a quarantine order or isolation order be issued.

F. Persons in charge of hospitals, nursing homes, homes for adults, and correctional facilities.

In accordance with § 32.1-37.1 of the Code of Virginia, any person in charge of a hospital, nursing home, home for adults or correctional facility shall, at the time of transferring custody of any dead body to any person practicing funeral services, notify the person practicing funeral services or his agent if the dead person was known to have had, immediately prior to death, an infectious disease which may be transmitted through exposure to any bodily fluids. These include any of the following infectious diseases:

Creutzfeldt-Jakob disease

Human immunodeficiency virus infection

Hepatitis B

Hepatitis Non A, Non B

Rabies

Infectious syphilis

PART IV.
CONTROL OF DISEASE.

§ 4.1. The "Methods of Control" sections of the ~~Fourteenth~~ *Fifteenth* Edition of the Control of Communicable Diseases in Man ~~(1985)~~ *(1990)* published by the American Public Health Association shall be complied with by the board and commissioner in controlling the diseases listed in § 3.1 A, except to the extent that the requirements and recommendations therein are outdated, inappropriate, inadequate, or otherwise inapplicable. The board and commissioner reserve the right to use any legal means to control any disease which is a threat to the public health.

PART V.
IMMUNIZATION.

§ 5.1. Dosage and age requirements for immunizations.

Every child in Virginia shall be immunized against the following diseases by receiving the specified number of doses of vaccine by the specified ages:

1. Diphtheria, Tetanus, and Pertussis (Whooping cough) Vaccine - three doses by age one year of toxoids of diphtheria and tetanus, combined with pertussis vaccine.

2. Poliomyelitis Vaccine, trivalent type - three doses by age 18 months of attenuated (live) trivalent oral polio virus vaccine or inactivated poliomyelitis vaccine.

3. Measles (Rubeola) Vaccine - one dose at 15 months of age, or by age two years, of further attentuated (live) measles virus vaccine (Schwartz or Moraten). *A second dose shall also be required at the time of initial entry to school and at the time of entry to grade six for children who had not received a second dose earlier.*

4. Rubella (German measles) Vaccine - one dose at 15 months of age or by age two years of attenuated (live) rubella virus vaccine.

5. Mumps Vaccine - one dose at 15 months of age or by age two years of mumps virus vaccine (live).

6. Haemophilus influenzae type b (Hib) vaccine - a maximum of four doses of Hib vaccine for children up to 30 months of age as appropriate for the child's age and in accordance with current recommendations of either the American Academy of Pediatrics or the U.S. Public Health Services.

§ 5.2. Obtaining immunization.

The required immunizations may be obtained from a physician licensed to practice medicine or from the local health department.

PART VI.
VENEREAL DISEASE.

§ 6.1. Prenatal testing.

Every physician attending a pregnant woman during gestation shall examine and test such woman for syphilis within 15 days after beginning such attendance. A second prenatal test for syphilis shall be conducted at the

beginning of the third trimester (28 weeks) for women who are at higher risk for syphilis. Persons at higher risk for syphilis include those who have had multiple sexual partners within the previous year and those with any prior history of a sexually transmitted disease. If the patient first seeks care during the third trimester, only one test shall be required. Every physician should also examine and test a pregnant woman for any sexually transmitted disease as clinically indicated.

PART VII.
PREVENTION OF BLINDNESS FROM OPHTHALMIA NEONATORUM.

§ 7.1. Procedure for preventing ophthalmia neonatorum.

The physician, nurse or midwife in charge of the delivery of a baby shall install in each eye of that newborn baby as soon as possible after birth one of the following: (i) two drops of a 1.0% silver nitrate solution; (ii) two drops of a 1.0% tetracycline ophthalmic solution; (iii) one quarter inch or an excessive of 1.0% tetracycline ophthalmic ointment; or (iv) one quarter inch or an excessive amount of 0.5% erythromycin ophthalmic ointment. This treatment shall be recorded in the medical record of the infant.

PART VIII.
CANCER REPORTING.

§ 8.1. Authority.

Title 32.1 (§ 32.1-70) of the Code of Virginia authorizes the establishment of a statewide cancer registry.

§ 8.2. Reportable cancers.

Newly diagnosed malignant tumors or cancers, as defined in Part I, shall be reported to the Virginia Tumor Registry in the department.

§ 8.3. Those required to report.

Any person in charge of a medical care facility or independent pathology laboratory which diagnoses or treats cancer patients is required to report. Any person making such report shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

§ 8.4. Data which must be reported.

Each report shall include the patient's name, address, age, sex, date of diagnosis, primary site of cancer, histology, basis of diagnosis, and history of service in the Vietnam war and exposure to dioxin-containing compounds. Medical care facility reports shall also include social security number, date of birth, race, marital status, usual occupation, and usual industry.

The reporting requirement may be met by submitting a copy of the hospital facesheet and pathology report to the Virginia Tumor Registry. Reports shall be made within four months of the diagnosis of cancer.

§ 8.5. Additional data which may be reported.

Any person in charge of a medical care facility may also elect to provide more extensive clinical information as required for cancer programs approved by the American College of Surgeons. These additional data may include staging, treatment, and recurrence information and may be reported by submitting a hospital abstract to the Virginia Tumor Registry within six months of the diagnosis of cancer. Annual follow-up may be conducted on persons reported in this manner.

PART IX.
REPORTING AND CONTROL OF DISEASES.

§ 9.1. Reporting and control of diseases.

Chapter 2 (§ 32.1-35 et seq.) of Title 32.1 of the Code of Virginia relating to the Reporting and Control of Diseases is incorporated by reference and made a part of these regulations.

PART X.
MEMORY LOSS DISORDER REPORTING.

§ 10.1. Authority.

Article 9.1 (§ 32.1-71.1 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia authorizes the establishment of a statewide Alzheimer's Disease and related disorders registry.

§ 10.2. Provisions.

Each *nursing facility,* hospital, clinic, individual practitioner or other ~~health care provider may~~ *agency or facility providing health care shall* report to the registry, on forms provided by the registry *or other forms approved by the Registry Director* , information regarding persons ~~in his care~~ *who are in the care of the provider and* who have been diagnosed as having a memory loss disorder, as defined in Part I. Any person making such report shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

Virginia Department of Health, Office of Epidemiology

Please report the following diseases (and any other disease or outbreak of public health importance) in the manner required by Section 32.1-36 of the Health Laws of Virginia and Section 3.2A of the Board of Health *Regulations for Disease Reporting and Control*. Enter as much information as possible on the reporting form.

Acquired immunodeficiency syndrome
Amebiasis
ANTHRAX *
Arboviral infection
Aseptic meningitis
Bacterial meningitis (specify etiology)
BOTULISM
Brucellosis
Campylobacter infection * (excluding *C. pylori*)
Chancroid
Chickenpox
Chlamydia trachomatis infection *
Congenital rubella syndrome
DIPHTHERIA *
Encephalitis
  primary (specify etiology)
  post-infectious
FOODBORNE OUTBREAK
Giardiasis
Gonorrhea *
Granuloma inguinale
HAEMOPHILUS INFLUENZAE
  INFECTION, INVASIVE *
HEPATITIS A *
Hepatitis B
Hepatitis Non-A Non-B
Hepatitis Unspecified
Histoplasmosis
Human immunodeficiency virus (HIV) infection *
Influenza *¶
Kawasaki syndrome
Lead Poisoning in Children *
Legionellosis *
Leprosy
Leptospirosis
Listeriosis *
Lyme disease
Lymphogranuloma venereum
Malaria *
MEASLES (RUBEOLA)
MENINGOCOCCAL INFECTION *
Mumps
Nosocomial outbreak
Occupational illness
Ophthalmia neonatorum
Pertussis (Whooping cough) *
Phenylketonuria (PKU)
PLAGUE *
POLIOMYELITIS *
PSITTACOSIS
Q fever
Rabies in animals *
RABIES IN MAN
Rabies treatment, post-exposure
Reye syndrome
Rocky Mountain spotted fever
Rubella (German measles)
Salmonellosis *
Shigellosis *
SMALLPOX
Syphilis, all stages*
  PRIMARY AND SECONDARY
Tetanus
Toxic shock syndrome
Toxic substance related illness
Trichinosis *
TUBERCULOSIS (Mycobacteria*)
Tularemia
Typhoid fever
Typhus, flea-borne
Vibrio infection,
  including CHOLERA*
WATERBORNE OUTBREAK
YELLOW FEVER

Physicians and Directors of Medical Care Facilities must report conditions listed in UPPER CASE by rapid reporting to the Local Health Director via telecommunication. Report all other diseases within seven days.

* These are the only conditions reportable by Directors of Laboratories. These and all other conditions are reportable by Physicians and Directors of Medical Care Facilities as well.

¶ Physicians and Directors of Medical Care Facilities should report influenza by number of cases only (and type of influenza, if available).

Mail the top two copies to your local health department. Retain the third copy for your files. Thank you.

Virginia Department of Health
Office of Epidemiology
Confidential Morbidity Report

Patient's Name (Last, First):	Telephone Numbers: Home ( ) ___-____
Patient's Address (Street, City or Town, State, Zip Code):	Work ( ) ___-____
	City or County of Residence:
Date of Birth: / Age: / Race: ☐ Asian ☐ White ☐ Black ☐ Other / Hispanic Ethnicity: ☐ Yes ☐ No ☐ Unk. / Sex: ☐ F ☐ M	
Disease or Condition:	Case Status: ☐ Confirmed ☐ Suspected
Date of Onset: / Date of Diagnosis: / If Influenza: No. of Cases ____ / Site of Infection:	
Physician Name: Address:	Phone: ( ) ___-____
Hospital Admission? ___Yes ___No Hospital Name: Date of Admission: _____ Chart ID No.:	
Laboratory Information and Results	
Source of Specimen:	Date Collected:
Laboratory Test:	
Results:	
Name/Address of Lab:	
Other Information	
Comments: (Risk Situation (Foodhandling, Patient Care, Day Care), STD/HIV Treatment, Immunization Status, Signs/Symptoms, Date of Death, Exposure, Etc.)	
Reported by:	Date Reported:
Address and Phone:	Check Here if You Need More of These Forms ☐
For Health Department Use:	Date Received:

(CD-24)

VIRGINIA DEPARTMENT OF HEALTH
CONFIDENTIAL MORBIDITY REPORT
(Send to Local Health Dept.)

1. Communicable Disease Reports

DISEASE				DATE OF ONSET	
NAME OF PATIENT — LAST	FIRST	MIDDLE	AGE	RACE	SEX
ADDRESS					
COMMENTS					
DISEASE				DATE OF ONSET	
NAME OF PATIENT — LAST	FIRST	MIDDLE	AGE	RACE	SEX
ADDRESS					
COMMENTS					
NAME OF PHYSICIAN		ADDRESS			

(Over)

II. OCCUPATIONAL DISEASE OR TOXIC SUBSTANCE EXPOSURE REPORT

PATIENT'S NAME — LAST	FIRST	MIDDLE	AGE	RACE	SEX
ADDRESS			OCCUPATION		
DIAGNOSIS			DATE OF ONSET		
NAME OF TOXIC SUBSTANCE (Generic or Trade Name if Known)					
DATE(S) OF EXPOSURE					
NAME AND ADDRESS OF LOCATION OF SUSPECTED EXPOSURE					
COMMENTS					
NAME OF PHYSICIAN		ADDRESS			

DEPARTMENT OF HEALTH - OFFICE OF EPIDEMIOLOGY

VIRGINIA CONFIDENTIAL MORBIDITY REPORT FOR MEDICAL CARE FACILITIES

PLEASE REPORT THE DISEASES LISTED BELOW AS REQUIRED BY SECTION 32.1-37 OF THE VIRGINIA CODE AND THE RULES AND REGULATIONS FOR THE LICENSURE OF GENERAL AND SPECIAL HOSPITALS IN VIRGINIA. COMPLETED FORMS SHOULD BE MAILED TO THE LOCAL HEALTH DEPARTMENT AT LEAST *WEEKLY* IF THERE *ARE* CASES. A MONTHLY REPORT SHOULD BE SUBMITTED IF THERE ARE *NO* CASES TO BE REPORTED FOR THAT MONTH.

FOR EPIDEMIOLOGICAL ASSISTANCE OR CONSULTATION, PLEASE CALL THE LOCAL HEALTH DEPARTMENT OR THE OFFICE OF EPIDEMIOLOGY, 109 GOVERNOR STREET, RICHMOND, VIRGINIA 23219 (PH: 804-786-6261). ADDITIONAL REPORT FORMS ARE AVAILABLE THROUGH THE SAME OFFICE.

NAME OF MEDICAL CARE FACILITY _____

ADDRESS _____

REPORTED BY _____ NAME _____ TITLE _____ PHONE NUMBER _____ DATE REPORTED

DIAGNOSIS	PATIENT'S NAME	ADDRESS	AGE	RACE	SEX	DATE OF ADMISSION	CHART NUMBER	ATTENDING PHYSICIAN	DATE EXPIRED

REPORT DISEASES PRECEDED BY AN ASTERISK (*) IMMEDIATELY BY TELEPHONE TO THE LOCAL HEALTH DIRECTOR OR STATE EPIDEMIOLOGIST AS WELL AS BY COMPLETING THE REPORTING FORM.

Acquired Immunodeficiency Syndrome
Amebiasis
*Anthrax
Bacterial Infections
Aseptic Meningitis
Bacterial Meningitis (specify etiology)
*Botulism
Brucellosis
Campylobacter Infections
*Chancroid
Chickenpox
Chlamydia Trachomatis Infections
*Cholera
Congenital Rubella Syndrome
*Diphtheria
Encephalitis
Primary (specify etiology)
Post Infectious
*Foodborne Outbreaks
Giardiasis
Gonorrhea
Granuloma Inguinale
*Haemophilus Influenzae Infections, Invasive
Hepatitis, Viral
A
B
Non A, Non B
Unspecified
Histoplasmosis
Human Immunodeficiency Virus (HIV) Infection
Influenza (number of cases and type only)
Kawasaki Syndrome
Legionellosis
Leprosy
Leptospirosis
Listeriosis
Lyme Disease
Lymphogranuloma Venereum
Malaria
*Measles (Rubeola)
*Meningococcal Infections
Mumps
Nosocomial Outbreaks
Occupational Illnesses
Ophthalmia Neonatorum
Pertussis (Whooping Cough)
Pneumocystosis (PCP)
*Plague
*Poliomyelitis
*Psittacosis
Q Fever
Rabies in Animals
*Rabies in Man
Rabies Treatment, Post-Exposure
Reye Syndrome
Rocky Mountain Spotted Fever
Rubella (German Measles)
Salmonellosis
Shigellosis
*Smallpox
Syphilis, All Stages
Primary and Secondary
Tetanus
Toxic Shock Syndrome
Toxic Substance Related Illnesses
Trichinosis
*Tuberculosis
Tularemia
Typhoid Fever
Typhus, Murine
Typhus, Rickettsial
*Viral Hemorrhagic Outbreaks
*Yellow Fever

ANY OTHER DISEASE OR OUTBREAK OF PUBLIC HEALTH IMPORTANCE

Venereal disease cases should be reported on form VD-35C available through the State STD/AIDS Program or the local health department.

An outbreak will be considered to be present when there is an increase in incidence of any infectious disease or rise in the usual incidence. Please complete form CD-24.2 to report outbreaks.

RETAIN COPY (3) FOR YOUR RECORDS, MAIL COPIES (1) AND (2) TO YOUR LOCAL HEALTH DEPARTMENT.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH - DIVISION OF EPIDEMIOLOGY

NOSOCOMIAL OUTBREAK REPORT

Hospital Name _____ Date of Report _____

Address _____

Reported By _____ (Name) _____ (Title) _____ (Phone Number)

Date of Onset of Index Case _____ Date of Onset of Last Case _____

Is Outbreak Continuing? _____ # Cases to Date _____ # Deaths to Date _____

Etiology _____

Description of Outbreak _____

Control Measures Instituted _____

Comments _____

(Please attach additional pages or information as needed.)
Division of Epidemiology

CD-242

VIRGINIA STATE DEPARTMENT OF HEALTH
CONFIDENTIAL REPORT: LABORATORY EVIDENCE OF CERTAIN COMMUNICABLE DISEASES

Last Name	First	Middle	Age	Race	Sex	Date Specimen Submitted

Address _____ City _____ Zip _____ County _____

Attending Physician _____ Address or Hospital _____

City _____ County _____ Zip _____ Phone _____

Type of Specimen: Blood ☐ CSF ☐ Stool ☐ Pharyngeal Swab ☐ Washing ☐ Sputum ☐ Discharge ☐ Other _____

Test: Culture: Bacterial ☐ Viral ☐ Parasitic ☐ Immunological (SPECIFY) _____ Microscopic ☐ Serological (SPECIFY) _____ Histologic ☐

Results _____

Date of Report _____ Name and Address of Lab _____ Director _____

Mail Copies (1) and (2) to Your Local Health Department

CD-243

Last Name	First Name	Middle Initial	Race	Sex	Date of Birth
Address		City		County	

Syphilis:

- ☐ (10) Primary
- ☐ (20) Secondary
- ☐ (30) Early Latent (Less than 1 yr.'s duration)

Clinical Manifestations

- ☐ (31) Early Latent (1-2 yrs.' duration)
- ☐ (40) Late Latent (Over 2 yrs.' duration)
  - ☐ (41) Neurosyphilis
  - ☐ (42) Cardiovascular
  - ☐ (43) Other _____
- ☐ (50) Congenital
- ☐ Not infected with syphilis

Other Venereal Diseases:

- ☐ (60) Gonorrhea
- ☐ (70) Chancroid
- ☐ (80) Granuloma Inguinale
- ☐ (90) Lymphogranuloma Venereum

FOR INFORMATION, INTERVIEWING & DARKFIELD SERVICES PLEASE CALL YOUR LOCAL HEALTH DEPARTMENT OR CALL COLLECT RICHMOND, VIRGINIA 786-6265

Signature	M.D.	Date of Report
Address		

CONFIDENTIAL REPORT OF VENEREAL DISEASE
VIRGINIA STATE DEPARTMENT OF HEALTH

Form No. VD 35C
Rev. 10-65

Laboratory Tests			Treatment
Date	Type of Test	Results	

Comments:

Do You Need?	Send To:
☐ Report Forms ☐ Drugs to Treat This Patient ☐ Professional Literature	Your Local Health Department, or Director—Division of Disease Control State Department of Health Richmond, Virginia 23219

COMMONWEALTH OF VIRGINIA — DEPARTMENT OF HEALTH
LABORATORY REPORT OF REACTIVE TESTS FOR VENEREAL DISEASE

Name of Laboratory

Address

Period Covered

(Date) From _____ To _____

Number of Tests Performed _____

Number Reactive _____

REPORTABLE TESTS INCLUDE:

1. All Reactive and Weakly Reactive Serologic Tests for Syphilis.
2. All Positive Darkfield Tests for Syphilis
3. All Positive Smears and Cultures for Gonorrhea

§32.1-36, Code of Virginia, 1950 as amended.

"... And every director of any laboratory doing business in this Commonwealth which performs any test whose results indicate the presence of any such disease shall make a report within such time and in such manner as may be prescribed by regulations of the Board. ..."

This report shall be submitted within seven (7) days of the laboratory examination by all laboratories in Virginia. Positive darkfield tests and quantitative serologics with a titer of 1:8 or greater shall be reported within 24 hours.

Mail to: Virginia State Health Dept.
109 Governor Street
STD Control-723 Madison Bldg.,
Richmond, Virginia 23219

Name of Patient	Address of Patient	Age	Sex	Race	Date	Test	Results	Name of Physician	Address of Physician

VIRGINIA TUMOR REGISTRY ABSTRACT

REPORTING HOSPITAL:

PATIENT INFORMATION

NAME: LAST | FIRST | M.I. | SOCIAL SECURITY NUMBER | VTR PATIENT IDENTIFYING NUMBER

ADDRESS: STREET | CITY | COUNTY/CODE | STATE | ZIP | USUAL OCCUPATION CODE | INDUSTRY CODE

DATE OF BIRTH | AGE AT DIAG | SEX | RACE | MARITAL STATUS | CLASS OF CASE | HOSPITAL ACCESSION NUMBER

NAME, ADDRESS, AND RELATIONSHIP OF ONE CONTACT: | HOSPITAL CHART NUMBER

1. NAME AND ADDRESS OF ATTENDING PHYSICIAN: | 3. OTHER: | DATE OF ADMISSION | DATE OF DISCHARGE

2. NAME AND ADDRESS OF FOLLOW-UP PHYSICIAN: | 4. OTHER: | DATE INITIAL DIAGNOSIS (MO/YR)

HOSPITAL REFERRED FROM: | PLACE OF DIAGNOSIS: | HOSPITAL REFERRED TO:

NON-ANA HISTORY

PRIOR THERAPY: SPECIFY CATEGORY, DATE, AND TYPE (NON-ANALYTIC CASES ONLY): | OTHER PRIMARIES: SITE, TYPE, DATE, AND PLACE OF DIAGNOSIS

DIAGNOSTIC PRO AIS

PRIMARY SITE: | TYPE: | TOPOGRAPHY CODE: | RECORD SASCR HISTOLOGY

PATH NO. | CYTOL NO. | MORPHOLOGY CODE: | ALCOHOL ABUSE:

BASIS OF DIAGNOSIS: ☐ HIST. ☐ EX. CYTOL ☐ MICRO CONFIRM NOS
☐ SURGICAL EVID - NMC ☐ CLINICAL ONLY ☐ UNKNOWN

EXTENT OF DISEASE: STAGE AT FIRST TREATMENT IN YOUR HOSPITAL

SUMMARY STAGE: | PATHOLOGICAL SIZE OF TUMOR: | # NODES POSITIVE: | # NODES EXAMINED: | LATERALITY: | REGIONAL TUMOR:

ACC. TNM BASIS: T - N - M | AJCC SUMMARY STAGE | SITES OF DISTANT METASTASIS:

STAGE:

FIRST COURSE OF TREATMENT

SPECIFY DATES, TYPES, (IF PLACE IF ELSEWHERE) FIRST COURSE ONLY

☐ SURGERY —
☐ BEAM RADIATION —
☐ OTHER RADIATION —
☐ CHEMO —
☐ HORMONES —
☐ IMMUNOTHERAPY —
☐ OTHER —
☐ NONE OF THE ABOVE (AND WHY) —

HISTORY OF SERVICE IN VIETNAM WAR:

EXPOSURE TO DIOXIN-CONTAINING COMPOUNDS: ☐ NO ☐ YES SPECIFY:

DATE LAST CONTACT: | VITAL STATUS: | TUMOR STATUS: | FOLLOW-UP SOURCE:

CAUSE OF DEATH/CODE: | AUTOPSY: ☐ YES, WITH INFORM ☐ YES, WITHOUT INFORM ☐ NO ☐ UNKNOWN

FORM VTR-1 6 (7/88) | DATE COMPLETED AND INITIALS

SUBSEQUENT TREATMENT

SURGERY & RADIATION - SPECIFY DATES

☐ SURGERY
☐ BEAM RADIATION
☐ OTHER RADIATION
☐ IMMUNOTHERAPY

CHEMOTHERAPY & HORMONAL THERAPY

☐ CHEMO
☐ HORMONES
☐ OTHER
☐ NONE OF THE ABOVE (AND WHY)

DATE	SOURCE OF CONTACT*	STATUS OF PATIENT: ALIVE	DEAD	NO EVIDENCE OF CANCER	EVIDENCE OF CANCER UNKNOWN	STATUS OF DISEASE: EVIDENCE OF CANCER	RESIDUAL	RECURRENT	METASTATIC	UNKNOWN	NO EVIDENCE OF CANCER	QUALITY OF SURVIVAL**	SUBSEQUENT TREATMENT AND REMARKS

* SOURCE OF CONTACT:

1 - HOSPITAL READMISSION
2 - CLINIC VISIT WITHOUT PHYSICAL EXAM
3 - CLINIC VISIT WITH PHYSICAL EXAM
4 - DOCTOR'S OFFICE WITH PHYSICAL EXAM
5 - DOCTOR'S OFFICE WITHOUT PHYSICAL EXAM
6 - PUBLIC HEALTH NURSE
7 - DIRECT PATIENT CONTACT
8 - OTHER: SPECIFY IN REMARKS COLUMN

** QUALITY OF SURVIVAL:

0 - NORMAL ACTIVITY
1 - SYMPTOMATIC & AMBULATORY
2 - AMBULATORY MORE THAN 50%
OCCASIONALLY NEEDS ASSISTANCE
3 - AMBULATORY LESS THAN 50%,
NURSING CARE NEEDED
4 - BEDRIDDEN, MAY REQUIRE HOSPITALIZATION
9 - UNKNOWN / UNSPECIFIED

VIRGINIA TUMOR REGISTRY
CANCER REPORTING - INCIDENCE ONLY

VTR use only

Medical Facility Reporting:

Patient Name: (Last) (First) (Middle) (Spouse)

Street Address

City County State Zip

Date of Birth | Age | Sex | Race | Marital Status

SSN#: Usual Occupation/Industry:

Date of diagnosis:

Primary site of cancer:

Basis of diagnosis: ☐ Hist. ☐ Ex. Cytol. ☐ Micro Confirm NOS ☐ Surgical Evid., NMC ☐ Clinical Only ☐ Unknown

Histology:

History of service in Vietnam War:

Exposure to dioxin-containing compounds: ☐ yes ☐ no

Specify:

Completed By:

Mailing address: Virginia Tumor Registry
Room 715
Madison Bldg.
109 Governor Street
Richmond, VA 23219

VTR form #2

THIS SIDE TO BE FILLED OUT BY FAMILY OR CAREGIVER

VIRGINIA DEPARTMENT OF HEALTH
MEMORY LOSS DISORDERS QUESTIONNAIRE

GENERAL INSTRUCTIONS: This form should be filled out as fully as possible for any adult in the State of Virginia who has MEMORY LOSS. Please mail completed forms to:
Virginia Department of Health, ADRD Registry
109 Governor Street, Room 701
Richmond, Virginia 23219
Date of Report: _____

Patient's Last Name: _____ First: _____ M.I.: _____
Street Address: _____
City: _____ County: _____ State: _____ Zip Code: _____
Date of Birth: _____ Age: ____ Date of Death: _____ Social Security Number: _____

SEX:
☐ Male
☐ Female

MARITAL STATUS:
☐ Never Married
☐ Married
☐ Widowed
☐ Divorced
☐ Other

RACE:
☐ Black
☐ White
☐ Hispanic
☐ American Indian
☐ Asian/Pacific Islander
☐ Other (Specify) _____

PATIENT'S PRESENT LIVING ARRANGEMENTS:
(If in a hospital, check the expected living arrangement upon discharge)
☐ Living Alone
☐ Living with Someone Else
☐ Nursing Home or Other Facility

SOURCE(S) OF HEALTH CARE PAYMENT:
☐ Medicare/Federal Insurance
☐ Medicaid
☐ Private Insurance
☐ None

SERVICES CURRENTLY USED:
☐ None
☐ Adult Day Care
☐ Home for Adults
☐ In Home Care by Relative
☐ In Home Care by Paid Attendant
☐ Respite Care (relief for caregiver)
☐ Support Group
☐ Other
Services Needed: _____

CHANGES IN EVERYDAY ACTIVITIES BECAUSE OF MEMORY LOSS
THE PERSON:

	Independently	Needs Assistance	Totally Dependent
1. Performs Simple Tasks?	☐	☐	☐
2. Handles Small Sums of Money?	☐	☐	☐
3. Remembers Short Lists of Items?	☐	☐	☐
4. Recognizes Familiar Objects?	☐	☐	☐
5. Recalls Events?	☐	☐	☐
6. Responds to Own Name?	☐	☐	☐

What year did the signs or symptoms of memory loss begin? 19____

DOES THIS PERSON HAVE A:
1. Hearing Impairment? ☐ No ☐ Slight ☐ Severe
2. History of Alcohol Abuse? ☐ Yes ☐ No
3. History of Head Injury? ☐ Yes ☐ No
4. History of a Stroke? ☐ Yes ☐ No
5. Family History of Dementia? ☐ Yes ☐ No
Relationship: _____
6. Family History of Down's Syndrome? ☐ Yes ☐ No
Relationship: _____
7. What was the Person's Primary Occupation? _____

NAME OF RELATIVE OR PERSON RESPONSIBLE FOR THE PATIENT'S AFFAIRS:
Last Name: _____ First: _____ M.I.: _____
Street Address: _____
City: _____ County: _____ State: _____ Zip Code: _____
Relationship to Patient: ☐ Spouse ☐ Guardian ☐ Son/Daughter ☐ Other Relative ☐ Friend ☐ Attorney ☐ Other

MAY WE CONTACT THE DOCTOR THAT EXAMINED THE PATIENT FOR MEMORY PROBLEMS? ☐ Yes ☐ No
Dr. _____
Street Address: _____
City: _____ County: _____ State: _____ Zip Code: _____

INFORMATION REQUEST:
I would like to receive information regarding services available to dementia patients and their families: ☐ Yes ☐ No
I am willing to release my name to service organizations for this purpose: ☐ Yes ☐ No
I am interested in a state-funded autopsy for my loved one if it is available when he or she dies ☐ Yes ☐ No

Name of Person Completing This Side of Form: _____

The primary purpose of this project is to collect information on persons with Memory Loss in Virginia. All information will be kept confidential. Patient and Physician identities will be released only for research studies approved by the [illegible]

THIS SIDE TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER

VIRGINIA DEPARTMENT OF HEALTH
MEMORY LOSS DISORDERS QUESTIONNAIRE

GENERAL INSTRUCTIONS: This form should be filled out as fully as possible for any adult in the State of Virginia who has progressive memory loss as provided in the Code of Virginia, Title 32.1, Article 9.1. Please mail completed forms to:

Virginia Department of Health, ADRD Registry
109 Governor Street, Room 701
Richmond, Virginia 23219

Date of Report: _____

PATIENT'S FULL NAME: _____ DATE OF BIRTH: _____

Provider's Name: _____ Speciality: _____

Name of Facility: _____ Type of Facility: _____

Street Address: _____ Telephone Number: (____) _____

City: _____ County: _____ State: _____ Zip Code: _____

May we contact this patient's guardian for additional information pertaining to memory loss?
☐ Yes ☐ No (If yes, provide name and address on reverse side.)

CLINICAL PROCEDURES AND RESULTS

TEST	NORMAL	ABNORMAL	NOT DONE	YEAR DONE
B12				
Folate				
Thyroid Function Test				
Syphilis Serology				
CT Scan of Head				
EEG				
Lumbar Puncture				
Brain Biopsy				
Autopsy (specify laboratory)				
Other (specify)				

CAUSES OF CHRONIC DEMENTIA	PRESENT AND RELATED	PRESENT AND UNRELATED	PRESENT AND MAY OR MAY NOT BE RELATED
AIDS			
Alcohol Abuse			
Probable Alzheimer's Disease			
Cerebral Vascular Disease			
Creutzfeldt-Jakob Disease			
Depression			
Head Trauma			
Normal Pressure Hydrocephalus			
Parkinson's Disease			
Space-Occupying Lesion			
Toxic or Metabolic Disorder			
Other (specify)			

Has cognitive impairment been identified by neuropsychological testing? ☐ Yes ☐ No

What year was the dementia diagnosis made? 19 ____

Name of Person Completing This Side of Form: _____

* * * * * * * *

Title of Regulation: **1987 State Medical Facilities Plan (REPEALING).**

Statutory Authority: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Public Hearing Date: March 17, 1993 - 1 p.m.
Written comments may be submitted through April 23, 1993.
(See Calendar of Events section for additional information)

Summary:

The repeal of the 1987 State Medical Facilities Plan is necessary to allow the implementation of the proposed State Medical Facilities Plan which is currently being promulgated by the Board of Health. The 1987 State Medical Facilities Plan provides statistical information and projections of need for medical services and facilities which were subject to review in accordance with the former Certificate of Public Need statute. The proposed State Medical Facilities Plan will provide the Department of Health all necessary guidance for making decisions on Certificate of Public Need projects that are submitted for review under the recently amended Certificate of Public Need law. The proposed State Medical Facilities Plan is, therefore, intended to supercede the 1987 State Medical Facilities Plan and, therefore, the repeal of the latter is warranted.

* * * * * * * *

REGISTRAR'S NOTICE: Due to its length, the proposed Virginia State Medical Facilities Plan filed by the Department of Health is not being published. However, in accordance with § 9-6.14:22 of the Code of Virginia, a 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, 910 Capitol Square, Room 262, Richmond, Virginia, and at the Department of Health, 1500 E. Main Street, Room 105, Richmond, Virginia.

Title of Regulations: **VR 355-30-100. Virginia State Medical Facilities Plan.**
355-30-101. General Acute Care Services.
355-30-102. Perinatal Services.
355-30-103. Cardiac Services.
355-30-104. General Surgical Services.
355-30-105. Organ Transplantation Services.
355-30-106. Psychiatric/Substance Abuse Treatment Services.
355-30-107. Mental Retardation Services.
355-30-108. Medical Rehabilitation Services.
355-30-109. Diagnostic Imaging Services.
355-30-110. Lithotripsy Services.
355-30-111. Radiation Therapy Services.
355-30-112. Miscellanous Capital Expenditures.
355-30-113. Nursing Home Services.

Statutory Authority: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Public Hearing Date: March 17, 1993 - 1 p.m.
Written comments may be submitted through April 23, 1993.
(See Calendar of Events section for additional information)

Summary:

The State Medical Facilities Plan (SMFP) provides criteria and standards for the full range of capital expenditure project categories which require certificate of public need review under the 1992 amendments to the law. This document serves as a basis for decision making on a wide range of project categories including general acute care services, perinatal services, cardiac services, general surgical services, organ transplant services, psychiatric/substance abuse treatment services, mental retardation services, medical rehabilitation services, diagnostic imaging services, lithotripsy services, miscellaneous capital expenditures, and nursing home services.

The SMFP is identical to the SMFP which became effective in July 1992 on an emergency basis and is currently in use by the department. The statutory amendments which became effective on July 1, 1992, substantially expanded the categories of capital expenditure projects that require COPN approval by the State Health Commissioner prior to initiation. The SMFP serves as a basis for decision making on a wide range of project categories and is essential to the implementation of the COPN program.

The SMFP provides guidance for assessing the public need for the full range of capital expenditure project categories which require COPN review under the 1992 law amendments. Without the SMFP, the Department of Health would have no specific standards in place to review such major medical equipment categories as lithotripsy, positron emission tomography, single photon emission computed tomography (SPECT), gamma knife surgery, or magnetic source imaging. Additionally, the SMFP is the department's only available guidance for the evaluation of service categories subject to COPN review such as medical rehabilitation and organ transplantation, and many other health service categories. Finally, under the 1992 law amendments, any capital expenditure, for whatever reason, which exceeds $1 million, is subject to COPN review. The SMFP establishes specific planning guidance for the review of the many COPN proposals which will fall in this category but do not involve changes in specific clinical health services or major medical equipment specifically subject to COPN

review.

* * * * * * * *

Title of Regulation: ~~VR 355-30-000-06~~ *VR 355-30-000* . **Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.**

Statutory Authority: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Public Hearing Date: March 17, 1993 - 10 a.m.
Written comments may be submitted through April 23, 1993.
(See Calendar of Events section for additional information)

Summary:

The proposed amendments to the Virginia Medical Care Facilities Certificate of Public Need (COPN) Rules and Regulations bring the current regulations into compliance with the recent amendment to the Virginia Medical Care Facilities Certificate of Public Need law which became effective on July 1, 1992. The amendments (i) expand the categories of projects which require COPN approval by the State Health Commissioner prior to initiation; (ii) allow the replacement of certain major medical equipment without the issuance of a COPN under certain circumstances; (iii) eliminate the registration and data reporting requirements for certain types of medical facilities and capital projects; (iv) provide a process for the expedited review and issuance of a COPN for projects which meet certain requirements; (v) eliminate the scheduled sunset of COPN review requirements for ambulatory surgery centers and hospitals; (vi) extend the moratorium on the issuance of COPNs for nursing home bed projects from June 30, 1993, to June 30, 1994, and provide several additional exemptions to the moratorium; and (vii) allow certain additional extensions to the schedules for completion of several previously authorized nursing home bed projects.

With the exception of the expedited review process (Part VI of the regulations), the proposed amendments were first promulgated as emergency regulations effective July 10, 1992.

VR 355-30-000. Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.

PART I.
DEFINITIONS.

§ 1.1. *Definitions.*

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

"Acquisition" means an expenditure of (i) $700,000 or more that changes the ownership of a medical care facility or (ii) $400,000 or more for the purchase of new major medical equipment. It shall also include the donation or lease of a medical care facility or new major medical equipment. An acquisition of a medical care facility shall not include a capital expenditure involving the purchase of stock.

"Amendment" means any modification to an application which is made following the public hearing and prior to the issuance of a certificate and includes those factors that constitute a significant change as defined in these regulations. An amendment shall not include a modification to an application which serves to reduce the scope of a project.

"Applicant" means the owner of an existing medical care facility or the sponsor of a proposed medical care facility project submitting an application for a certificate of public need.

"Application" means a prescribed format for the presentation of data and information deemed necessary by the board to determine a public need for a medical care facility project.

"Application fees" means fees required to be submitted with a project application and application for a significant change. Fees shall not exceed the lesser of 0.5% of the proposed capital expenditure or cost increase for the project or $5,000.

"Board" means the State Board of Health.

"Capital expenditure" means any expenditure by or in behalf of a medical care facility which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance. *Such expenditure shall also include a series of related expenditures during a 12-month period or a financial obligation or a series of related financial obligations made during a 12-month period by or in behalf of a medical care facility.* Capital expenditures need not be made by a medical care facility so long as they are made in behalf of a medical care facility by any person. See definition of "person."

"Certificate of public need" means a document which legally authorizes a medical care facility project as defined herein and which is issued by the commissioner to the owner of such project.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"Commissioner" means the State Health Commissioner who has authority to make a determination respecting the issuance or revocation of a certificate.

"Competing applications" means applications for the same or similar services and facilities which are proposed for the same planning district or medical service area and which are in the same review cycle. See § 5.6.

"Completion" means conclusion of construction activities necessary for substantial performance of the contract.

"Construction" means the building of a new medical facility or the expansion, remodeling, or alteration of an existing medical care facility.

"Construction, initiation of" means project shall be considered under construction for the purpose of certificate extension determinations upon the presentation of evidence by the owner of: (i) a signed construction contract; (ii) the completion of short term financing and a commitment for long term (permanent) financing when applicable; (iii) the completion of predevelopment site work; and (iv) the completion of building foundations.

"Date of issuance" means the date of the commissioner's decision awarding a certificate of public need.

"Department" means the State Department of Health.

"Ex parte" means any meeting which takes place between (i) any person acting in behalf of the applicant or holder of a certificate of public need or any person opposed to the issuance or in favor of the revocation of a certificate of public need and (ii) any person who has authority in the department to make a decision respecting the issuance or revocation of a certificate of public need for which the department has not provided 10 days written notification to opposing parties of the time and place of such meeting. An ex parte contact shall not include a meeting between the persons identified in (i) and staff of the department.

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Informal fact-finding conference" means a conference held pursuant to § 9-6.14:11 of the Code of Virginia.

"Inpatient beds" means accommodations within a medical care facility with continuous support services (such as food, laundry, housekeeping) and staff to provide health or health-related services to patients who generally remain in the medical care facility in excess of 24 hours. Such accommodations are known by varying nomenclatures including but not limited to: nursing beds, intensive care beds, minimal or self care beds, isolation beds, hospice beds, observation beds equipped and staffed for overnight use, and obstetric, medical, surgical, psychiatric, substance abuse, medical rehabilitation and pediatric beds, including pediatric bassinets and incubators. Bassinets and incubators in a maternity department and beds located in labor or birthing rooms, recovery rooms, emergency rooms, preparation or anesthesia inductor rooms, diagnostic or treatment procedures rooms, or on-call staff rooms are excluded from this definition.

"Medical care ~~facilities~~ *facility"* means any institution, place, building, or agency, *at a single site,* whether or not licensed or required to be licensed by the board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately owned or operated or owned or operated by a local governmental unit, (i) by or in which facilities are maintained, furnished, conducted, operated, or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical, or nursing attention or services as acute, chronic, convalescent, aged, physically disabled, or crippled or (ii) which is the recipient of reimbursements from third party health insurance programs or prepaid medical service plans. For purposes of these regulations, only the following medical care facility classifications shall be subject to review:

~~1. *"Medical care facility classifications"* means the following:~~

~~a.~~ *1.* General hospitals.

~~b.~~ *2.* Sanitariums.

~~c.~~ *3.* Nursing homes.

~~d.~~ *4.* Intermediate care facilities.

~~e.~~ *5.* Extended care facilities.

~~f.~~ *6.* Mental hospitals.

~~g.~~ *7.* Mental retardation facilities.

~~h.~~ *8.* Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.

~~i.~~ *9.* Specialized centers or clinics *or that portion of a physician's office* developed for the provision of out-patient or ambulatory surgery , *cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, single photon emission computed tomography (SPECT) scanning, or such other specialty services as may be designated by the board by regulation.*

~~j.~~ *10.* Rehabilitation hospitals.

~~2. "Exclusions" means that the following shall not be included as a medical care facility classification subject to review:~~

For purposes of the regulations, the following medical care facility classifications shall not be subject to review:

~~a.~~ *1.* Any facility of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

~~b.~~ *2.* Any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services Comprehensive Plan.

3. Any physician's office, except that portion of the physician's office which is described in subdivision 9 of the definition of "medical care facility."

"Medical service area" means the geographic territory from which at least 75% of patients come or are expected to come to existing or proposed medical care facilities, the delineation of which is based on such factors as population characteristics, natural geographic boundaries, and transportation and trade patterns, and all parts of which are reasonably accessible to existing or proposed medical care facilities.

"Modernization" means the alteration, repair, remodeling, replacement or renovation of an existing medical care facility or any part thereto, including that which is incident to the initial and subsequent installation of equipment in a medical care facility. See definition of "construction."

"Operating expenditure" means any expenditure by or in behalf of a medical care facility which, under generally accepted accounting principles, is properly chargeable as an expense of operation and maintenance and is not a capital expenditure.

"Operator" means any person having designated responsibility and legal authority from the owner to administer and manage a medical care facility. See definition of "owner."

"Other plans" means any plan(s) which is formally adopted by an official state agency or regional health planning agency and which provides for the orderly planning and development of medical care facilities and services and which is not otherwise defined in these regulations.

"Owner" means any person ~~which~~ *who* has legal responsibility and authority to construct, renovate or equip or otherwise control a medical care facility as defined herein.

"Person" means an individual, corporation, partnership, association or any other legal entity, whether governmental or private. Such person may also include *the following:*

1. The applicant for a certificate of public need;

2. The regional health planning agency for the health planning region in which the proposed project is to be located;

3. Any resident of the geographic area served or to be served by the applicant;

4. Any person who regularly uses health care facilities within the geographic area served or to be served by the applicant;

5. Any facility or health maintenance organization (HMO) established under § 38.2-4300 et seq. which is located in the health planning region in which the project is proposed and which provides services similar to the services of the medical care facility project under review;

6. Third party payors who provide health care insurance or prepaid coverage to 5.0% or more patients in the health planning region in which the project is proposed to be located; and

7. Any agency which reviews or establishes rates for health care facilities.

"Physician's office" means a place, owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever, which is designed and equipped solely for the provision of fundamental medical care whether diagnostic, therapeutic, rehabilitative, preventive or palliative to ambulatory patients and which does not participate in cost-based or facility reimbursement from third party health insurance programs or prepaid medical service plans excluding pharmaceuticals and other supplies administered in the office. *See definition of "medical care facility."*

"Planning district" means a contiguous area within the boundaries established by the Department of Planning and Budget as set forth in § 15.1-1402 of the Code of Virginia.

"Predevelopment site work" means any preliminary activity directed towards preparation of the site prior to the completion of the building foundations. This includes, but is not limited to, soil testing, clearing, grading, extension of utilities and power lines to the site.

"Progress" means actions which are required in a given period of time to complete a project for which a certificate of public need has been issued. See § ~~6.3~~ *7.3* on Progress.

"Project" means:

1. The establishment of a medical care facility. See definition of "medical care facility."

2. An increase in the total number of beds *or operating rooms* in an existing or authorized medical care facility.

3. Relocation *at the same site* of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of 10% of its beds as nursing home beds as provided in § 32.1-132 of the Code of Virginia.

4. The introduction into any existing medical care facility of any new nursing home service such as intermediate care facility services, extended care facility services or skilled nursing facility services except when such medical care facility is an existing nursing home as defined in § 32.1-123 of the Code *of Virginia* .

5. The introduction into an existing medical care facility of any new ~~open heart surgery, psychiatric, medical rehabilitation, or substance abuse treatment service which the facility has never provided or has not provided in the previous 12 months.~~ *cardiac catheterization, computed tomography (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), medical rehabilitation, neonatal special care services, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, organ or tissue transplant service, radiation therapy, single photon emission computed tomography (SPECT), psychiatric, substance abuse treatment, or such other specialty clinical services as may be designated by the board by regulation, which the facility has never provided or has not provided in the previous 12 months.*

6. The addition or replacement by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomography (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, single photon emission computed tomography (SPECT), or other specialized service designated by the board by regulation, except for the replacement of any medical equipment identified in this part which the commissioner has determined to be an emergency in accordance with § 3.5 of these regulations.

7. Any capital expenditure of $1 million or more by or on behalf of a medical care facility which is not defined as reviewable under this definition. See definition of "capital expenditure."

"Public hearing" means a proceeding conducted by a regional health planning agency at which an applicant for a certificate of public need and members of the public may present oral or written testimony in support or opposition to the application which is the subject of the proceeding and for which a verbatim record is made. See subsection A of § 5.7.

"Regional health plan" means the regional plan adopted by the regional health planning agency board.

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Virginia Health Planning Board to perform health planning activities within a health planning region.

~~*"Registration"* means the recordation of the establishment of certain new or expansion of existing clinical health services, acquisition of certain major medical equipment or initiation of certain capital expenditures as required by §§ 3.2 and 3.3.~~

"Schedule for completion" means a timetable which identifies the major activities required to complete a project as identified by the applicant and which is set forth on the certificate of public need. The timetable is used by the commissioner to evaluate the applicant's progress in completing an approved project.

"Significant change" means any alteration, modification or adjustment to a reviewable project for which a certificate of public need has been issued or requested following the public hearing which:

1. Changes the site;

2. Increases the capital expenditure amount ~~approved~~ *authorized by the commissioner on the certificate of public need issued* for the project by 10% or more;

3. Changes the service(s) proposed to be offered;

4. Extends the schedule for completion of the project beyond three years (36 months) from the date of certificate issuance or beyond the time period approved by the commissioner at the date of certificate issuance, whichever is greater. See §§ ~~6.2 and 6.3~~ *7.2 and 7.3* .

"State health plan" means the document approved by the Virginia Health Planning Board which shall include, but not be limited to, analysis of priority health issues, policies, needs and methodologies for assessing statewide health care needs. The State Health Plan 1980-84 and all amendments thereto including all methodologies therein shall remain in force and effect until any such regulation is amended, modified or repealed by the Board of Health.

"State Medical Facilities Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to (i) methodologies for projecting need for medical care facility beds and

services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services. In developing the plan, the Board of Health shall take into consideration the policies and recommendations contained in the State Health Plan. The most recent applicable State Medical Facilities Plan shall remain in force until any such regulation is amended, modified or repealed by the Board of Health.

"Virginia Health Planning Board" means the statewide health planning body established pursuant to § 32.1-122.02 of the Code of Virginia which serves as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning.

PART II.
GENERAL INFORMATION.

§ 2.1. Authority for regulations.

The Virginia Medical Care Facilities Certificate of Public Need Law, which is codified as §§ 32.1-102.1 through 32.1-102.11 of the Code of Virginia, requires the owners or sponsors of medical care facility projects to secure a certificate of public need from the State Health Commissioner prior to initiating such projects. Sections 32.1-102.2 and 32.1-12 of the Code of Virginia direct the Board of Health to promulgate and prescribe such rules and regulations as are deemed necessary to effectuate the purposes of this statute.

§ 2.2. Purpose of rules and regulations.

The board has promulgated these rules and regulations to set forth an orderly administrative process for making public need decisions.

§ 2.3. Administration of rules and regulations.

These rules and regulations are administered by the following:

A. State Board of Health.

The Board of Health is the governing body of the State Department of Health. The Board of Health has the authority to promulgate and prescribe such rules and regulations as it deems necessary to effectuate the purposes of the Act.

B. State Health Commissioner.

The State Health Commissioner is the executive officer of the State Department of Health. The commissioner is the designated decision maker in the process of determining public need under the Act.

§ 2.4. Public meetings and public hearings.

All meetings and hearings convened to consider any certificate of public need application shall be open to the public in accordance with the provisions of the Virginia Freedom of Information Act (§ 2.1-340 et seq.) of the Code of Virginia.

§ 2.5. Official records.

Written information including staff evaluations and reports and correspondence developed or utilized or received by the commissioner during the review of a medical care facility project shall become part of the official project record maintained by the Department of Health and shall be made available to the applicant, competing applicant and review bodies. Other persons may obtain a copy of the project record upon request. All records are subject to the Virginia Freedom of Information Act.

~~Exclusions. Information submitted to the commissioner to comply with registration requirements set forth in §§ 3.2 and 3.3 of these regulations shall be excluded from the provisions of the Virginia Freedom of Information Act until such time as the registered service or equipment becomes operational.~~

§ 2.6. Application of rules and regulations.

These rules and regulations have general applicability throughout the Commonwealth. The requirements of the Virginia Administrative Process Act (§ 9-6.14:1, et seq.) of the Code of Virginia apply to their promulgation.

~~§ 2.7. Effective date of rules and regulations.~~

~~These rules and regulations shall become effective June 6, 1992.~~

~~§ 2.8.~~ *§ 2.7.* Powers and procedures of regulations not exclusive.

The commissioner and the board reserve the right to authorize any procedure for the enforcement of these regulations that is not inconsistent with the provisions set forth herein and the provisions of § 32.1-102.1 et seq. of the Code of Virginia.

~~§ 2.9.~~ *§ 2.8.* Annual report.

The department shall prepare and shall distribute upon request an annual report on all certificate of public need applications considered by the State Health Commissioner. Such report shall include a general statement of the findings made in the course of each review, the status of applications for which there is a pending determination, an analysis of the consistency of the decisions with the recommendation made by the regional health planning agency and an analysis of the costs of authorized projects.

PART III.
MANDATORY REQUIREMENTS.

§ 3.1. Requirements for reviewable medical care facility projects.

Prior to initiating a reviewable medical care facility project the owner or sponsor shall obtain a certificate of public need from the commissioner. In the case of an acquisition of an existing medical care facility, the notification requirement set forth in § ~~3.7~~ *§ 3.2* of these regulations shall be met.

~~§ 3.2. Requirements for registration of affected clinical health services and major medical equipment.~~

~~At least 30 days prior to (i) establishing a new or expanding an existing clinical health service or (ii) the date of contractual obligation or other commitment to acquire any major medical equipment with an expenditure or expenditure value of $400,000 or more which is not defined as a project under these regulations, and has not been previously authorized by the commissioner prior to July 1, 1989, the owner of any medical care facility listed in these regulations, physician's office, or specialized center or clinic shall register such services or acquisitions of equipment with the commissioner. The format for registration shall be prescribed by the commissioner and shall include information concerning the owner and operator, description, site, capital, financing and lease costs, beginning date and hours of operation of clinical health service and major medical equipment. For purposes of registration, (i) owner shall include any person offering affected clinical health services and major medical equipment and (ii) affected clinical health services and major medical equipment shall include only the following:~~

~~1. radiation therapy;.~~

~~2. cardiac catheterization;~~

~~3. obstetrical;~~

~~4. neonatal special care unit;~~

~~5. lithotripsy;~~

~~6. magnetic resonance imaging;~~

~~7. position emission tomography (PET) scanning;~~

~~8. computed tomography (CT) scanning;~~

~~9 heart, lung, and kidney, other major internal organ or tissue transplants~~

~~10. other specialized services or major medical equipment that evolves through changes in medical technology upon designation by the commissioner.~~

~~The commissioner shall acknowledge the registration within 15 days of receipt.~~

~~§ 3.3. Requirements for registration of capital expenditures.~~

~~At least 30 days prior to making a capital expenditure of $1,000,000 or more which is not defined as a project under these regulations and has not been previously authorized by the commissioner, the owner of any medical care facility as defined in these regulations, physician's office, or specialized center or clinic, shall register in writing such expenditure with the commissioner. The format for registration shall be prescribed by the commissioner and shall include information concerning the purpose of such expenditure and projected impact that the expenditure will have upon the charges for services. For purposes of registration, the owner shall include any person making the affected capital expenditure.~~

~~§ 3.4. Reporting requirements for registered services and equipment.~~

~~Owners of services and equipment registered in accordance with § 3.2 of these regulations shall report to the commissioner on a quarterly basis information concerning patient volumes, morbidity and mortality, aggregate costs and charges, and other information which is designated by the commissioner about the services provided. Data reports shall be provided on a format prescribed by the commissioner and shall cover the periods of July 1 through September 30; October 1 through December 31; January 1 through March 31; and April 1 through June 30. Reports shall be submitted to the commissioner within 30 days following the last day of the quarter report period in which the registered service or equipment becomes operational and 30 days following the last day of every quarter report period thereafter.~~

~~§ 3.5. Penalties for noncompliance with registration and reporting requirements.~~

~~Any person willfully refusing, failing or neglecting to comply with registration or reporting requirements set forth in §§ 3.2, 3.3 and 3.4 of these regulations will be subject to a civil penalty of $100 per violation per day from the date written notification is received from the department until the required registration or reporting forms are submitted to the department. Upon information and belief that a person has failed to comply with registration and reporting requirements in accordance with this provision, the department shall notify the person in writing, and 15 days shall be provided for a response in writing, including a plan for immediate correction. In the absence of adequate response or the necessary compliance or both, a judicial action shall be initiated in accordance with provisions of § 32.1-27 of the Code.~~

~~§ 3.6. Confidentiality of information.~~

~~Information provided to the department by persons to satisfy registration requirements set forth in §§ 3.2 and 3.3 of these regulations shall be excluded from the provisions of the Virginia Freedom of Information Act as provided in § 2.1-342 of the Code of Virginia until such time as the~~

~~new or expanded clinical health service becomes operational. In accordance with this provision, the department shall not provide information it receives about registered services to any person until the new or expanded service becomes operational. Persons registering the new service or equipment or capital expenditure shall notify the department in writing of the date the service or equipment becomes operational or the expenditure is made and provide a copy of this notification to the appropriate regional health planning agency.~~

§ ~~3.7.~~ *§ 3.2.* Requirement for notification of proposed acquisition of medical care facilities.

At least 30 days before any person is contractually obligated to acquire an existing medical care facility, the cost of which is $700,000 or more, that person shall provide written notification to the commissioner and the regional health planning agency that serves the area in which the facility is located. Such notification shall identify the name of the medical care facility, the current and proposed owner, the cost of the acquisition, the services to be added or deleted, the number of beds to be added or deleted, and the projected impact that the cost of the acquisition will have upon the charges of the services to be provided in the medical care facility. The commissioner shall provide written notification to the person who plans to acquire the medical care facility within 30 days of receipt of the required notification. If the commissioner finds that a reviewable clinical health service or beds are to be added as a result of the acquisition, the commissioner may require the proposed new owner to obtain a certificate prior to the acquisition. If such certificate is required, an application will be considered under an appropriate batch group which will be identified at the time of written notification by the commissioner to the applicant for such acquisition.

§ ~~3.8.~~ *§ 3.3.* Significant change limitation.

No significant change in a project for which a certificate of public need has been issued shall be made without prior written approval of the commissioner. Such request for a significant change shall be made in writing by the owner to the commissioner with a copy to the appropriate regional health planning agency. The owner shall also submit the application fee to the department if applicable at the time the written request is made. The written request shall identify the nature and purpose of the change. The regional health planning agency shall review the proposed change and notify the commissioner of its recommendation with respect to the change within 30 days from receipt of the request by both the department and the regional health planning agency. Failure of the regional health planning agency to notify the commissioner within the 30-day period shall constitute a recommendation of approval. The commissioner shall act on the significant change request within 35 days of receipt. A public hearing during the review of a proposed significant change request is not required unless determined necessary by the commissioner. The commissioner shall not approve a significant change in cost for a project which exceeds the authorized capital expenditure by more than 20%. The commissioner shall not extend the schedule for completion of a project beyond three years from the date of issuance of the certificate or beyond the time period approved by the commissioner at the date of certificate issuance, whichever is greater, except when delays in completion of a project have been caused by events beyond the control of the owner and the owner has made substantial and continuing progress toward completion of the project.

§ ~~3.9.~~ *§ 3.4.* Requirements for health maintenance organizations *(HMO)* .

An HMO must obtain a certificate of public need prior to initiating a project. Such HMO must also adhere to the requirements for the acquisition of medical care facilities if appropriate. See definition of "project" and § ~~3.7~~ *§ 3.2* .

§ 3.5. Requirements for emergency replacement of equipment.

The commissioner shall consider requests for emergency replacement of medical equipment as identified in Part I of these regulations. Such an emergency replacement is not a "project" of a medical care facility requiring a certificate of public need. To request authorization for such replacement, the owner of such equipment shall submit information to the commissioner to demonstrate that (i) the equipment is inoperable as a result of a mechanical failure, Act of God, or other reason which may not be attributed to the owner and the repair of such equipment is not practical or feasible; or (ii) the immediate replacement of the medical equipment is necessary to maintain an essential clinical health service or to assure the safety of patients or staff.

For purposes of this section, "inoperable" means that the equipment cannot be put into use, operation, or practice to perform the diagnostic or therapeutic clinical health service for which it was intended.

Within 15 days of the receipt of such requests the commissioner will notify the owner in the form of a letter of the decision to deny or authorize the emergency replacement of equipment.

PART IV.
DETERMINATION OF PUBLIC NEED ~~(REQUIRED CONSIDERATIONS)~~ .

§ 4.1. *Required considerations.*

In determining whether a public need exists for a proposed project, the following factors shall be taken into account when applicable:

~~A.~~ *1.* The recommendation and the reasons therefor of the appropriate regional health planning agency.

~~B.~~ *2.* The relationship of the project to the applicable health plans of the regional health planning agency, and the Virginia Health Planning Board and the Board of Health.

~~C.~~ *3.* The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

~~D.~~ *4.* The need that the population served or to be served by the project has for the project.

~~E.~~ *5.* The extent to which the project will be accessible to all residents of the area proposed to be served.

~~F.~~ *6.* The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health planning region in which the project is proposed.

~~G.~~ *7.* Less costly or more effective alternate methods of reasonably meeting identified health service needs.

~~H.~~ *8.* The immediate and long-term financial feasibility of the project.

~~I.~~ *9.* The relationship of the project to the existing health care system of the area in which the project is proposed.

~~J.~~ *10.* The availability of resources for the project.

~~K.~~ *11.* The organizational relationship of the project to necessary ancillary and support services.

~~L.~~ *12.* The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.

~~M.~~ *13.* The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health planning region in which the project is to be located.

~~N.~~ *14.* The need and the availability in the health planning region for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

~~O.~~ *15.* The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the commissioner may grant a certificate for a project if the commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organizations or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other maintenance organizations in a reasonable and cost effective manner.

~~P.~~ *16.* The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

~~Q.~~ *17.* The costs and benefits of the construction associated with the proposed project.

~~R.~~ *18.* The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

~~S.~~ *19.* Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

~~T.~~ *20.* In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed.

PART V.
REVIEW PROCESS.

§ 5.1. Preconsultation.

Each regional health planning agency and the department shall provide upon request advice and assistance concerning community health resources needs to potential applicants. Such advice and assistance shall be advisory only and shall not be a commitment on behalf of the regional health planning agency or the commissioner.

§ 5.2. Application forms.

A. Letter of intent.

~~At least 30 days prior to submission of an application,~~ An applicant shall file a letter of intent with the commissioner to request appropriate application forms *by the later of (i) 30 days prior to the submission of an application for a project included within a particular batch group or (ii) 10 days after the first letter of intent is filed for a project within a particular batch group to be located within the same health planning region as that of the applicant* . The letter shall identify the owner, the type of project for which an application is requested, and the proposed scope (size) and location of the proposed project. A copy of the letter shall also be submitted by the applicant to the appropriate regional health planning

agency. The department shall transmit application forms to the applicant within seven days of the receipt of the letter of intent. *See § 6.4 C.*

B. Application fees.

The department shall collect application fees for applications submitted requesting a certificate of public need. The fee required for an application is the lesser of 0.5% of the proposed capital expenditure for the project or $5,000. No application will be deemed to be complete for review until the required application fee is paid. *See § 6.4 C.*

C. Filing application forms.

Applications must be submitted at least 40 days prior to the first day of a scheduled review cycle to be considered for review in the same cycle. All applications including the required data and information shall be prepared in triplicate; two copies to be submitted to the department; one copy to be submitted to the appropriate regional health planning agency ~~; and the application fee has been paid to the department~~ . No application shall be deemed to have been submitted until required copies have been received by the department and the appropriate regional health planning agency *, and the application fee has been paid to the department* .

§ 5.3. Review for completeness.

The applicant shall be notified by the department within 15 days following receipt of the application if additional information is required to complete the application or the application is complete as submitted. No application shall be reviewed until the department has determined that it is complete. To be complete, all questions must be answered to the satisfaction of the commissioner and all requested documents supplied, when applicable and the application fee submitted. Additional information required to complete an application shall be submitted to the department and the appropriate regional health planning agency *at least* five days prior to the first day of a review cycle to be considered complete for review in the same review cycle. In the event that the first day of a review cycle falls on the weekend, the review of the completed application will begin on the next work day.

§ 5.4. One hundred twenty-day review cycle.

The department shall review the following groups of completed applications in accordance with the following 120-day scheduled review cycles and the following descriptions of projects within each group, except as provided for in § 5.6.

BATCH GROUP	GENERAL DESCRIPTION	REVIEW CYCLE Begins	Ends
A	General *hospitals/* ~~Hospital Beds/~~ ~~Ambulatory Surgery Centers~~ *Obstetrical Services/ Neonatal Special Care Services*	Feb. 10 Aug. 10	June 10 Dec. 8
~~B~~	~~Psychiatric Facility Beds/ Services~~	~~Apr. 10~~ ~~Oct. 10~~	~~Aug. 8~~ ~~Feb. 7~~
B	*Open Heart Surgery/Cardiac Catheterization/Ambulatory Surgery Centers/ Operating Room Additions/Transplant Services*	*Mar. 10* *Sep. 10*	*July 8* *Jan. 8*
~~C~~	~~Medical Rehabilitation Beds/ Services~~	~~Jun. 10~~ ~~Dec. 10~~	~~Oct. 8~~ ~~Apr. 9~~
C	*Psychiatric Facilities/ Substance Abuse Treatment/ Mental Retardation Facilities*	*Apr. 10* *Oct. 10*	*Aug. 8* *Feb. 7*
~~D~~	~~Open Heart Surgery Services~~	~~Feb. 10~~ ~~Aug. 10~~	~~Jun. 10~~ ~~Dec. 8~~
D	*Diagnostic Imaging Facilities/ Services*	*May 10* *Nov. 10*	*Sep. 7* *Mar. 10*
~~E~~	~~Substance Abuse Treatment Beds/Services/Mental Retardation Facilities~~	~~Apr. 10~~ ~~Oct. 10~~	~~Aug. 8~~ ~~Feb. 7~~
E	*Medical Rehabilitation Beds/ Services*	*June 10* *Dec. 10*	*Oct. 8* *Apr. 9*
F	*Selected Therapeutic Facilities/ Services*	*July 10* *Jan. 10*	*Nov. 7* *May 9*
~~F~~ G	Nursing Home Beds/Services		
	Planning Districts 6, 11 & 22	Feb. 10	June 10
	Planning Districts 1, 9, 13 & 20	Apr. 10	Aug. 8
	Planning Districts 3, 8, 14 & 16	June 10	Oct. 8
	Planning Districts 5, 17, 18 & 19	Aug. 10	Dec. 8
	Planning Districts 2, 10 & 15	Oct. 10	Feb. 7
	Planning Districts 4, 7, 12 & 21	Dec. 10	Apr. 9

Batch Group A includes:

1. The establishment of a ~~new~~ general hospital.

2. An increase in the total number of general acute care beds in an existing or authorized general hospital.

3. The relocation *at the same site* of 10 general hospital beds or 10% of the general hospital beds of a ~~general hospital~~ *medical care facility* , whichever is less, from one existing physical facility to any other in any two-year period.

~~4. The establishment of a new ambulatory surgery center.~~

4. The introduction into an existing medical care facility of any new neonatal special care or obstetrical services which the facility has never provided or has not provided in the previous 12 months.

5. Any capital expenditure of $1 million or more, not defined as a project category included in Batch Groups B through G, by or in behalf of a general hospital.

Batch Group B includes:

~~1. The establishment of a new mental hospital or psychiatric hospital.~~

~~2. An increase in the total number of beds in an existing or authorized mental hospital or psychiatric hospital.~~

~~3. An increase in the total number of mental hospital or psychiatric hospital beds in an existing or authorized medical care facility which is not a dedicated mental hospital or psychiatric hospital which increases the total number of beds in the existing or authorized medical care facility.~~

~~4. The relocation of 10 mental hospital or psychiatric hospital beds or 10% of the mental hospital or psychiatric hospital beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period.~~

~~5. The introduction into an existing medical care facility of any new psychiatric service which the facility has never provided or has not provided in the previous 12 months.~~

1. The establishment of a specialized center, clinic, or portion of a physician's office developed for the provision of outpatient or ambulatory surgery or cardiac catheterization services.

2. An increase in the total number of operating rooms in an existing medical care facility or establishment of operating rooms in a new facility.

3. The introduction into an existing medical care facility of any new cardiac catheterization, open heart surgery, or organ or tissue transplant services which the facility has never provided or has not provided in the previous 12 months.

4. The addition or replacement by an existing medical care facility of any medical equipment for the provision of cardiac catheterization services.

5. Any capital expenditure of $1 million or more, not defined as a project category in Batch Group A or Batch Groups C through G, by or in behalf of a specialized center, clinic, or portion of a physician's office developed for the provision of outpatient or ambulatory surgery or cardiac catheterization services.

6. Any capital expenditure of $1 million or more, not defined as a project category in Batch Group A or Batch Groups C through G, by or in behalf of a medical care facility, which is primarily related to the provision of surgery, cardiac catheterization, open heart surgery, or organ or tissue transplant services.

Batch Group C includes:

~~1. The establishment of a new medical rehabilitation hospital.~~

~~2. An increase in the total number of beds in an existing or authorized medical rehabilitation hospital.~~

~~3. An increase in the total number of medical rehabilitation beds in an existing or authorized medical care facility which is not a dedicated medical rehabilitation hospital which increases the total number of beds in the existing or authorized medical care facility.~~

~~4. The relocation of 10 medical rehabilitation beds or 10% of the medical rehabilitation beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period.~~

~~5. The introduction into an existing medical care facility of any new medical rehabilitation service which the facility has never provided or has not provided in the previous 12 months.~~

1. The establishment of a mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.

2. A increase in the total number of beds in an existing or authorized mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.

3. An increase in the total number of mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds in an existing or authorized medical care facility which is not a dedicated mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility which increases the total number of beds in the existing or authorized medical care

facility.

4. The relocation at the same site of 10 mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds or 10% of the mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period.

5. The introduction into an existing medical care facility of any new psychiatric or substance abuse treatment service which the facility has never provided or has not provided in the previous 12 months.

6. Any capital expenditure of $1 million or more, not defined as a project category in Batch Groups A and B or Batch Groups D through G, by or in behalf of a mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facilities.

7. Any capital expenditure of $1 million or more, not defined as a project category in Batch Groups A and B or Batch Groups D through G, by or in behalf of a medical care facility, which is primarily related to the provision of mental health, psychiatric, substance abuse treatment or rehabilitation, or mental retardation services.

Batch Group D includes:

~~The introduction into an existing medical care facility of any new open heart surgery service which the facility has never provided or has not provided in the previous 12 months.~~

1. The establishment of a specialized center, clinic, or that portion of a physician's office developed for the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or single photon emission computed tomography (SPECT).

2. The introduction into an existing medical care facility of any new computed tomography (CT), magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or single photon emission computed tomography (SPECT) services which the facility has never provided or has not provided in the previous 12 months.

3. The addition or replacement by an existing medical care facility of any equipment for the provision of computed tomography (CT), magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or single photon emission computed tomography (SPECT).

4. Any capital expenditure of $1 million or more, not defined as a project category in Batch Groups A through C or Batch Groups E through G, by or in behalf of a specialized center, clinic, or that portion of a physician's office developed for the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or single photon emission computed tomography (SPECT).

5. Any capital expenditure of $1 million or more, not defined as a project category in Batch Groups A through C or Batch Groups E through G, by or in behalf of a medical care facility, which is primarily related to the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or single photon emission computed tomography (SPECT).

Batch Group E includes:

~~1. The establishment of an intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.~~

~~2. An increase in the total number of beds in an existing or authorized intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts or a mental retardation facility.~~

~~3. An increase in the total number of substance abuse treatment beds or mental retardation beds in an existing or authorized medical care facility which is not a dedicated intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or a mental retardation facility, which increases the total number of beds in the existing or authorized medical care facility.~~

~~4. The relocation of 10 substance abuse treatment beds or 10% of the substance abuse treatment or mental retardation beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period.~~

~~5. The introduction into an existing medical care facility of any new substance abuse treatment service which the facility has never provided or has not provided in the previous 12 months.~~

1. The establishment of a medical rehabilitation hospital.

2. An increase in the total number of beds in an existing or authorized medical rehabilitation hospital.

3. An increase in the total number of medical rehabilitation beds in an existing or authorized medical care facility which is not a dedicated medical rehabilitation hospital which increases the total number of beds in the existing or authorized medical care facility.

4. The relocation at the same site of 10 medical rehabilitation beds or 10% of the medical rehabilitation beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period.

5. The introduction into an existing medical care facility of any new medical rehabilitation service which the facility has never provided or has not provided in the previous 12 months.

6. Any capital expenditure of $1 million or more, not defined as a project category in Batch Groups A through D or Batch Groups F and G, by or in behalf of a medical rehabilitation hospital.

7. Any capital expenditure of $1 million or more, not defined as a project category in Batch Groups A through D or Batch Groups F and G, by or in behalf of a medical care facility, which is primarily related to the provision of medical rehabilitation services.

Batch Group F includes:

1. The establishment of a specialized center, clinic, or that portion of a physician's office developed for the provision of gamma knife surgery, lithotripsy, or radiation therapy.

2. Introduction into an existing medical care facility of any new gamma knife surgery, lithotripsy, or radiation therapy services which the facility has never provided or has not provided in the previous 12 months.

3. The addition or replacement by an existing medical care facility of any medical equipment for the provision of gamma knife surgery, lithotripsy, or radiation therapy.

4. Any capital expenditure of $1 million or more, not defined as a project in Batch Groups A through E or Batch Group G, by or in behalf of a specialized center, clinic, or that portion of a physician's office developed for the provision of gamma knife surgery, lithotripsy, or radition therapy.

5. Any capital expenditure of $1 million or more, not defined as a project in Batch Groups A through E or Batch Group G, by or in behalf of a medical care facility, which is primarily related to the provision of gamma knife surgery, lithotripsy, or radiation therapy.

Batch Group ~~F~~ *G* includes:

1. The establishment of a nursing home, intermediate care facility, or extended care facility.

2. An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility.

3. An increase in the total number of nursing home beds, intermediate care facility beds, or extended care facility beds in an existing or authorized medical care facility which is not a dedicated nursing home, intermediate care facility, or extended care facility.

4. The relocation *at the same site* of 10 nursing home, intermediate care facility, or extended care facility beds or 10% of the nursing home, intermediate care facility, or extended care facility beds of a medical care facility, whichever is less, from one physical facility to another in any two-year period.

5. The introduction into any existing medical care facility of any new nursing home service such as intermediate care facility services, extended care facility services or skilled nursing facility services except when such medical care facility is an existing nursing home as defined in § 32.1-123 of the Code *of Virginia* .

6. Any capital expenditure of $1 million or more, not defined as a project category in Batch Groups A through F, by or in behalf of a nursing home, intermediate care facility, or extended care facility.

7. Any capital expenditure of $1 million or more, not defined as a project category in Batch Groups A through F, by or in behalf of a medical care facility, which is primarily related to the provision of nursing home, intermediate care, or extended care services.

§ 5.5. Requests for application (RFA).

The commissioner may request the submission of applications for his consideration which address a specific need for services and facilities as identified in the State Medical Facilities Plan. The department shall give notice of such RFA in a newspaper of general circulation in the locality or the planning district where the specific services or facility is requested. Such notice shall be published at least 120 days prior to the first day of the appropriate review cycle for the type of project being requested. A written copy of an RFA shall also be available upon request from the department and the regional health planning agency in the appropriate geographic area. The process for adoption of an RFA by the commissioner shall be set forth in the State Medical Facilities Plan.

§ 5.6. Consideration of applications.

Applications for the same or similar services which are proposed for the same planning district or medical service area shall be considered as competing applications by the commissioner. The commissioner shall determine ~~if~~ *whether* an application is competing and shall provide written notification to the competing applicants and the regional health planning agency. The commissioner may, upon the request of an applicant, waive the review schedule requirements of § 5.4 in the case of a documented emergency *or in cases where, as of the deadline for filing a letter of intent for the otherwise applicable cycle, there are no competing applicants, and the applicant who has filed a letter of intent for a particular project proposes to combine the intended project with another related project for which an application will be filed in a subsequent batch group* .

§ 5.7. Review of complete application.

A. Review cycle.

At the close of the work day on the 10th day of the month, the department shall provide written notification to applicants specifying the acceptance date and review schedule of completed applications including a proposed date for any informal fact-finding conference that may be held. The regional health planning agency shall conduct no more than two meetings, one of which must be a public hearing conducted by the regional health planning agency board or a subcommittee of the board and provide applicants with an opportunity, prior to the vote, to respond to any comments made about the project by the regional health planning agency staff, any information in a staff report, or comments by those voting in completing its review and recommendation by the 60th day of the cycle. By the 70th day of the review cycle, the department shall complete its review and recommendation of an application and transmit the same to the applicant(s) and other appropriate persons. Such notification shall also include the proposed date, time and place of any informal fact-finding conference.

An informal fact-finding conference shall be held when (i) determined necessary by the department or (ii) requested by any person opposed to a project seeking to demonstrate good cause at the conference. Any person seeking to demonstrate good cause shall file, no later than seven days prior to the conference, written notification with the commissioner, applicant(s) and other competing applicants, and regional health planning agency stating the grounds for good cause.

For purposes of this section, "good cause" ~~shall mean~~ *means* that (i) there is significant, relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing or (iii) there is a substantial material mistake of fact or law in the department staff's report on the application or in the report submitted by the regional health planning agency. See § 9-6.14:11 of the Code of Virginia.

The commissioner shall render a final determination by the 120th day of the review cycle. Unless agreed to by the applicant and, when applicable, the parties to any informal fact-finding conference held, the review schedule shall not be extended.

B. Regional health planning agency required notifications.

Upon notification of the acceptance date of a complete application as set forth in subsection A of § ~~6.6 of these regulations~~ *this section* , the regional health planning agency shall provide written notification of its review schedule to the applicant. The regional health planning agency shall notify health care providers and specifically identifiable consumer groups who may be affected by the proposed project directly by mail and shall also give notice of the public hearing in a newspaper of general circulation in such county or city wherein a project is proposed or a contiguous county or city at least nine days prior to such public hearing. Such notification by the regional health planning agency shall include: (i) the date and location of the public hearing which shall be conducted on the application except as otherwise provided in these rules and regulations, in the county or city wherein a project is proposed or a contiguous county or city and (ii) the date, time and place the final recommendation of the regional health planning agency shall be made. The regional health planning agency shall maintain a verbatim record which may be a tape recording of the public hearing. Such public hearing record shall be maintained for at least a one-year time period following the final decision on a certificate of public need application. See definition of "public hearing."

C. Ex parte contact.

After commencement of a public hearing and before a final decision is made, there shall be no ex parte contacts between the State Health Commissioner and any person acting on behalf of the applicant or holder of a certificate or any person opposed to the issuance or in favor of revocation of a certificate of public need, unless written notification has been provided. See definition of "ex parte."

§ 5.8. Participation by other persons.

Any person affected by a proposed project under review may directly submit written opinions, data and other information to the appropriate regional health planning agency and the commissioner for consideration prior to their final action.

§ 5.9. Amendment to an application.

The applicant shall have the right to amend an application at any time. Any amendment which is made to an application following the public hearing and prior to

the issuance of a certificate unless otherwise specified in these regulations shall constitute a new application and shall be subject to the review requirements set forth in Part V of the regulations. If such amendment is made subsequent to the issuance of a certificate of public need, it shall be reviewed in accordance with § ~~3.8~~ *§ 3.3* of the regulations.

§ 5.10. Withdrawal of an application.

The applicant shall have the right to withdraw an application from consideration at any time, without prejudice by written notification to the commissioner.

§ 5.11. Action on an application.

A. Commissioner's responsibility.

Decisions as to approval or disapproval of applications or a portion thereof for certificates of public need shall be rendered by the commissioner. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State Health Plan or State Medical Facilities Plan. However, if the commissioner finds, upon presentation of appropriate evidence, that the provisions of either such plan are inaccurate, outdated, inadequate or otherwise inapplicable, the commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan.

Conditions of approval. The commissioner may condition the approval of an application for a project on the agreement by the applicant to provide an acceptable level of free care or care at a reduced rate to indigents or to provide care to persons with special needs. The terms of such agreements shall be specified in writing prior to the commissioner's decision to approve a project. Any person willfully refusing, failing or neglecting to honor such agreement shall be subject to a civil penalty of $100 per violation per day from the date of receipt from the department of written notice of noncompliance until the date of compliance. Upon information and belief that a person has failed to honor such agreement in accordance with this provision, the department shall notify the person in writing and 15 days shall be provided for response in writing including a plan for immediate correction. In the absence of an adequate response or necessary compliance or both, a judicial action shall be initiated in accordance with the provisions of § 32.1-27 of the Code *of Virginia* .

B. Notification process-extension of review time.

The commissioner shall make a final determination on an application for a certificate of public need and provide written notification detailing the reasons for such determination to the applicant with a copy to the regional health planning agency by the 120th day of the review cycle unless an extension is agreed to by the applicant and an informal fact-finding conference described in § 5.7 is held. When an informal fact-finding conference is held, the 120-day review cycle shall not be extended unless agreed to by the parties to the conference. Such written notification shall also reference the factors and bases considered in making a decision on the application and, if applicable, the remedies available for appeal of such decision and the progress reporting requirements. The commissioner may approve a portion of a project provided the portion to be approved is agreed to by the applicant following consultation, which may be subject to the ex parte provision of these regulations, between the commissioner and the applicant.

PART VI.
EXPEDITED REVIEW PROCESS.

§ 6.1. Applicability.

Projects of medical care facilities that satisfy the criteria set forth below as determined by the State Health Commissioner shall be subject to an expedited review process:

1. Relocation at the same site of 10 beds or 10% of the beds, whichever is less, from on existing physical facility to another when the cost of such relocation is less than $1 million.

2. The replacement at the same site by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomography (CT), lithotripsy, magnetic resonance imaging (MRI), open heart surgery, positron emission tomographic scanning (PET), radiation therapy, or single photon emission computed tomography (SPECT) when the medical care facility meets applicable standards for replacement of such medical equipment which are set forth in the State Medical Facilities Plan.

§ 6.2. Application forms.

A. Obtaining application forms.

Application forms for an expedited review shall be available from the department upon the written request of the applicant. The request shall identify the owner, the type of project for which forms are requested and the location of the proposed project. A copy of this request shall also be submitted by the applicant to the appropriate regional health planning agency. The department shall transmit application forms to the applicant within seven days of receipt of such request.

B. Application fees.

The department shall collect application fees for applications submitted requesting a certificate of public need under the expedited review process. The fee required for an application is the lesser of 0.5% of the proposed capital expenditure for the project or $5,000. No application will be reviewed until the required application

fee is paid.

C. Filing application forms.

All requests for a certificate of public need in accordance with the expedited review process shall be reviewed by the department and the regional health planning agency which shall each forward a recommendation to the commissioner within 40 days from the date the submitted application has been deemed complete. No application for expedited review shall be deemed to have been submitted until the application form has been received by the department and the appropriate regional health planning agency, has been deemed complete, and the application fee has been paid to the department.

§ 6.3. Participation by other persons.

Any person directly affected by the review of a project under the expedited review process may submit written opinions, data and other information to the appropriate regional health planning agency and to the commissioner prior to their final action.

§ 6.4. Action on application.

A. Decisions to approve any project under the expedited review process shall be rendered by the commissioner within 45 days of the receipt of such request. The commissioner shall approve and issue a certificate for any project which is determined to meet the criteria for expedited review set forth in § 6.1.

B. If the commissioner determines that a project does not meet the criteria for an expedited review set forth in § 6.1, the applicant will be notified in writing of such determination within 45 days of the receipt of such request. In such cases, the department will forward the appropriate forms to the project applicant for use in filing an application for review of a project in the appropriate review cycle in accordance with Part V of these regulations.

C. Any project which does not qualify for an expedited review in accordance with § 6.1, as determined by the commissioner, shall be exempted from the requirements of §§ 5.2 A and 5.2 B when such project is filed for consideration in accordance with Part V of these regulations.

PART ~~VI~~ *VII* .
DURATION/EXTENSION/REVOCATION OF CERTIFICATES.

§ ~~6.1~~ *§ 7.1* . Duration.

A certificate of public need shall be valid for a period of 12 months and shall not be transferrable from the certificate holder to any other legal entity regardless of the relationship, under any circumstances.

§ ~~6.2~~ *§ 7.2* . Extension.

A certificate of public need is valid for a 12-month period and may be extended by the commissioner for additional time periods which shall be specified at the time of the extension.

A. Basis for certificate extension within 24 months.

An extension of a certificate of public need beyond the expiration date may be granted by the commissioner by submission of evidence to demonstrate that progress is being made towards the completion of the authorized project as defined in § ~~6.3~~ *§ 7.3* of the regulations. Such request shall be submitted to the commissioner in writing with a copy to the appropriate regional health planning agency at least 30 days prior to the expiration date of the certificate or period of extension.

B. Basis for certificate extension beyond 24 months.

An extension of a certificate of public need beyond the two years following the date of issuance may be granted by the commissioner when substantial and continuing progress is being made towards the development of the authorized project. In making the determination, the commissioner shall consider whether: (i) any delays in development of the project have been caused by events beyond the control of the owner; (ii) substantial delays in development of the project may not be attributed to the owner; and (iii) a schedule of completion has been provided and determined to be reasonable. Such request shall be submitted in writing with a copy to the appropriate regional health planning agency at least 30 days prior to the expiration date of the certificate of period of extension. The commissioner shall not grant an extension to the schedule for completion of a project beyond three years (36 months) of the date of certificate issuance or beyond the time period approved at the date of certificate issuance, whichever is greater, unless such extension is authorized in accordance with the provisions for a significant change. See § ~~3.8~~ *§ 3.3* Significant change limitation.

C. Basis for indefinite extension.

A certificate shall be considered for an indefinite extension by the commissioner when satisfactory completion of a project has been demonstrated as set forth in subsection C of § ~~6.3~~ *§ 7.3* .

D. Regional health planning agency review.

All requests for an extension of a certificate of public need shall be reviewed by the appropriate regional health planning agency within 30 days of receipt by the department and the regional health planning agency. The recommendations on the request by that agency shall be forwarded to the commissioner who shall act upon the progress report within 35 days of receipt by the department and the regional health planning agency.

Failure of the regional health planning agency to notify the commissioner within the time frame prescribed shall constitute a recommendation of approval by such regional health planning agency.

E. Notification of decision.

Extension of a certificate of public need by the commissioner shall be made in the form of a letter from the commissioner with a copy to the appropriate regional health planning agency and shall become part of the official project file.

§ ~~6.3~~ *§ 7.3* . Demonstration of progress.

The applicant shall provide reports to demonstrate progress made towards the implementation of an authorized project in accordance with the schedule of development which shall be included in the application. Such progress reports shall be filed in accordance with the following intervals and contain such evidence as prescribed at each interval:

A. Twelve months following issuance. Documentation that shows: (i) proof of ownership or control of site; (ii) the site meets all zoning and land use requirements; (iii) architectural planning has been initiated; (iv) preliminary architectural drawings and working drawings have been submitted to appropriate state reviewing agencies and the State Fire Marshal; (v) construction financing has been completed or will be completed within two months and (vi) purchase orders of lease agreements exist for equipment and new service projects.

B. Twenty-four months following issuance. Documentation that shows that (i) all required financing is completed; (ii) preconstruction site work has been initiated; (iii) construction bids have been advertised and the construction contractor has been selected; (iv) the construction contract has been awarded and (v) construction has been initiated.

C. Upon completion of a project. Any documentation not previously provided which: (i) shows the final costs of the project, including the method(s) of financing; and (ii) shows that the project has been completed as proposed in accordance with the application originally submitted, including any subsequent approved changes. See "completion" in § 1.1.

§ ~~6.4~~ *§ 7.4* . Revocation of certificate.

A. Lack of progress.

Failure of any project to meet the progress requirements stated in § ~~6.3~~ *§ 7.4* shall be cause for certificate revocation, unless the commissioner determines sufficient justification exists to permit variance, considering factors enumerated in § ~~6.3~~ *§ 7.3* .

B. Failure to report progress.

Failure of an applicant to file progress reports on an approved project in accordance with § ~~6.3~~ *§ 7.3* of these regulations shall be cause for revocation, unless, due to extenuating circumstances, the commissioner, in his sole discretion, extends the certificate, in accordance with subsection B of § ~~6.2~~ *§ 7.2* of these regulations.

C. Unapproved changes.

Exceeding a capital expenditure amount not authorized by the commissioner or not consistent with the schedule of completion shall be cause for revocation. See definition of "significant change" and "schedule of completion."

D. Failure to initiate construction.

Failure to initiate construction of the project within two years following the date of issuance of the certificate of public need shall be cause for revocation, unless due to extenuating circumstances the commissioner extends the certificate, in accordance with subsection B of § ~~6.2~~ *§ 7.2* of these regulations.

E. Misrepresentation.

Upon determination that an applicant has knowingly misrepresented or knowingly withheld relevant data or information prior to issuance of a certificate of public need, the commissioner may revoke said certificate.

F. Noncompliance with assurances.

Failure to comply with the assurances or intentions set forth in the application or written assurances provided at the time of issuance of a certificate of public need shall be cause for revocation.

PART ~~VII~~ *VIII* .
APPEALS.

§ ~~7.1~~ *§ 8.1* . Court review.

A. Appeal to circuit court. Appeals to a circuit court shall be governed by applicable provisions of Virginia's Administrative Process Act, § 9-6.14:15 et seq. of the Code of Virginia.

Any applicant aggrieved by a final administrative decision on its application for a certificate, any third party payor providing health care insurance or prepaid coverage to 5.0% or more of the patients in the applicant's service area, a regional health planning agency operating in the applicant's service area or any person showing good cause or any person issued a certificate aggrieved by a final administrative decision to revoke said certificate, within 30 days after the decision, may obtain a review, as provided in § 9-6.14:17 of the Code of Virginia by the circuit court of the county or city where the project is intended to be or was constructed, located or undertaken. Notwithstanding the provisions of § 9-6.14:16 of the Administrative Process Act, no other person may obtain such review.

B. Designation of judge.

The judge of the court referred to in subsection A of § ~~7.1~~ ~~of~~ ~~these regulations~~ *this section* shall be designated by the Chief Justice of the Supreme Court from a circuit other than the circuit where the project is or will be under construction, located or undertaken.

C. Court review procedures.

Within five days after the receipt of notice of appeal, the department shall transmit to the appropriate court all of the original papers pertaining to the matter to be reviewed. The matter shall thereupon be reviewed by the court as promptly as circumstances will reasonably permit. The court review shall be upon the record so transmitted. The court may request and receive such additional evidence as it deems necessary in order to make a proper disposition of the appeal. The court shall take due account of the presumption of official regularity and the experience and specialized competence of the commissioner. The court may enter such orders pending the completion of the proceedings as are deemed necessary or proper. Upon conclusion of review, the court may affirm, vacate or modify the final administrative decision.

D. Further appeal.

Any party to the proceeding may appeal the decision of the circuit court in the same manner as appeals are taken and as provided by law.

PART ~~VIII~~ *IX* .
SANCTIONS.

§ ~~8.1~~ *§ 9.1* . Violation of rules and regulations.

Commencing any project without a certificate required by this statute shall constitute grounds for refusing to issue a license for such project.

§ ~~8.2~~ *§ 9.2* . Injunctive relief.

On petition of the commissioner, the Board of Health or the Attorney General, the circuit court of the county or city where a project is under construction or is intended to be constructed, located or undertaken shall have jurisdiction to enjoin any project which is constructed, undertaken or commenced without a certificate or to enjoin the admission of patients to the project or to enjoin the provision of services through the project.

PART ~~IX~~ *X* .
OTHER.

§ ~~9.1~~ *§ 10.1* . Certificate of public need moratorium.

Notwithstanding any law to the contrary, the Commissioner shall not approve, authorize or accept applications for the issurance of any certificate of public need pursuant to the regulations for a medical care facility project which would increase the number of nursing home beds from the effective date of the regulations through June 30, ~~1993~~ *1994* . However, the commissioner may approve or authorize the issuance of a certificate of public need for the following projects:

1. The renovation or replacement on site of a nursing home, intermediate care or extended care facility or any portion thereof or replacement off-site of an existing facility at a location within the same city or county and within reasonable proximity to the current site when replacement on the current site is proven unfeasible)when a capital expenditure is required to comply with life safety codes, licensure, certification or accreditation standards. Under no circumstances shall the State Health Commissioner approve, authorize, or accept an application for the issuance of a certificate for any project which would result in the continued use of the facility replaced as a nursing home.

2. The conversion on site of existing licensed beds of a medical care facility other than a nursing home, extended care, or intermediate care facility to beds certified for skilled nursing services (SNF) when (i) the total number of beds to be converted does not exceed the lesser of 20 beds or 10% of the beds in the facility; (ii) the facility has demonstrated that the SNF beds are needed specifically to serve as specialty heavy care patient population, such as ventilator-dependent and AIDS patients and that such patients otherwise will not have reasonable access to such services in existing or approved facilities; and (iii) the facility further commits to admit such patients on a priority basis once the SNF unit is certified and operational.

3. The conversion on site of existing beds in a home for adults facility licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1 *of the Code of Virginia* as of March 1, 1990, to beds certified as nursing facility beds when (i) the total number of beds to be converted does not exceed the less of 30 beds or 25% of the beds in the home for adults facility; (ii) the home for adults facility has demonstrated that nursing facility beds are needed specifically to serve a patient population of AIDS, or ventilator-dependent, or head and spinal cord injured patients, or any combination of the three, and that such patients otherwise will not have reasonable access to such services in existing or approved nursing facilities; (iii) the home for adults facility further commits to admit such patients once the nursing facility beds are certified and operational; and (iv) the licensed home for adults facility otherwise meets the standards for nursing facility beds as set forth in the regulations of the Board of Health.

4. Any project for an increase in the number of beds in which nursing home or extended care services are provided, or the creation of new beds in which such

services are to be provided, by a continuing care provider registered as of January 15, 1991, with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of ~~this Code~~ *the Code of Virginia* , if (i) the total number of new or additional nursing home beds does not exceed 32 when the beds are to be added by new construction, or 25 when the beds are to be added by conversion on site of existing beds in a home for adults facility licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1 *of the Code of Virginia* as of January 15, 1991, and (ii) such beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility pursuant to continuing care contracts meets the requirements of § 38.1-4905 *of the Code of Virginia* . No application for a certificate of public need for the creation or addition of nursing home beds pursuant to this section shall be accepted from a provider who, as of January 15, 1991, had an existing complement of beds, unless such provider agrees in writing not to seek certification for the use of such new or additional beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United State Social Security Act. Further, if a certificate is approved, pursuant to this section, to increase the number of nursing home beds for a provider who has an existing complement of such beds, admissions to such beds shall, thereafter, be restricted to persons who have entered into continuing care contracts meeting the requirements of § 38.2-4905 *of the Code of Virginia* .

5. Notwithstanding the foregoing and other provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code *of Virginia* , the state home for aged and infirm veterans authorized by Chapter 668, 1989 Acts of Assembly, shall be exempt from all certificate of public need review requirements as a medical care facility.

6. The development of a project in an existing nursing facility owned and operated by the governing body of a county when (i) the total number of new beds to be added by construction does not exceed the lesser of 30 beds or 25% of the existing nursing home beds in the facility; (ii) the facility has demonstrated that the nursing home beds are needed specifically to serve a specialty heavy care patient population, such as dementia, ventilator-dependent, and AIDS patients; and (iii) the facility has executed an agreement with a state-supported medical college to provide training in geriatric nursing.

7. The development of a nursing facility project located in Albemarle County when (i) the total number of new beds to be constructed does not exceed 30 beds; (ii) the facility is owned by and will be operated as a nonprofit entity; (iii) the project was under construction on February 1, 1992; and (iv) the facility will be ready for occupancy by November 1, 1992.

~~§ 9.2. Expiration of requirements for general hospitals and outpatient or ambulatory surgery centers or clinics.~~

~~Notwithstanding any law to the contrary, as of July 1, 1993, general hospitals and specialized centers or clinics developed for the provision of outpatient or ambulatory surgery shall no longer be medical care facilities subject to review pursuant to these Regulations except with respect to the establishment of nursing home beds in general hospitals.~~

~~§ 9.3.~~ *§ 10.2. Extension of the schedule of completion for nursing home projects approved prior to January 1, 1991.*

Notwithstanding the authority of the commissioner to grant an extension of a schedule for completion of the project pursuant to Part VI of these regulations, no extension shall be granted beyond June 30, 1992, for any nursing home project approved prior to January 1, 1991. However, the commissioner may grant an extension of a schedule for completion for an additional ~~six~~ *nine* months upon determining that (i) substantial and continuing progress has been made toward completion of the project; ~~and~~ (ii) the project owner had agreed in writing prior to February 13, 1991, to delay the project to facilitate cost savings for the Commonwealth ~~.~~ *; and (iii) construction of the project was initiated on or before April 15, 1992. The commissioner may also grant an extension of a schedule for completion for an additional six months to project owners who did not agree in writing prior to February 13, 1991, to delay their projects upon determining that (i) substantial and continuing progress has been made toward completion of the project and (ii) construction of the project was initiated on or before April 15, 1992.* The certificate for any such nursing home bed project approved prior to January 1, 1991, which has not been completed by June 30, 1992, or by the expiration date of any approved extension *, which in no case shall be later than March 31, 1993,* shall be revoked. *However, the commissioner shall not revoke the certificate of public need for:*

1. Any nursing home bed project for 60 beds proposed as part of a retirement community that is not a continuing care provider as defined in § 38.2-4900 of the Code of Virginia if (i) the certificate of public need was issued after May 1, 1988, and was in force on November 1, 1991, (ii) construction of the nursing home bed project is initiated by June 30, 1992, and (iii) the facility is completed by June 30, 1993.

2. Any nursing home bed project to add 40 beds to an existing facility if (i) the project owner had agreed to delay the project to facilitate cost savings for the Commonwealth prior to February 13, 1991, (ii) the owner was seeking funding from the Department of Housing and Urban Development prior to February 13, 1992, (iii) the facility receives a feasibility approval for such funding from the Department of

Housing and Urban Development by May 1, 1992, and (iv) the facility is completed by June 30, 1993.

3. Any nursing home bed project for less than 30 beds proposed as part of a retirement community that is not a continuing care provider as defined in § 38.2-4900 of the Code of Virginia if (i) the certificate of public need was issued after May 1, 1988, and was in force on November 1, 1991, (ii) construction of the nursing home bed project was initiated before December 1, 1991, (iii) the owner of the nursing home bed project agrees in writing prior to July 1, 1992, to restrict use of the nursing home beds to residents of such retirement community, (iv) construction on the nursing home bed project that was not completed by August 27, 1991, is resumed by August 1, 1993, and (v) the nursing home bed project is completed by July 31, 1994.

COMMONWEALTH OF VIRGINIA

APPLICATION FOR EXPEDITED REVIEW

FOR

CERTIFICATE OF PUBLIC NEED

IN ACCORDANCE WITH

PART VI OF THE

VIRGINIA MEDICAL CARE FACILITIES

CERTIFICATE OF PUBLIC NEED RULES AND REGULATIONS

EXPEDITED REVIEW PROCESS

This form is to be used to request an expedited review for certificate of public need (COPN) projects which may qualify for consideration in accordance with Part VI of the Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations (Regulations). The State Health Commissioner will issue a COPN for those projects which he determines meet the criteria for an expedited review within 45 days of the receipt of an application filed under the expedited review process. The appropriate application fee must accompany all requests for an expedited review as set forth in § 6.2.B. of the Regulations.

The applicant will be required to demonstrate to the satisfaction of the Commissioner that the project being proposed complies with the criteria for an expedited review. If the Commissioner denies a request for an expedited review of a project, the applicant may file an application for review of such project in the appropriate batch cycle in accordance with the process set forth in Part V of the Regulations. In cases when an expedited review is denied by the Commissioner, the project applicant will not be required to file a letter of intent or pay a second application fee to submit such application for review in the appropriate batch cycle. (See § 6.4.C. of the Regulations.)

CRITERIA FOR EXPEDITED REVIEW

Applicability - Projects of medical care facilities that satisfy the criteria set forth below as determined by the State Health Commissioner shall be subject to an expedited review process:

a. Relocation at the same site of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another when the cost of such relocation is one million dollars or less.

b. The replacement at the same site by an existing medical care facility, of any medical equipment for the provision of cardiac catheterization, computed tomography (CT), lithotripsy, magnetic resonance imaging (MRI), open heart surgery, positron emission tomographic scanning (PET), radiation therapy, or single photon emission computed tomography (SPECT) when the medical care facility meets applicable standards for replacement of such medical equipment which are set forth in the State Medical Facilities Plan (SMFP).

CONSIDERATION UNDER THE SECOND CATEGORY FOR EXPEDITED REVIEW

For the second category for expedited review it will be necessary for the project applicant to obtain a copy of the SMFP and review the relevant plan component that addresses the type of medical equipment which is being replaced. The SMFP provides specific criteria and standards for replacement of

equipment within the individual plan components. A project must comply with the relevant SMFP criteria for replacement of equipment in order to qualify for expedited review under the second classification. Therefore, it is incumbent upon an applicant for expedited review to provide all appropriate data and information, as part of its application, to demonstrate that its project complies with the specific criteria in the SMFP. Copies of the SMFP are available from:

Virginia Department of Health
Division of Resources Development
1500 East Main Street, Suite 105
Richmond, Virginia 23219

APPLICATION FORM

Please complete the following form to apply for a COPN under the expedited review process in accordance with Part VI of the Regulations. One copy of the form should be filed with the appropriate regional health planning agency and two copies should be filed with the Department. The Division of Resources Development and the regional health planning agencies may be contacted for assistance and responses to questions concerning the COPN Program at the following addresses and telephone numbers:

Virginia Department of Health Division of Resources Development 1500 E. Main Street, Suite 105 Richmond, Virginia 23219	(804) 786-7463
Northwestern Virginia Health Systems Agency Blue Ridge Hospital Charlottesville, Virginia 22901	(804) 977-6010
Health Systems Agency of Northern Virginia 7245 Arlington Boulevard, Suite 300 Falls Church, Virginia 22042	(703) 573-3100
Southwest Virginia Health Systems Agency 3100A Peters Creek Road, N.W. Roanoke, Virginia 24019	(703) 362-9528
Central Virginia Health Planning Agency 1201 Broad Rock Boulevard Bldg. 507, Suite 317 No., Room 14 Richmond, Virginia 23249 MAIL: P.O. Box 24287 Richmond, Virginia 23224	(804) 233-6206
Eastern Virginia Health Systems Agency 18 Koger Executive Center, Suite 232 Norfolk, Virginia 23502	(804) 461-3834

SECTION I FACILITY ORGANIZATION AND IDENTIFICATION

A. _____
Official Name of Facility

_____
Address

_____
City State Zip Code

_____
Telephone Number

B. _____
Legal Name of Applicant

_____
Address

_____
City State Zip Code

C. Chief Administrative Officer

_____
Name

_____
Address

_____
City State Zip Code

_____
Telephone Number

D. Person(s) to whom questions regarding application should be directed.

_____
Name

_____
Address

_____
City State Zip Code

_____
Telephone Number

E. Type of Control and Ownership (Complete appropriate section for both owner and operator.)

Will the facility be operated by the owner? ____ Yes ____ No

Owner of Facility (Check One)	Proprietary	Operator of Facility (Check One)
(1) ____	(1) Individual	(1) ____
(2) ____	(2) Partnership - attach copy of Partnership Agreement and receipt showing that agreement has been recorded	(2) ____
(3) ____	(3) Corporate - attach copy of Articles of Incorporation and Certificate of Incorporation	(3) ____
(4) ____	(4) Other _____(Identify)	(4) ____
	Non-Profit	
(5) ____	(5) Corporation - attach copy of Articles of Incorporation and Certificate of Incorporation	(5) ____
(6) ____	(6) Other _____(Identify)	(6) ____
	Governmental	
(7) ____	(7) State	(7) ____
(8) ____	(8) County	(8) ____
(9) ____	(9) City	(9) ____
(10)____	(10) City/County	(10)____
(11)____	(11) Hospital Authority or Commission	(11)____
(12)____	(12) Other _____(Identify)	(12)____

F. Ownership of the Site (Check one and attach copy of document).

(1) ____ Fee simple title held by the applicant

(2) ____ Option to purchase held by the applicant

(3) ____ Leasehold interest for not less than ____ years

(4) ____ Renewable lease, renewable every ____ years

(5) ____ Other _____(Identify)

G. Attach a list of names and addresses of all owners or persons having a financial interest of five percent (5%) or more in the medical care facility.

(a) In the case of a proprietary corporation also attach:

(1) A list of the names and addresses of the board of directors of the corporation.

(2) A list of the officers of the corporation.

(3) The name and address of the registered agent for the corporation.

(b) In the case of a non-profit corporation also attach:

(1) A list of the names and addresses of the board of directors of the corporation.

(2) A list of the officers of the corporation.

(3) The name and address of the registered agent for the corporation.

(c) In the case of a partnership also attach:

(1) A list of names and addresses of all partners.

(2) The name and address of the general or managing partner.

(d) In the case of other types of ownership, also attach such documents as will clearly identify the owner.

H. List all subsidiaries wholly or partially owned by the applicant.

I. List all organizations of which the applicant is a wholly or partially owned subsidiary.

J. If the operator is other than the owner, attach a list of the name(s) and address(es) of the operator(s) of the medical care facility project. In the case of a corporate operator, specify the name and address of the Registered Agent. In the case of partnership operator, specify the name and address of the general or managing partner.

K. If the operator is other than the owner, attach an executed copy of the contract or agreement between the owner and the operator of the medical care facility.

SECTION II PROJECT IDENTIFICATION

A. Type of project for which a certificate of public need is being requested. (Check all that may be applicable).

(1) ____ Relocation at the same site of beds from one physical facility to another

(2) Replacement at the same site by an existing medical care facility of any medical equipment for the provision of

____ cardiac catheterization
____ computed tomography (CT)
____ lithotripsy
____ magnetic resonance imaging (MRI)
____ positron emission tomographic scanning (PET)
____ single photon emission computed tomography (SPECT)

B. Provide a full, but concise description of the proposed project. For equipment replacements, describe the specific equipment now available at the site and the type of equipment which is proposed to be acquired (include a copy of the manufacturer's quotation for new equipment).

C. For bed relocations:

1. Identify the present site of the beds to be relocated.

a. Site: _____ acres or square feet

b. Address or directions _____

_____

_____

2. Identify the proposed new location of the beds

a. Site: _____ acres or square feet

b. Address or directions _____

_____

_____

D. For equipment replacements:

1. Identify the location of the proposed equipment if the location is different is different from the present location of the existing equipment.

a. Site: _____ square feet

b. Address or directions _____

_____

_____

E. If the bed complement at the facility will change as a result of the project, complete the relevant portions of the following chart:

	Distribution of Existing Beds	Total Beds to be Lost or Removed from Service	Total Beds After Construction (Should equal sum of Columns 1 and 2)
Medical/Surgical			
Obstetrical			
Pediatric			
Psychiatric			
Rehabilitation			
Intensive/Coronary Care			
Long-Term/Extended Care			
Self Care			
Other (Specify)			
_____			
_____			
_____			
_____			
TOTAL			

SECTION V

FINANCIAL DATA

1. Direct Construction Costs $_____
2. Equipment not included in construction contract $_____
3. Site Acquisition Costs $_____
4. Site Preparation Costs $_____
5. Off Site Costs $_____
6. Architectural and Engineering Fees $_____
7. Other Consultant Fees $_____
8. Taxes During Construction $_____
9. HUD-232 Financing $_____
10. Industrial Development Authority Revenue & General Revenue Bond Financing $_____
11. Conventional Loan Financing $_____
12. Other (Specify) _____ $_____
13. **TOTAL CAPITAL COSTS (Add Lines 1 thru 12)** $_____
14. Percent of total construction costs to be financed _____
15. Dollar amount of long term mortgage $_____
16. Interest cost on long term financing
    a. HUD-232 Financing $_____
    b. Industrial Development Authority Revenue & General Revenue Bond Financing $_____
    c. Conventional Loan Financing $_____
    d. Other (Specify) _____ $_____
17. **TOTAL INTEREST COST ON LONG TERM FINANCING (Add Lines 16a, b, c, and d)** $_____
18. Anticipated Bond discount
    a. HUD-232 Financing $_____
    b. Industrial Development Authority Revenue & General Revenue Bond Financing $_____
    c. Conventional Loan Financing $_____
    d. Other (Specify) _____ $_____
19. **TOTAL ANTICIPATED BOND DISCOUNT (Add Lines 18a, b, c, and d)** $_____
20. **TOTAL PROJECT COST (Capital and Financing Costs) (Add Lines 13, 17, and 19)** $_____

SECTION III

For equipment purchases - Attach all documentation showing that the project complies with the relevant section of the State Medical Facilities Plan for "Replacement" of the medical equipment.

SECTION IV

Provide a timetable for completion of the project.

SECTION VI **ASSURANCES**

I hereby assure and certify that the information included in this application is correct to the best of my knowledge and belief and that it is my intent to carry out the proposed project as described, to the extent it is approved and no more.

Signature of Authorizing Officer	Address Ln 1
Type or Print Name of Authorizing Officer	Address Ln 2
Title of Authorizing Officer	City, State and Zip
Date	Telephone Number

Copies of the request should be sent to:

A. Virginia Department of Health
Division of Resources Development
1500 E. Main Street, Suite 105
Richmond, Virginia 23219
(Send two copies)

B. The regional health planning agency which serves the area where the project will be located.
(Send one copy)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: **State Plan for Medical Assistance Relating to EPSDT and Inpatient Psychiatric Services.**
VR 460-01-22. Services.
VR 460-03-3.1100. Amount, Duration and Scope of Services.
VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality of Care.
VR 460-02-4.1920. Methods and Standards 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 through April 23, 1993.
(See Calendar of Events section for additional information)

Summary:

The purpose of this proposal is to promulgate permanent regulations to supersede the current emergency regulations which provide for the same policies. The emergency regulations provided for the coverage of inpatient psychiatric services under the Early and Periodic Screening, Diagnosis, and Treatment Program and specified provider criteria for the provision of such services and established the reimbursement methodology.

The sections of the State Plan for Medical Assistance (the Plan) affected by this proposed regulation are: preprinted page 22; the Amount, Duration, and Scope of Services narrative (Supplement 1 to Attachment 3.1 A and B); Standards Established and Methods Used to Assure High Quality of Care (Attachment 3.1 C); and Methods and Standards for Establishing Payment Rates - Other Types of Care (Attachment 4.19 B).

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) requires that state Medicaid programs provide to recipients any and all services permitted to be covered under federal law, when the need for those services are identified as a result of screenings through the Early and Periodic Screening, Diagnosis, and Treatment Program. Such services must be provided even if they are not otherwise covered under the Plan, and are thus not available to recipients independent of EPSDT referral.

The EPSDT program provides for screening and diagnostic services to determine physical and mental defects in recipients up to age 21; and health care, treatment, and other services to correct or ameliorate any defects or chronic conditions discovered. EPSDT is a mandatory program which must be provided for all Medicaid-eligible recipients who are 18 years old or younger and, at the state's option, up to age 21. The Commonwealth provides EPSDT for recipients to age 21.

One service now required to be covered for recipients because of EPSDT is inpatient psychiatric services in psychiatric hospitals. These regulations reflect the definition of covered services and the fee-for-service reimbursement methodology.

During the development of the department's policy concerning EPSDT, the Health Care Financing Administration (HCFA) provided initial guidance to the states. DMAS incorporated this guidance into its emergency regulations which HCFA subsequently approved. DMAS has tightened its definition of covered psychiatric services to be those provided in psychiatric hospitals when the services are the result of EPSDT.

VR 460-01-22. Services.

Citation

§ 3.1(A)(5) (Continued)

(iii) Services made available to the medically needy are equal in amount, duration, scope for each person in a medically needy coverage group.

☒ Yes.

☐ Not applicable. The medically needy are not included in the plan.

(a)(6) The Medicaid agency meets the requirements of 42 CFR 441.56 through 441.62 and P.L. 101-239 with respect to early and periodic screening, diagnosis, and treatment (EPSDT) services. (Citation: 441.55 50 FR 43654, P.L. 101-239 (§ 6403) and 1902(a)(43), 1905(a)(4), and 1905(r) of the Act.)

☐ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

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. 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 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. Consistant with CFR 441.57~~ *A.* 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.~~ *B.* 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.~~ *C.* 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.

D. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by the Act § 1905(a).

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. 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 annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.

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 annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.

D. 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 annually. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

§ 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~~ *Speech-Language* 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.

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

12a. Prescribed drugs.

1. Nonlegend drugs, except insulin, syringes, needles, diabetic test strips for clients under 21 years of age, and family planning supplies are not covered by Medicaid. This limitation does not apply to Medicaid recipients who are in skilled and intermediate care facilities.

2. Legend drugs, with the exception of anorexiant drugs prescribed for weight loss and transdermal drug delivery systems, are covered. Coverage of anorexiants for other than weight loss requires preauthorization.

3. The Program will not provide reimbursement for drugs determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

4. Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, prescriptions for Medicaid recipients for specific multiple source drugs shall be filled with generic drug products listed in the Virginia Voluntary Formulary unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written.

5. New drugs, except for Treatment Investigational New Drugs (Treatment IND), are not covered until approved by the board, unless a physician obtains prior approval. The new drugs listed in Supplement 1 to the New Drug Review Program Regulations (VR 460-05-2000.1000) are not covered.

12b. Dentures.

Provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

12c. Prosthetic devices.

A. Prosthetics services shall mean the replacement of missing arms and legs. Nothing in this regulation shall be construed to refer to orthotic services or devices.

B. Prosthetic devices (artificial arms and legs, and their necessary supportive attachments) are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and preauthorized for the minimum applicable component necessary for the activities of daily living.

12d. Eyeglasses.

Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

§ 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.

Screening mammograms for the female recipient population aged 35 and over shall be covered, consistent with the guidelines published by the American Cancer Society.

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 shall 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 eight 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 five 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 shall 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 shall 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 shall 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 shall 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 shall 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 shall 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 shall 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 shall 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 shall be a licensed doctor of medicine or osteopathy.

d. Counseling services. Counseling services shall 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.

Transportation services are provided to Virginia Medicaid recipients to ensure that they have necessary access to and from providers of all medical services. Both emergency and nonemergency services are covered. The single state agency may enter into contracts with friends of recipients, nonprofit private agencies, and public carriers to provide transportation to Medicaid recipients.

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 460-02-3.1300. Standards Established and Methods Used to Assure High Quality 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. Psychiatric services resulting from an EPSDT screening.

Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403 and § 4b to Attachment 3.1 A & B Supplement 1, psychiatric services shall be covered, based on their prior authorization of medical need, for individuals younger than 21 years of age when the need for such services has been identified in a screening as defined by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The following utilization control requirements shall be met before preauthorization of payment for services can occur.

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

"Admission" means the provision of services that are medically necessary and appropriate, and there is a reasonable expectation the patient will remain at least overnight and occupy a bed.

"CFR" means the Code of Federal Regulations.

"Psychiatric services resulting from an EPSDT screening" means services rendered upon admission to a psychiatric hospital.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DMAS" means the Department of Medical Assistance Services.

"JCAHO" means Joint Commission on Accreditation of Hospitals.

"Medical necessity" means that the use of the hospital setting under the direction of a physician has been demonstrated to be necessary to provide such services in lieu of other treatment settings and the services can reasonably be expected to improve the recipient's condition or to prevent further regression so that the services will no longer be

needed.

"VDH" means the Virginia Department of Health.

2. It shall be documented that treatment is medically necessary and that the necessity was identified as a result of an EPSDT screening. Required patient documentation shall include, but not be limited to, the following:

a. Copy of the screening report showing the identification of the need for further psychiatric diagnosis and possible treatment.

b. Copy of supporting diagnostic medical documentation showing the diagnosis that supports the treatment recommended.

c. For admission to a psychiatric hospital, for psychiatric services resulting from an EPSDT screening, certification of the need for services by an interdisciplinary team meeting the requirements of 42 CFR §§ 441.153 or 441.156 that:

(1) Ambulatory care resources available in the community do not meet the recipient's treatment needs;

(2) Proper treatment of the recipient's psychiatric condition requires admission to a psychiatric hospital under the direction of a physician; and

(3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed, consistent with 42 CFR § 441.152.

3. The absence of any of the above required documentation shall result in DMAS' denial of the requested preauthorization.

4. Providers of psychiatric services resulting from an EPSDT screening must:

a. Be a psychiatric hospital accredited by JCAHO;

b. Assure that services are provided under the direction of a physician;

c. Meet the requirements in 42 CFR Part 441 Subpart D;

d. Demonstrate that it is their policy to provide services to individuals in need of comprehensive services without regard to the individual's ability to pay or eligibility for Medicaid reimbursement; and

e. Be enrolled in the Commonwealth's Medicaid program for the specific purpose of providing psychiatric services resulting from an EPSDT screening.

~~C.~~ *D.* 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. Further specialized care services requirements are set forth below.

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 60 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.

8. Specialized care services.

a. Providers must be nursing facilities certified by the Division of Licensure and Certification, State Department of Health, and must have a current signed participation agreement with the Department of Medical Assistance Services to provide nursing facility care. Providers must agree to provide care to at least four residents who meet the specialized care criteria for children/adolescents or adults.

b. Providers must be able to provide the following specialized services to Medicaid specialized care recipients:

(1) Physician visits at least once weekly;

(2) Skilled nursing services by a registered nurse available 24 hours a day;

(3) Coordinated multidisciplinary team approach to meet the needs of the resident;

(4) For residents under age 21, provision for the educational and habilitative needs of the child;

(5) For residents under age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of six sessions each day, 15 minutes per session, five days per week;

(6) For residents over age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of four sessions per day, 30 minutes per session, five days a week;

(7) Ancillary services related to a plan of care;

(8) Respiratory therapy services by a board-certified therapist (for ventilator patients, these services must be available 24 hours per day);

(9) Psychology services by a board-certified psychologist related to a plan of care;

(10) Necessary durable medical equipment and supplies as required by the plan of care;

(11) Nutritional elements as required;

(12) A plan to assure that specialized care residents have the same opportunity to participate in integrated nursing facility activities as other residents;

(13) Nonemergency transportation;

(14) Discharge planning;

(15) Family or caregiver training; and

(16) Infection control.

~~D.~~ *E.* 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.~~ *F.* 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~~ *Speech-Language* 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.~~ *G.* 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.~~ *H.* 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.~~ *I.* Standards in other specialized high quality programs such as the program of Crippled Children's Services will be incorporated as appropriate.

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

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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~~ *Speech-Language* 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~~ *Speech-Language* 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 typically but not solely in the client's residence; service shall be recommended in the Individual Service Plan (ISP) which shall be fully completed within 30 days of initiation of services.

2. Services shall 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 shall 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 shall 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 shall 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 which shall be fully completed within 30 days of initiation of the service.

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, and in accordance with an ISP which shall be fully completed within 30 days of service initiation.

1. The provider of day treatment/partial hospitalization shall be licensed by DMHMRSAS.

2. The program shall 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. Services shall be provided following an assessment which clearly documents the need for services and in accordance with an ISP which shall be fully completed within 30 days of service initiation.

2. The provider of psychosocial rehabilitation shall be licensed by DMHMRSAS.

3. The program shall 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.

4. 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 shall 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. When travel is required to provide out-of-clinic services, such time is reimbursable. 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, significant others, service providers, 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 be fully completed within 30 days of initiation of the service, and the case manager shall 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.

5. The ISP shall be updated at least annually.

§ 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 shall 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 shall be preauthorized annually by DMHMRSAS.

4. Each individual shall have a written plan of care developed by the provider which shall be fully complete within 30 days of initiation of the service, 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 shall update the plan of care at least annually.

6. The individual's record shall contain adequate documentation concerning progress or lack thereof in meeting plan of care goals.

7. The program shall 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 shall be licensed by DMHMRSAS.

B. Appropriate use of case management services for persons with mental retardation 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 shall be obtained from DMHMRSAS Care Coordination Unit annually.

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.

4. The individual's record shall 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~~ *Speech-Language* 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 Used for Establishing Payment Rates–Other Types of Care.

§ 1. General.

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.~~ *1.* 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.~~ *2.* 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.~~ *3.* 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.~~ *§ 2. Services which are reimbursed on a cost basis.*

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.

A. 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.

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

C. 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. 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, including those obstetric and pediatric procedures contained in Supplement 1 to Attachment 4.19 B, 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 performed 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.

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.

4. Rehabilitation agencies

5. Comprehensive outpatient rehabilitation facilities

6. Rehabilitation hospital outpatient services.

~~e.~~ *§ 3.* Fee-for-service providers.

~~(1)~~ *A.* Payment for the following services shall be the lowest of ~~:~~ *the* state agency fee schedule, actual charge (charge to the general public), or Medicare (Title XVIII) allowances:

~~(a)~~ *1.* Physicians' services (Supplement 1 has obstetric/pediatric fees.) The following limitations shall apply to emergency physician services.

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 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.

b. 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)~~ *(1)* DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services, including those obstetric and pediatric procedures contained in Supplement 1 to Attachment 4.19 B, rendered in emergency rooms which DMAS determines are nonemergency care.

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

~~(iii)~~ *(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 ~~(ii)~~ *(2)* above. Services not meeting certain criteria shall be paid under the methodology of ~~(i)~~ *(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.

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

~~(v)~~ *(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 objectives, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

~~(b)~~ *2.* Dentists' services

~~(c)~~ *3.* Mental health services including:

Community mental health services

Services of a licensed clinical psychologist

Mental health services provided by a physician

~~(d)~~ *4.* Podiatry

~~(e)~~ *5.* Nurse-midwife services

~~(f)~~ *6.* Durable medical equipment

~~(g)~~ *7.* Local health services

~~(h)~~ *8.* Laboratory services (Other than inpatient hospital)

~~(i)~~ *9.* Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)

~~(j)~~ *10.* X-Ray services

~~(k)~~ *11.* Optometry services

~~(l)~~ *12.* Medical supplies and equipment.

~~(m)~~ *13.* Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by Supplement 3.

~~(2)~~ *B.* 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.~~ *C.* Payment for pharmacy services shall be the lowest of items ~~(1)~~ *1* through ~~(5)~~ *5* (except that items ~~(1)~~ *1* and ~~(2)~~ *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)~~ *6* and ~~(7)~~ *7* below:

~~(1)~~ *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)~~ *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)~~ *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)~~ *a* through ~~(e)~~ *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)~~ *a.* Percent discount shall be determined by a statewide survey of providers' acquisition cost.

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

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

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

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

~~(6)~~ *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)~~ *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)~~ *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.~~ *D.* 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.~~ *E.* 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.~~ *F.* 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.~~ *G.* 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.~~ *H.* 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.~~ *I.* 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.~~ *J.* Targeted case management for high-risk pregnant women and infants up to age two 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.~~ *§ 4.* Reimbursement for all other nonenrolled institutional and noninstitutional providers.

~~(1)~~ *A.* 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)~~ *B.* 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)~~ *C.* 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)~~ *D.* 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 12 months shall be declared inactive.

~~(5)~~ *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.

~~o.~~ *§ 5.* Refund of overpayments.

~~(1)~~ *A.* Providers reimbursed on the basis of a fee plus cost of materials.

~~(a)~~ *1.* 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)~~ *2.* 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.

3. 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.

4. 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.

5. 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.

6. 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.

~~(e)~~ *7.* 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)~~ *8.* 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.

9. 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.

10. 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.

B. Providers reimbursed on the basis of reasonable costs.

1. 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 disputed in whole or in part DMAS's determination of the overpayment.

2. 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, an underpayment discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. One 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.

10. 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.

11. 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.

§ 6. EPSDT.

Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, reimbursement shall be provided for services resulting from early and periodic screening, diagnostic, and treatment services. Reimbursement shall be provided for such other measures described in Social Security Act § 1905(a) required to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan.

A. Payments to fee-for-service providers shall be in accordance with § 3 of Attachment 4.19B the lower of (i) state agency fee schedule or (ii) actual charge (charge to the general public).

B. Payments to outpatient cost-based providers shall be in accordance with § 2 in 4.19B.

C. Psychiatric services delivered in a psychiatric hospital for individuals under age 21 shall be reimbursed at a uniform all-inclusive per diem fee and shall apply to all service providers. The fee shall be all-inclusive to include physician and pharmacy services. The methodology to be used to determine the per diem fee shall be as follows. The base period uniform per diem fee for psychiatric services resulting from an EPSDT screening shall be the median (weighted by children's admissions in state-operated psychiatric hospitals) variable per day cost of state-operated psychiatric hospitals in the fiscal year ending June 30, 1990. The base period per diem fee shall be updated each year using the hospital market basket factor utilized in the reimbursement of acute care hospitals in the Commonwealth.

~~p.~~ *§ 7.* Dispute resolution for state-operated providers.

~~(1)~~ *A.* Definitions.

~~(a)~~"DMAS" means the Department of Medical Assistance Services.

~~(b)~~"Division director" means the director of a division of DMAS.

~~(c)~~"State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

~~(2)~~ *B.* Right to request reconsideration.

~~(a)~~ A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

~~(b)~~ The appropriate DMAS division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

~~(3)~~ *C.* Informal review.

The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought, and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

~~(4)~~ *D.* Division director action.

The division director shall consider any recommendation of his designee and shall render a decision.

~~(5)~~ *E.* DMAS director review.

A state-operated provider may, within 30 days after receiving the informal review decision of the division director, request that the DMAS director or his designee review the decision of the division director. The DMAS director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

~~(6)~~ *F.* Secretarial review.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after the receipt of the decision of the DMAS director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

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Title of Regulation: **State Plan for Medical Assistance Relating to Copayments for Outpatient Rehabilitative Services and Removal of XVIII Cap on Fees.**
VR 460-02-4.1810. Charges Imposed on Categorically Needy for Certain Services.
VR 460-02-4.1830. Charges Imposed on Medically Needy for Certain Services.
VR 460-02-4.1920. Methods and Standards 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 through April 23, 1993.
(See Calendar of Events section for additional information)

Summary:

The purpose of this proposal is (i) to promulgate permanent regulations which will provide for equitable application of recipient cost sharing policies for outpatient rehabilitative services and the elimination of the Medicare cap on all services' fees; and (ii) to replace emergency regulations currently in effect.

The sections of the Plan which are affected by this action are: Recipient Cost Sharing Obligations (Attachments 4.18 A and C); and Methods and Standards for Establishing Payment Rates – Other Types of Care (Attachment 4.19 B). Recipient cost sharing for outpatient rehabilitative services and the elimination of the Medicare cap on all services' fees are discussed below.

Recipient Cost Sharing for Outpatient Rehabilitative Services

The 1992 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to impose copayments on home health services. These services were intended to mean health services rendered in the home setting regardless of the kind of provider. Home health services include nursing, home health aide, speech and language services, physical therapy, and occupational therapy. The only agencies delivering nursing and home health aide services in the home setting are home health agencies. However, therapy services (speech, physical therapy and occupational) are also offered in the home by rehabilitation agencies. Therefore, it was necessary to place a copayment on the in-home therapy services offered by rehabilitation agencies as well as those offered by home health agencies.

In developing the implementation plans for complying with this Appropriations Act mandate, DMAS identified that while rehabilitation agencies offer therapy services in the homes of recipients, they also offer these in their offices. If Medicaid imposes a copayment on in-home services then there will be an incentive for rehabilitation agencies to shift the location of services from the home to their offices. If this occurs then DMAS will not achieve the savings directed in the Appropriations Act. In order to ensure that the projected savings are achieved, DMAS proposes to impose a copayment on therapy services offered by rehabilitation agencies regardless of whether those services are offered in the home or in the office.

Moreover, an issue of equitable treatment of recipients is created if copayments are not imposed on therapy treatments in the offices of rehabilitation agencies. Individuals who are homebound and unable to leave their homes for treatment and people who go to hospital outpatient departments will be required to pay copayments, while individuals who are able to go to the offices of the rehabilitation agencies will not be required to pay a copayment. In order to resolve this inequity, it is proposed that copayments be imposed on therapy visits rendered by rehabilitation agencies regardless of the place of treatment.

Because the Appropriations Act directed DMAS to impose copayments on home health services effective July 1, 1992, and because it is necessary to apply these copayments equitably to all recipients of outpatient therapy services an emergency regulation was issued. Without the emergency regulation, DMAS could not meet the requirement of the Appropriations Act nor could it apply the copayment equitably until after a public comment period. Since emergency regulations are time limited in their effectiveness, these proposed permanent regulations, once adopted in their final form, will supersede the existing emergency regulation.

This proposed regulation varies from the emergency regulation by the exclusion of emergency services and all services delivered in emergency rooms from the

application of the copay policy. Federal regulations exclude the imposition of recipient cost sharing for emergency services and define how such services are to be interpreted (Code of Federal Regulations § 447.53(b)(4)). Moreover, DMAS has determined that nonemergency services, as identified by the Reimbursement Adjustment for Non-Emergency Care in Emergency Rooms programs, provided in emergency rooms should not be subject to recipient copayment. The administrative cost and complexity of providers attempting to collect the copayment from the recipient after the service has been delivered was determined to be an unnecessary, costly burden to providers and, therefore, was excluded from the copayment policy.

Elimination of Medicare Cap on All Services' Fees

Effective January 1, 1992, Medicare implemented a major revision of its fee schedule for physician services. This new fee schedule was not intended to change total Medicare expenditures for physician services but did change amounts paid for many individual services significantly. Many kinds of surgical and diagnostic services are being reimbursed at a lower rate than before, while the services of primary care physicians are being reimbursed at a higher rate.

Although on average, Virginia Medicaid fees are lower than those of Medicare, there are some instances where the new Medicare fees have been reduced so sharply that they are now lower than those of Virginia Medicaid for the same services. For example, Medicare allows a payment of $670 for routine obstetrical care, including antepartum care, vaginal delivery, and postpartum care. The Medicaid allowed payment is $1200 which is still well below payments made by other third party payers. To simply follow the language of the current state plan would mean reducing payment, sometimes significantly, for many physician services.

DMAS has used the payment rates set by the Medicare program for a number of years. It was voluntary on DMAS' part and not related to any federal policy or law. After further study and experience with the current emergency regulation, DMAS determined that removing the Medicare cap on all services was appropriate and consequently has reflected this policy in this proposed regulation.

Also in this proposed regulation, the numbering scheme of Attachment 4.19 B is being revised. This is a technical change and has no policy or fiscal impact.

VR 460-02-4.1810. Charges Imposed on Categorically Needy for Certain Services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VIRGINIA

A. The following charges are imposed on the categorically needy and qualified Medicare beneficiaries for services other than those provided under 42 CFR § 447.53.

Service	Type Charge Deduct	Coins	Copay	Amount and Basis for Determination
Inpatient Hospital	$100	-0-	-0-	State's average daily payment of $594 is used as basis.
Outpatient Hospital Clinic	-0-	-0-	$3.00	State's average payment of $136 is used as basis.
Clinic Visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician Office Visit	-0-	-0-	$1.00	State's average payment of $23 is used as basis.
Eye examination	-0-	-0-	$1.00	State's average payment of $30 is used as basis.
Prescriptions	-0-	-0-	$1.00	State's average per script of $18 is used as payment basis.
Home Health Visit	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Other Physician Service	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.)	*-0-*	*-0-*	*$3.00*	*State's average payment of $78 is used as basis.*

**Note: The applicability of copays to emergency services is discussed further in this attachment.*

B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

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

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

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

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR

447.53(b) are described below:

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

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

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

F. Emergency services.

No recipient copayment shall be collected for the following services:

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

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

b. Serious impairment to bodily functions; or

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

2. All services delivered in emergency rooms.

VR 460-02-4.1830. Charges Imposed on Medically Needy for Certain Services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: VIRGINIA

A. The following charges are imposed on the medically needy *and qualified Medicare beneficiaries* for services *other than those provided under 42 CFR § 447.53* :

Service	Type Charge Deduct	Coins	Copay	Amount and Basis for Determination
Inpatient hospital	$100.00	-0-	-0-	State's average daily payment of $594 is used as basis.
Out-patient hospital clinic	-0-	-0-	$3.00	State's average payment of $136 is used as basis.
Clinic visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician office visit	-0-	-0-	$1.00	State's average payment of $23 is used as basis.
Eye examination	-0-	-0-	$1.00	State's payment of $30.00 is used as basis.
Prescriptions	-0-	-0-	$1.00	State's average per script of $18 is used as basis.
Home Health Visit	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Other Physician Service	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.	*-0-*	*-0-*	*$3.00*	*State's average payment of $78 is used as basis.*

**Note: The applicability of copays to emergency services is discussed further in this attachment.*

B. The method used to collect cost sharing charges for medically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

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

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

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

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

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

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

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

F. Emergency services.

No recipient copayment shall be collected for the following services.

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

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

b. Serious impairment to bodily functions; or

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

2. All services delivered in emergency rooms.

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

§ 1. General.

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.~~ *1.* 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.~~ *2.* 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.~~ *3.* 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.~~ *§ 2. Services which are reimbursed on a cost basis.*

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.

A. 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.

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

C. 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. 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, including those obstetric and pediatric procedures contained in Supplement 1 to Attachment 4.19 B, 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 performed 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.

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.

4. Rehabilitation agencies

5. Comprehensive outpatient rehabilitation facilities

6. Rehabilitation hospital outpatient services.

~~c.~~ *§ 3.* Fee-for-service providers.

~~(1)~~ *A.* Payment for the following services shall be the ~~lowest~~ *lower* of : *the* state agency fee schedule ; *or* actual charge (charge to the general public) ; ~~or Medicare (Title XVIII) allowances~~ :

~~(a)~~ *1.* Physicians' services (Supplement 1 has obstetric/pediatric fees.) The following limitations shall apply to emergency physician services.

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 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.

b. 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)~~ *(1)* DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services, including those obstetric and pediatric procedures contained in Supplement 1 to Attachment 4.19 B, rendered in emergency rooms which DMAS determines are nonemergency care.

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

~~(iii)~~ *(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 ~~(ii)~~ *(2)* above. Services not meeting certain criteria shall be paid under the methodology of ~~(i)~~ *(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.

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

~~(v)~~ *(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 objectives, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

~~(b)~~ *2.* Dentists' services

~~(c)~~ *3.* Mental health services including:

Community mental health services

Services of a licensed clinical psychologist

Mental health services provided by a physician

~~(d)~~ *4.* Podiatry

~~(e)~~ *5.* Nurse-midwife services

~~(f)~~ *6.* Durable medical equipment

~~(g)~~ *7.* Local health services

~~(h)~~ *8.* Laboratory services (Other than inpatient hospital)

~~(i)~~ *9.* Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)

~~(j)~~ *10.* X-Ray services

~~(k)~~ *11.* Optometry services

~~(l)~~ *12.* Medical supplies and equipment.

~~(m)~~ *13.* Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by Supplement 3.

~~(2)~~ *B.* 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.~~ *C.* Payment for pharmacy services shall be the lowest

of items ~~(1)~~ *1* through ~~(5)~~ *5* (except that items ~~(1)~~ *1* and ~~(2)~~ *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)~~ *6* and ~~(7)~~ *7* below:

~~(1)~~ *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)~~ *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)~~ *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)~~ *a* through ~~(c)~~ *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)~~ *a.* Percent discount shall be determined by a statewide survey of providers' acquisition cost.

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

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

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

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

~~(6)~~ *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)~~ *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)~~ *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.~~ *D.* 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.~~ *E.* 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.~~ *F.* 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.~~ *G.* 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.~~ *H.* 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.~~ *I.* 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.~~ *J.* Targeted case management for high-risk pregnant women and infants up to age two 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.~~ *§ 4.* Reimbursement for all other nonenrolled institutional and noninstitutional providers.

~~(1)~~ *A.* 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)~~ *B.* 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 5.0%. The 5.0% is for the cost of the additional manual processing of the claims. Outpatient hospitals that are nonenrolled shall submit claims on DMAS invoices.

~~(3)~~ *C.* 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)~~ *D.* 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 12 months shall be declared inactive.

~~(5)~~ *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.

~~o.~~ *§ 5.* Refund of overpayments.

~~(1)~~ *A.* Providers reimbursed on the basis of a fee plus cost of materials.

~~(a)~~ *1.* 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)~~ *2.* 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.

3. 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.

4. 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.

5. 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.

6. 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)~~ *7.* 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)~~ *8.* 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.

9. 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.

10. 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 fact finding 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.

B. Providers reimbursed on the basis of reasonable costs.

1. 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 disputed in whole or in part DMAS's determination of the overpayment.

2. 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, an underpayment discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

§ 6. Reserved.

~~P.~~ *§ 7.* Dispute resolution for state-operated providers

~~(1)~~ *A.* Definitions.

~~(a)~~"DMAS" means the Department of Medical Assistance Services.

~~(b)~~"Division director" means the director of a division of DMAS.

~~(c)~~"State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

~~(2)~~ *B.* Right to request reconsideration.

~~(a)~~ A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

~~(b)~~ The appropriate DMAS division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

~~(3)~~ *C.* Informal review.

The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought, and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

~~(4)~~ *D.* Division director action.

The division director shall consider any recommendation of his designee and shall render a decision.

~~(5)~~ *E.* DMAS director review.

A state-operated provider may, within 30 days after receiving the informal review decision of the division director, request that the DMAS director or his designee review the decision of the division director. The DMAS director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

~~(6)~~ *F.* Secretarial review.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after the receipt of the decision of the DMAS director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

DEPARTMENT OF TAXATION

Title of Regulation: **VR 630-3-414. Corporation Income Tax: Sales Factor.**

Statutory Authority: § 58.1-203 of the Code of Virginia.

Public Hearing Date: March 1, 1993 - 10 a.m.
Written comments may be submitted through April 23, 1993.
(See Calendar of Events section for additional information)

Summary:

This regulation sets forth the proper method for including receipts from installment sales in the sales factor. The basis portion is included in the sales factor in the year of sale. The net gain portion and interest income are included in the sales factor in the year recognized for federal income tax purposes. The regulation also clarifies when such receipts should be included in the numerator of the sales factor.

VR 630-3-414. Corporation Income Tax: Sales Factor.

§ 1. In general.

The sales factor is a fraction, the numerator of which is the total sales in Virginia during the taxable year, and the denominator of which is the total sales of the corporation everywhere during the taxable year.

§ 2. Sales.

"Sales" is defined in § 58.1-302 of the Code of Virginia and means all gross receipts of the corporation except dividends allocated under § 58.1-407 of the Code of Virginia. In the case of the sale or disposition of intangible property (including, but not limited to patents, copyrights, bonds, stocks and other securities) gross receipts shall be disregarded and only the net gain from the transaction shall be included. Sales shall be included in the sales factor if the gross receipts or net gain are included in

Virginia taxable income and are connected with the conduct of taxpayer's trade or business within the United States. See ~~Va. Reg.~~ § *VR* 630-3-408.

1. Net gain is computed on a per transaction basis. A sale or disposition of intangible property is included in the sales factor only to the extent that it results in a net gain.

2. A disposition of intangible property resulting in a loss is ignored in computing the sales factor. A loss is not used to offset gains from the sale or other disposition of intangible property, and a loss is not used to reduce other gross receipts.

3. The net gain from the transaction must be recognized, i.e., includable in federal taxable income, in order to be included in the Virginia sales factor.

4. "Sale or other disposition" includes the sale, exchange, redemption, maturity or other disposition of intangible property.

§ 3. Example.

In 1990, Corporation C, a calendar year taxpayer, redeems bonds with an adjusted basis of $46 million for $50 million, recognizing a net gain of $4 million. C also sells stock with an adjusted basis of $98 million for $95 million, recognizing a net loss of $3 million. Only the $4 million dollar net gain is reflected in C's sales factor; the $3 million loss from the sale of stock is ignored and is not used to offset the $4 million net gain in computing C's sales factor. Likewise, the loss is not used to reduce C's other gross receipts in 1990.

§ 4. Installment sales.

A. Receipts from an installment sale of real or tangible personal property shall be included in the sales factor based on the following:

1. The basis portion of the sales proceeds shall be included in the sales factor in the year of sale. The basis portion of the sales proceeds shall be included in the numerator of the sales factor if: (i) the tangible personal property sold was received in Virginia by the purchaser, or (ii) the real property sold was located in Virginia.

2. The net gain portion of the sales proceeds shall be included in the sales factor to the extent and in the year recognized for federal income tax purposes. The net gain portion of the sales proceeds shall be included in the numerator of the sales factor if a greater proportion of the income producing activity in the year of receipt is performed in Virginia.

3. The interest income shall be included in the sales factor in the year it is recognized for federal income tax purposes. The interest is included in the numerator of the sales factor if a greater proportion of the recordkeeping, collection and other income producing activity in the year of receipt is performed in Virginia.

B. Receipts from an installment sale of intangible property shall be included in the sales factor based on the following:

1. The net gain portion of the sales proceeds shall be included in the sales factor to the extent and in the year recognized for federal income tax purposes. The net gain portion of the sales proceeds shall be included in the numerator of the sales factor if a greater proportion of the income producing activity in the year of receipt is performed in Virginia.

2. The interest income shall be included in the sales factor in the year it is recognized for federal income tax purposes and in the same manner as interest income from an installment sale of real or tangible personal property.

3. The basis portion of the sales proceeds shall not be included in the sales factor in the year of sale.

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Title of Regulation: **VR 630-3-419. Corporation Income Tax: Construction Corporation; Apportionment.**

Statutory Authority: § 58.1-203 of the Code of Virginia.

Public Hearing Date: March 1, 1993 10 a.m.
Written comments may be submitted through April 23, 1993.
(See Calendar of Events section for additional information)

Summary:

This regulation clarifies that the "completed contract method" mentioned in § 58.1-419 of the Code of Virginia does not include any of the "percentage of completion" methods available under federal law. In addition, the regulation clarifies which apportionment formula should be used when a construction corporation reports income under two or more accounting methods.

Other nonsubstantive changes are made to conform to the style of The Virginia Register.

VR 630-3-419. Corporation Income Tax: Construction Corporation; Apportionment.

~~A.~~ *§ 1.* In general.

~~1.~~ *A.* If a construction corporation used the completed contract method of accounting for its federal income tax return it is required by ~~Va. Code~~ § 58.1-440 *of the Code of*

Virginia to use the same method for computing Virginia taxable income.

~~2.~~ *B.* If a construction corporation is required to allocate and apportion income by ~~Va. Code~~ § 58.1-405 *of the Code of Virginia* , it shall apportion income (other than dividend income allocable under ~~Va. Code~~ § 58.1-407 *of the Code of Virginia*) within and without this ~~state~~ *Commonwealth* in the ratio that the business within this ~~state~~ *Commonwealth* is to the total business of the corporation.

~~3.~~ *C.* If a corporation does not use the completed contract method, it shall use the three factor apportionment formula in ~~Va. Code~~ § 58.1-408 et seq. *of the Code of Virginia.*

D. If a portion of a construction corporation's income is reported under the completed contract method and a portion is reported under a percentage of completion method or some other accounting method, the applicable apportionment formula is determined by the method used to report a majority (more than 50%) of the total business (measured by gross revenue) conducted by the taxpayer for the taxable year. If no one method is used to report a majority of the taxpayer's total business, the three factor apportionment formula in § 58.1-408 et seq. of the Code of Virginia shall be used.

E. An example follows:

A construction corporation's total business is $500,000 for the taxable year ended December 31, 1991: $275,000 is reported on the completed contract basis, $150,000 is reported under a percentage of completion method, and the remainder is reported on a cash basis. Because a majority of the total business was reported using the completed contract method of accounting, the taxpayer is required to apportion income using the single factor of business within Virginia over total business of the corporation.

~~B.~~ *§ 2.* Definitions.

~~1.~~ *A.* The total business of a corporation using the completed contract method of accounting is its gross receipts from completed contracts and all other gross receipts except income allocable under ~~Va. Code~~ § 58.1-407 *of the Code of Virginia* .

~~2.~~ *B.* Business within this ~~state~~ *Commonwealth* is the gross receipts of such corporations from completed contracts on jobs within Virginia and all other gross receipts attributable to income from sources within Virginia.

C. The "completed contract method" does not include any of the percentage of completion methods available under federal law.

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Title of Regulation: **VR 630-10-73. Retail Sales and Use Tax: Newspapers, Magazines, Periodicals and Other Publications.**

Statutory Authority: § 58.1-203 of the Code of Virginia.

Public Hearing Date: March 1, 1993 - 10 a.m.

Written comments may be submitted through April 23, 1993.

(See Calendar of Events section for additional information)

Summary:

This regulation has been revised to clarify what constitutes taxable and exempt publications for purposes of the retail sales and use tax. Publications devoted primarily to matters of specialized interest, such as legal, mercantile, political, religious or sporting matters, as well as those which are issued under a subscription basis, are exempt. Taxable publications include shopping guides, real estate guides and other publications of which the advertising portion, including product publicity, exceeds 90% of the printed area of the entire issue; crossword puzzle magazines; and newsletters and other printed materials available to a limited audience only and not to the general public.

Purchases of back issues of any newspaper, magazine or other publication are taxable.

VR 630-10-73. Retail Sales and Use Tax: Newspapers, Magazines, Periodicals and Other Publications.

~~A. Generally.~~

~~The tax does not apply to the retail sale of any newspaper, magazine or other publication issued daily, or regularly at average intervals not exceeding three months, except that newstand sales of such are taxable.~~

~~B.~~ *§ 1.* Definitions.

The following words and terms, when used in this regulation, shall have the following meanings unless the context clearly indicates otherwise:

"Back copies" means copies of publications which are no longer current and readily available at newsstands.

"Magazine" is included within the definition of "publication."

"Newspaper" means those publications which are commonly understood to be newspapers and which are printed and distributed periodically at daily, weekly, or other short intervals for the dissemination of news.

"Newsstand" means a definite place of business at which newspapers or magazines are sold, but does not

include coin-operated newspaper boxes.

~~1. Publications. As used herein the term "publication" shall mean~~

"Publication" means any written compilation of information available to the general public. ~~Publication does not include general reference materials and their periodic updates.~~ *It includes publications devoted primarily to matters of specialized interest, such as legal, mercantile, political, religious or sporting matters. It also includes publications that are issued under a subscription basis, such as trade magazines whose subscription price is a separately stated part of a member's dues. It does not include:*

1. General reference materials and their periodic updates, such as Moody's and Standard and Poor's reference volumes (loose leaf reference volumes published annually and updated biweekly or periodically), reference materials identified as "Reporters" which are devoted to matters of specialized interest, such as legal matters (West's Federal Reporter), and industry-specific statistical reports and publications.

2. Books complete in themselves issued at stated intervals, such as books sold by the Book-of-the-Month Club or similar organizations;

3. So-called "pocket books," a new one of which may be issued once a month or some other interval;

4. Shopping guides, real estate guides, or other compilations of which the advertising portion, including product publicity, exceeds 90% of the printed area of the entire issue;

5. Crossword puzzle magazines or similar type publications; and

6. Newsletters and other printed materials available to a limited audience only and not to the general public on a subscription basis, such as an insurance magazine available only to licensed insurance agents or organization newsletters available only to the members of the organization.

~~2. Newsstand. As used herein the term "newsstand" means a definite place of business at which newspapers or magazines are sold, but does not include coin-operated newspaper boxes.~~

§ 2. Generally.

The tax does not apply to the retail sale of any newspaper, magazine or other publication issued daily, or regularly at average intervals not exceeding three months, except that newstand sales of such are taxable.

The tax does apply, however, to sales of back copies of any newspaper, magazine or other publication.

This regulation is applicable only to retail sales of publications and generally has no impact on the charges for printing which are addressed in VR 630-10-86. However, printers who are engaged in "publisher printing" as defined in VR 630-10-86 are subject to the provisions of this regulation on their retail sales.

~~C.~~ *§ 3.* Advertising inserts.

Advertising inserts or supplements and other printed matter distributed with or as a part of a nontaxable publication are not subject to the tax. However, materials printed as inserts or supplements which are not distributed with a nontaxable publication, for example those distributed in stores or through the mails, are subject to the tax, unless otherwise specifically exempted by law ~~(for example, see § 630-10-18.1)~~ .

~~D.~~ *§ 4.* Other printed matter.

The purchase of printed material other than newspapers, magazines, and other publications and material distributed with or as a part of such items is subject to the tax unless otherwise specifically exempted. ~~For example, see § 630-10-86. For custom printing, see § 630-10-86. Section revised 7/69; 1/79; 1/85.~~

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Title of Regulation: **VR 630-10-74. Retail Sales and Use Tax: Nonprofit Organizations.**

Statutory Authority: § 58.1-203 of the Code of Virginia.

Public Hearing Date: March 1, 1993 - 10 a.m.
(See Calendar of Events section for additional information)

Summary:

This proposed regulation clarifies the sales and use tax treatment of sales and purchase transactions made by nonprofit organizations. The list of exemptions shown in § 58.1-608 of the Code of Virginia is removed from the regulation, and the treatment of sales and purchase transactions made by nonprofit organizations is addressed in this proposed regulation. Specifically, this proposed regulation includes information on criteria for the exemption, strict construction, exempt transactions, purchases for resale, intercompany sales and transfers, and occasional sale transactions.

VR 630-10-74. Retail Sales and Use Tax: Nonprofit Organizations.

~~A. Purchases. All tangible personal property purchased for use or consumption by religious, charitable, civic and other nonprofit organizations is taxable except:~~

1. Tangible personal property for use or consumption by a college or other institution of learning conducted not for profit. (See § 630-10-96.)

2. Tangible personal property for use or consumption by, or purchased for donation to, a non-commercial educational telecommunications entity conducted not for profit.

3. Tangible personal property for use or consumption by a hospital, a licensed nursing home or a home for adults (as defined in Virginia Code Section 63.1-172A) provided it is conducted not for profit.

4. Tangible personal property for use or consumption by a volunteer fire department or volunteer rescue squad conducted not for profit, and construction materials to be incorporated into realty when sold to and used by the organization, rather than a contractor, in construction, maintenance or repair of any property of such organization.

5. Tangible personal property for use or consumption by hospital cooperatives or hospital corporations conducted not for profit that are organized and operated for the sole purpose of providing services exclusively to hospitals conducted not for profit.

6. Historical documents, maps, rare books, and manuscripts acquired by a State historical society conducted not for profit provided such society maintains a research library open to the public without charge for research and educational purposes. (Only historical societies devoted to the study of the history of this state as a whole are entitled to exemption. The exemption is not applicable to local, regional, or national historical societies).

7. Tangible personal property for use or consumption at a national or international camping assembly within this state sponsored by a nonsectarian youth organization, provided all the following conditions are met: (a) the sponsoring organization is exempt from taxation under Section 501 (c)(3) of the Internal Revenue Code; (b) the camping assembly is for at least (7) continuous days; (c) the assembly has an attendance of more than 20,000; and (d) the tangible personal property is purchased by the sponsoring organization.

8. Books and other reading materials for use by a nonprofit group organized solely to distribute such books and reading materials to school age children.

9. Tangible personal property sold or leased for use in nonprofit nutrition programs for the elderly qualifying under 42 U.S.C. Section 3030(e) through 3030(g), as amended, as administered by the Department for the Aging of the Commonwealth of Virginia, and the food and food products sold under such programs to elderly persons.

10. Tangible personal property bought, sold or used by the Virginia Federation of Humane Societies or any chartered, nonprofit organization incorporated under the laws of this Commonwealth and organized for the purpose of preventing cruelty to animals and promoting humane care of animals, when such property is used for the operation of such organizations or the construction or maintenance of animal shelters.

11. Tangible personal property purchased for use or consumption by a nonprofit museum of fine arts which is located on property owned by a city in Virginia and which receives more than half of its operating budget from appropriations by the city.

12. Tangible personal property purchased for use or consumption by an organization exempt from taxation under § 501(c)(3) of the Internal Revenue Code and organized exclusively for the purpose of providing education, training and services to retarded citizens of this Commonwealth, provided that such property is used exclusively for the purpose set forth herein and further provided that such organization receives more than half of its total funding from federal, state or local governments.

13. Tangible personal property purchased for use by a nonprofit, nonstock corporation which receives no financial aid from the Commonwealth or the federal government and is organized exclusively for the purpose of operating, at no charge to the pupils, a combination boarding and day school for the severely physically handicapped children and young adults of the Commonwealth.

14. Tangible nonmedical personal property purchased by a nonprofit organization organized exclusively for the purpose of providing housing and ancillary assistance for children suffering from leukemia or oncological diseases, for other ill children, and for the families of such children during periods of medical treatment of such children at any hospital in the Commonwealth.

15. Tangible personal property purchased by a voluntary health organization exempt from taxation under § 501 (c)(3) of the Internal Revenue Code and organized exclusively for the purpose of providing direct therapeutic and rehabilitative services, such as speech therapy, physical therapy, and camping and recreational activities, to the children and adults of the Commonwealth regardless of the nature of their diseases or socioeconomic position.

B.Sales. If an organization conducted not for profit regularly engages in selling tangible personal property, it is required to register as a dealer and collect and pay the tax on retail sales except that: (1) tangible personal property sold by a noncommercial, educational telecommunications entity conducted not for profit; and (2)

~~charges for gift wrapping services performed by a nonprofit organization are not subject to tax.~~

~~If an organization is not regularly engaged in selling tangible personal property, and buys its merchandise from a dealer who is registered to collect the sales or use tax, the organization pays the tax to its supplier for payment to the state. If the supplier is not registered to collect the sales or use tax, the organization must report and pay the tax on a Consumer's Use Tax Return, Form ST-7.~~

~~Purchases of certain tangible personal property by churches conducted not for profit are covered in § 630-10-22.1; sales of medicines, drugs and certain other items of tangible personal property by hospitals are covered in § 630-10-47; sales of school textbooks by schools conducted not for profit and by certain dealers are covered in § 630-10-96. Section revised 7/69; 1/70; 8/82; 11/83; 8/84.~~

§ 1. Generally.

A. Criteria for exemption.

The Tax Commissioner has no authority to grant an exemption from the retail sales and use tax to a nonprofit organization. Only the General Assembly can enact legislation which will grant exemption from the tax.

The General Assembly has not enacted a general exemption from the retail sales and use tax for nonprofit organizations. The only nonprofit organizations exempt from the tax are those specifically set forth in §§ 58.1-608 and 58.1-608.1 of the Code of Virginia. These organizations are typically exempt from federal and state income taxes and serve educational, medical, civic, religious, charitable or cultural purposes. However, the vast majority of nonprofit organizations which are exempt from federal and state income taxes are not exempt from the Virginia retail sales and use tax because they do not qualify for a sales and use tax exemption set out in the Code of Virginia.

If a nonprofit organization is not exempt by statute from purchasing tangible personal property or taxable services, it must pay tax on those purchases used or consumed in its operations. If a supplier of the nonprofit organization is not registered to collect the tax or if the supplier is a registered dealer who fails to collect the tax, the nonprofit organization must report and pay the use tax on a Consumer's Use Tax Return, Form ST-7.

If a nonprofit organization regularly engages in selling tangible personal property, it is required to register as a dealer and collect and remit the tax to the department on retail sales unless it is specifically exempt by statute from collecting the tax.

B. Strict construction of the exemption.

As indicated in VR 630-10-35.2, when determining which organizations qualify for exemption from the tax, the department is bound by court decisions to strictly construe laws granting the tax exemption. This means that a nonprofit organization must meet all of the requirements specified in the law in order to qualify for an exemption. For example, § 58.1-608 A 4 o of the Code of Virginia exempts:

"From July 1, 1991, through June 30, 1996, tangible personal property purchased for use and consumption by a nonprofit organization exempt from taxation under § 501 c 3 of the Internal Revenue Code and organized exclusively to combat illiteracy by tutoring and training adults and by increasing community awareness of the illiteracy problem within the metropolitan Richmond area.

Under strict construction of the statute, to meet the criteria established for this exemption, an organization must (i) purchase tangible personal property during the period July 1, 1991, and June 30, 1996, (ii) have a § 501 c 3 designation from the Internal Revenue Service, (iii) be organized for the sole purpose of combating illiteracy in adults, and (iv) conduct operations in the metropolitan Richmond area. Organizations that provide illiteracy programs as part of a larger operation do not qualify for this exemption. In addition, similar organizations created solely to combat illiteracy, but operating outside the metropolitan Richmond area, would not qualify for this exemption. Lastly, when an exemption "sunsets," it typically applies to a specific period and expires after a certain date. Purchases before or after that period are taxable. Therefore, in the example above, purchases made before July 1, 1991, or after June 30, 1996, would be taxable.

§ 2. Exempt transactions.

The exemptions that have been granted by the General Assembly typically apply only to the use or consumption of tangible personal property by an organization. When an exemption is limited solely to the use or consumption of tangible personal property, the organization generally will be subject to the tax on purchases of meals and lodging, which are considered taxable services. In addition, when an organization regularly makes taxable sales, it must register as a dealer and collect the tax on these sales. In limited situations, the General Assembly has granted broader exemptions to certain organizations so as to exempt taxable services, such as meals and lodging, and sales of tangible personal property.

When a nonprofit organization is exempt for the purchase of tangible personal property or services, it should furnish to its supplier a properly completed exemption certificate, either Form ST-13 or ST-13A. If such a nonprofit organization is not making taxable sales as a registered dealer or is not required to register for consumer use tax, it will usually not have a Virginia Retail Sales and Use Tax registration number. In this instance, there is no requirement to place a registration

number on the exemption certificate when making purchases. Instead, "Non Applicable" should be placed on the Certificate of Exemption where the registration number is required.

If the nonprofit organization does not have an exemption certificate but has received a letter ruling from the department stating that it is exempt by statute, then this letter may be furnished to suppliers instead of the exemption certificate in order to verify that the purchase is exempt from the tax.

A. Meals and lodging.

According to VR 630-10-97.1, meals and lodging are considered to be taxable services and not tangible personal property. In order to make an exempt purchase of meals and lodging, an organization's exemption must contain specific language which exempts the purchase of services. An example of this language is found in § 58.1-608 A 4 d of the Code of Virginia, which exempts:

> *TANGIBLE PERSONAL PROPERTY AND SERVICES purchased by an educational institution doing business in the Commonwealth which (i) admits regularly enrolled high school and college students, and (ii) provides a face-to-face educational experience in American government, a program which leads towards the successful completion of United States history, civics, and problems in democracy courses in high school, or which is acceptable for full credit towards an undergraduate or graduate level college degree, provided such institution is conducted not for profit.*

B. Sales

If an organization is regularly engaged in selling tangible personal property, it is not required to collect the tax if the organization's exemption contains specific language to exempt these sales. An example of this language is found in § 58.1-608 A 8 n of the Code of Virginia, which exempts:

> *... TANGIBLE PERSONAL PROPERTY purchased for use or consumption, or TO BE SOLD AT RETAIL, by any nonsectarian youth organization exempt from taxation under § 501(c)(3) of the Internal Revenue Code which is organized for the purposes of the character development and citizenship training of its members using the methods now in common use by Girl Scout and Boy Scout organizations in Virginia.*

§ 3. Purchases for resale.

A purchase of tangible personal property for sale or resale is not subject to the tax. Therefore, a nonprofit organization that is regularly engaged in selling tangible personal property and required to register as a dealer may purchase this tangible personal property exempt from the tax using a resale exemption certificate, Form ST-10.

§ 4. Intercompany sales and transfers.

There is no exemption for sales or transfers between separately organized chapters of an organization, including sales to or from a chapter of an organization and its parent organization unless the sale or transfer involves interstate commerce or other transaction which is specifically exempt by statute.

§ 5. Occasional sale.

Notwithstanding any other provision of this regulation, a nonprofit organization that is not regularly engaged in selling tangible personal property may not be required to register as a dealer and collect the tax on its sales provided it makes sales on three or fewer separate occasions within the calendar year. However, sales made at fairs, flea markets, festivals and carnivals are not considered occasional sales. For more information on the occasional sale exemption, see VR 630-10-75.

§ 6. Change of organization or operations.

If a nonprofit organization changes its organizational structure or the nature of its operation in a way that voids its exemption from retail sales and use tax, it is required to register to collect and remit sales and use tax, if applicable, in accordance with § 58.1-612 of the Code of Virginia.

§ 7. Misuse of exemption certificates.

Any misuse of exemption certificates will be subject to the penalties prescribed in § 58.1-623.1 of the Code of Virginia, which include a penalty of up to $1,000 or suspension of the use of the exemption for a period of at least one year. In all cases, the person misusing an exemption certificate will be liable for the unpaid tax and interest thereon.

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Title of Regulation: **VR 630-10-80. Retail Sales and Use Tax: Penalties and Interest.**

Statutory Authority: § 58.1-203 of the Code of Virginia.

Public Hearing Date: March 1, 1993 - 10 a.m.

Written comments may be submitted through April 23, 1993.

(See Calendar of Events section for additional information)

Summary:

This regulation addresses recent law changes regarding penalty and interest application to assessments of delinquent tax payments. It further explains current operating policies and procedures concerning the application of penalty and interest to audit assessments.

The object of amending the regulation is to directly apply the statutory authority granted under Title 58.1 of the Code of Virginia in light of Virginia's 1990 Tax Amnesty Program.

Specifically, the revision of the regulation (i) reflects law changes regarding penalties; (ii) explains the application of criminal penalties; (iii) increases the compliance ratios regarding audit assessments; (iv) explains the application of penalty to first and subsequent audits; and (v) explains the application of penalty to exemption certificates.

The law changes took effect on July 1, 1991, and July 1, 1992.

VR 630-10-80. Retail Sales and Use Tax: Penalties and Interest.

~~A. Penalties, generally.~~ *§ 1. Generally.*

A. Civil penalties.

A dealer who fails to file a return and pay the full amount of tax by the required due date is subject to a penalty of ~~5%~~ *6.0%* of the amount of the tax due and unpaid for each month or fraction thereof, until paid, not to exceed ~~25%~~ *30%* . In no case will the penalty be less than $10, even if no tax is due for the period.

However, in the case of filing a false or fraudulent return with intent to defraud the ~~State~~ *Commonwealth* or of willful failure to file a return with intent to defraud the ~~State~~ *Commonwealth* , a penalty of 50% of the amount of tax actually due will be assessed. Under reporting gross sales, gross proceeds or cost price by 50% or more is prima facie evidence of intent to defraud the ~~State~~ *Commonwealth* .

At the discretion of the ~~State~~ Tax Commissioner, the penalty may be abated or waived provided the taxpayer can demonstrate good cause for the failure to file ~~and/~~ or pay on time. Requests for waiver or abatement of penalty must be made in writing to the Department of Taxation and must include all pertinent facts to support the request.

B. Criminal penalties.

1. Misdemeanors.

a. Collection of tax. Any dealer who neglects, fails, or refuses to pay or collect the tax, either by himself or through his agents or employees, shall be guilty of a Class 1 misdemeanor.

b. Records. Every dealer required to pay or collect the sales and use tax shall keep a record of all sales, leases and purchases of tangible personal property. Records and supporting documents shall be retained for a period of three years from the required date for filing a return to which such records and documents pertain. Any dealer failing to keep such records shall be guilty of a Class 1 misdemeanor.

The Tax Commissioner is authorized to examine the books, records and other documents of all transportation companies, agencies, firms or persons that conduct business by truck, rail, water, airplane or otherwise to identify the dealers who ship tangible personal property into or out of Virginia which may be subject to the tax. Any transportation company, agency, firm or person who refuses to permit such examination shall be guilty of a Class 1 misdemeanor.

c. Returns. Any dealer failing or refusing to file a return or failing or refusing to file a supplemental return or other data in response to a summons or other inquiry by the Tax Commissioner or who makes a false or fraudulent return with intent to evade the tax, or who gives or knowingly receives a false or fraudulent exemption certificate shall be guilty of a Class 1 misdemeanor.

d. Certificates of registration. Any dealer and each officer of any corporation who conducts business in the Commonwealth without obtaining a certificate of registration, or who conducts business in the Commonwealth after a certificate of registration has been suspended or revoked, shall be guilty of a Class 2 misdemeanor.

2. Felonies. Any dealer engaged in business in the Commonwealth who, through two or more acts or omissions within a period of 90 days, collects, or is deemed to have collected or withheld, any state sales or use or withholding tax totaling $1,000 or more and willfully fails to truthfully account for and remit to the department such tax shall be guilty of a Class 6 felony. For example, assume that a dealer collects $5,000 in sales tax and withholds Virginia income tax of $500 from his employees for the same period and willfully fails to remit such taxes, instead converting the funds to his own use. The failure to remit the sales and withholding taxes are separate acts for purposes of this section and could result in the dealer being charged with a Class 6 felony.

~~B. Interest, generally~~

C. Interest.

Interest at the rate established in ~~Section~~ *§* 6621 of the Internal Revenue Code ~~of 1954~~ , as amended, *plus 2.0%* accrues on the tax until paid or until an assessment is issued. At the time the assessment is issued, a bill will be sent to the taxpayer for the tax, penalty and interest which must be paid within 30 days from the date of the bill. If the bill is not paid in full within the 30-day period, interest at the prescribed rate will accrue on the full amount of the ~~initial~~ assessment from the date of *initial*

assessment until payment is made. Interest *is mandatory and* cannot be waived. *(See Article 1 (§ 58.1-1 et seq.) of Title 58.1 of the Code of Virginia.)*

~~C.~~ *§ 2.* Audits.

~~1.~~ *A.* Penalty.

The application of penalty to audit deficiencies is mandatory ; ~~but its application may be waived at the discretion of the State Tax Commissioner based upon the extent of a dealer's compliance with requirements for collection and payment of sales tax and requirements for payment of use tax or good cause. For example, a dealer who demonstrates acceptable compliance with sales and use tax requirements, but who fails to comply with certain provisions of the law for good cause may have penalty waived with respect to all or a portion of the audit deficiency. Generally, absent indications of fraud, penalty will be waived on the first audit of all taxpayers. On a second or subsequent audit, a dealer is expected to demonstrate a higher degree of sales and use tax compliance. Penalty will not be waived on second or subsequent audits for other than exceptional mitigating circumstances.~~ *and its application is based on the percentage of compliance determined by computing the dealer's compliance ratio. The compliance ratio for the sales or use tax may be computed by using the following ratio:*

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        Measure Reported      = Compliance Ratio
Measure Reported + Measure Found
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"Measure reported" means dollar amounts of sales or use measure reported on returns for the audit period. "Measure found" means dollar amounts of additional sales or use measure disclosed by the audit. Separate ratios for sales and use taxes will be necessary if the audit contains deficiencies in both areas. Tax paid to vendors will not be included in the computation of the compliance ratio.

1. First generation audits. Generally penalty cannot be waived if any of the following conditions exist:

a. The taxpayer has been previously notified in writing to collect tax on sales or to pay tax on purchases, but has failed to follow instructions.

b. The taxpayer has collected the sales tax, but failed to remit it to the Department of Taxation.

c. Indications of fraud in which the taxpayer has willfully evaded reporting and remitting the tax to the Department of Taxation.

The audit of a business which has experienced a change in responsible partners or officers or the addition of new locations and where the business is conducted in the same manner and for the same purposes as during a prior audit will not be considered a first audit for purposes of this subsection.

Similarly, audits performed for periods subsequent to the institution of reorganization plans, where during such reorganizations, the continuity of the business was not affected and the business entity maintained operations for the purpose of producing the same product(s) or rendering the same service(s), will not qualify for first generation audit status. In addition, audits performed for periods subsequent to business mergers, absorptions and like ventures, where the intent is to diversify or expand, will not qualify for first generation audit status. However, penalty generally will not be applied to audit deficiencies occurring in new areas not covered in prior audit(s) as set forth in subdivision 6 of this subsection.

2. Second generation audits. Penalty will generally be applied unless the taxpayer's compliance ratios meet or exceed 85% for sales tax and 60% for use tax.

3. All subsequent generation audits. Penalty will generally be applied unless the taxpayer's compliance ratios meet or exceed 85% for sales tax and 85% for use tax.

4. Taxable sales. Penalty, based on the compliance ratio, will generally be applied to the net understatement of the sales tax. "Net understatement" means sales tax deficiency determined by the audit less allowable credits.

5. Taxable purchases. Penalty, based on the compliance ratio, will generally be applied to the net underpayment of the use tax on recurring purchases of tangible personal property used regularly in the business. "Net underpayment" means use tax deficiency determined by the audit less allowable credits.

a. Withdrawals from inventory. Withdrawals are subject to the use tax on cost basis (or fabricated cost basis in the case of a fabricator/manufacturer) and should be added to taxable recurring purchases for purposes of computing the compliance ratio.

b. Fixed assets. The tax applies to purchases of fixed assets used in the business and such purchases should be added to taxable recurring purchases and taxable withdrawals from inventory for purposes of computing the compliance ratio.

6. Exceptions. Penalty generally will not be applied to audit deficiencies occurring in new areas not covered by prior audit(s), provided the application of the tax is not clearly established under existing law, regulations or other published documents of which the taxpayer reasonably should have had knowledge, or areas where the taxpayer has relied on prior correspondence with the department that has not been superseded by a law change, a change in

regulations, or other published documents of which the taxpayer reasonably should have had knowledge. Deficiencies in these areas will not be included in compliance ratio computations. Notwithstanding the above, items of like class or similar nature may be subject to penalty even though the specific item was not addressed in the previous audit(s) if the general class of items was held taxable in previous audit(s). The application of penalty to audit deficiencies will not be waived on second and subsequent audits for other than exceptional mitigating circumstances.

B. Interest.

The application of interest to all audit deficiencies is mandatory and accrues as set forth in ~~Subsection (B)~~ *§ 1 C* .

§ 3. Exemption certificates.

The Tax Commissioner may impose penalties or suspend the use of an exemption certificate for one year for any person or entity found to have misused an exemption certificate. In lieu of suspension, the Tax Commissioner may assess a penalty of up to $1,000 for the misuse of an exemption certificate by that person or entity or by any other person or entity who, with the consent or knowledge of the exemption holder, has misused the certificate. Any person who uses an exemption certificate after suspension is guilty of a Class 1 misdemeanor.

Examples:

1. An officer of a corporation engaged in the manufacturing of products for sale or resale purchases furnishings for his home using a manufacturing exemption certificate, Form ST-11. Such purchases would be deemed as a misuse of the exemption certificate.

2. A representative of a nonprofit organization, exempt under Chapter 6 (§ 58.1-600 et seq.) of Title 58.1 of the Code of Virginia, purchases groceries for his own use using a nonprofit exemption certificate, Form ST-13. Such purchases would also be deemed as a misuse of the exemption certificate.

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 EDUCATION (STATE BOARD OF)

Title of Regulation: **VR 270-01-0000. Teacher Certification Regulations. REPEALED.**

Title of Regulation: **VR 270-01-0000:1. Regulations Governing the Licensure of School Personnel.**

Statutory Authority: § 22.1-298 of the Code of Virginia.

Effective Date: July 1, 1993.

Summary:

The Licensure Regulations for School Personnel state the criteria for licensing of teachers, administrators, and support personnel. The regulations are established to maintain standards of professional competence and to ensure a level of training and preparation that will lead to successful practice in the classroom. Licensing of teachers and administrators in Virginia facilitates reciprocity in the licensure process across states.

In 1989, a steering committee composed of subcommittees in the areas of licensure, teaching areas, and support personnel was established to submit proposed licensure revisions to the Advisory Board on Teacher Education and Licensure. Task forces, subcommittees, and the steering committee were composed of representatives from local school divisions, institutions of higher education, associations, the Department of Education, and other concerned parties. During the past year and a half, the Advisory Board on Teacher Education and Licensure has been reviewing and refining their proposal. Following a preliminary public comment period which ended September 30, 1991, the Advisory Board completed its work in January 1992 and made its recommendations to the State Board of Education.

The requirements include the following general areas: general studies, professional studies, and specific endorsement requirements. The regulations also set forth types of licenses; procedures for adding and deleting endorsements; testing requirements; alternate route to licensure; licensure renewal; requirements governing revocation, cancellation, suspension, denial, and reinstatement of teaching licenses; and the responsibility of the Advisory Board on Teacher Education and Licensure.

Major revisions include the establishment of two new licenses (vocational evaluator and division superintendent); eight new endorsement areas (adult education, adult English as a second language, computer science, keyboarding, dance, foreign languages in elementary grades, gifted education, and vocational special needs); new procedure to adding and deleting endorsements; and a new approach to the alternative route to licensure. Other revisions include: (i) renaming the vocational education certificate to the technical professional license–only individuals without a baccalaureate degree would be eligible for the technical professional license; (ii) increasing the number of hours required in professional studies; (iii) requiring one year of full-time teaching under a mentor teacher in the alternate route to certification; and (iv) changing the grade-level designations in elementary/middle schools to early education NK-3, elementary grades 3-6, and middle education grades 6-8.

VR 270-01-0000:1. Regulations Governing the Licensure of School Personnel.

PART I.
DEFINITIONS.

§ 1.1. Definitions.

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

"Accredited institution" means an institution of higher education which is accredited by a state, regional, or national accrediting agency recognized by the United States Department of Education.

"Cancellation" means the annulment, voiding, or invalidation of a teaching license following voluntary surrender of the license by the license holder.

"Collegiate Professional License" means a five-year, renewable license available to an individual who has satisfied all requirements for licensure, including the NTE. It is also issued to an applicant from out-of-state with a current, valid license from that state or who has completed an approved teacher preparation program in another state in a comparable endorsement area and who has met the NTE requirement.

"Content area course work" means courses at the undergraduate level (two or four-year institution) or at the graduate level that will not duplicate previous courses taken in the humanities, history and the social sciences, the sciences, mathematics, health and physical education,

and the fine arts. These courses are usually available through the college or department of arts or sciences.

"Denial" means the refusal to grant a teaching license to a new applicant, or to an applicant who is reapplying after the expiration of a license.

"Postgraduate Professional License" means a five-year, renewable license available to an individual who has qualified for the Collegiate Professional License and who holds an appropriate earned graduate degree from an accredited institution.

[~~*"Probationary NTE License" means a license which is issued only at the request of the employing educational agency for the employed individual who is eligible for licensure but who needs to successfully complete the National Teacher Examinations (NTE). The license is nonrenewable and may not be extended. The license is issued upon the date of employment for one year to allow the NTE requirement to be met. The probationary NTE license year will be counted as one of the two years of the two-year provisional license.*~~]

"Provisional License" means a nonrenewable license issued for a period of two years [*to individuals who have been employed be a Virginia educational agency. The Provisional License will be issued for a two-year period for the 1992-93 school year; thereafter, the license will be issued for a three-year period.*] *It is available to:*

1. An individual holding a baccalaureate degree from an accredited institution who meets the requirements for one or more endorsement areas (in-state or out-of-state); or

2. An individual entering the teaching field through the alternate route to licensure upon recommendation of the employing educational agency; or

3. An individual failing to meet an allowable portion of general, professional or specific endorsement requirements; [~~*or*~~]

4. An individual seeking the Technical Professional License [*: ; or*]

[*5. An individual who is eligible for licensure but who needs to successfully complete the National Teacher Examinations (NTE) requirement. (The NTE requirement will be replaced by the PRAXIS series at the preservice level July 1994.)]*

"Pupil Personnel Services License" means a five-year, renewable license available to an individual who has earned an appropriate graduate degree from an accredited institution with an endorsement for guidance counselor, school psychologist, school social worker or visiting teacher. This license does not require teaching experience.

"Revocation" means the annulment by recalling, repealing, or rescinding a teaching license.

[~~*"School Nurse License" means a five-year, renewable license available to a person licensed as a registered nurse in Virginia and who has completed a minimum of one-year, full-time experience in nursing (child health or community health preferred) and 12 semester hours of specific undergraduate/graduate credit distributed in the areas of nursing and related support. Refer to the School Nurse License requirements listed under the Support Personnel section of these regulations.*~~]

"Superintendent License" means a five-year, renewable license and is available to an individual who has completed an earned master's degree from an accredited institution of higher education and completed specific requirements through one of three options outlined in the Support Personnel section of these regulations. The individual's name must be listed on the Board of Education's Eligible List of Division Superintendents.

"Suspension" means the temporary withdrawal of a teaching license.

"Technical Professional License" means a five-year, renewable license available to a person who [~~*does not hold a baccalaureate degree, but has exhibited academic proficiency, technical competency, and occupational experience. Individuals must complete the Vocational Teacher Development Program and nine semester hours of college credit to be eligible*~~ *has graduated from an accredited high school (or possession of a General Education Development Certificate) who does not hold a baccalaureate degree, but has exhibited academic proficiency, technical competency and occupational experience. Individuals must: (i) hold a license issued by the appropriate Virginia board for those program areas requiring a license and a minimum of two years of satisfactory experience at the journeyman level or an equivalent, or (ii) have completed a registered apprenticeship program and two years of satisfactory experience at the journeyman level or an equivalent level in the trade, or (iii) have four years of work experience at the management or supervisory level or equivalent, or (iv) have a combination of four years of training and work experience at the management or supervisory level or equivalent. Individuals must have completed nine semester hours of specialized professional studies credit from an accredited college or university. The Technical Professional License is issued at the recommendation of an employing educational agency.*

"Vocational Evaluator License" means a five-year, renewable license available to an individual who has earned at least a bachelor's degree from an accredited institution. Refer to the vocational evaluator license requirements listed under Part VIII of these regulations. Teaching experience is not a requirement of this license.]

PART II.
ADMINISTERING THE REGULATIONS.

§ 2.1. In administering the regulations, modifications may be made in exceptional cases by the Superintendent of Public Instruction.

PART III.
LICENSURE.

§ 3.1. Purpose and responsibility for licensure.

The primary purpose of licensure of teachers and other school personnel is to maintain standards of professional competence. The responsibility for licensure is set forth in § 22.1-298 of the Code of Virginia. The Board of Education shall, by regulation, prescribe the requirements for licensure of teachers.

§ 3.2. Conditions for licensure.

In accordance with this authority, the Board of Education prescribes these regulations. Applicants for licensure will:

1. Be at least 18 years of age;

2. Pay the appropriate fees as determined by the Board of Education and complete the application process;

3. Have earned a baccalaureate degree (with the exception of the Technical Professional License [~~and the School Nurse License~~]) , from an accredited institution of higher education; and

4. Possess good moral character (free of conditions outlined in Part IV).

§ 3.3. Types of licenses.

The following types of licenses are available:

[~~1. Probationary NTE License.~~]

[~~2.~~ 1.] Provisional License.

[~~3.~~ 2.] Technical Professional License.

[~~4. School Nurse License.~~]

[~~5.~~ 3.] Collegiate Professional License.

[~~6.~~ 4.] Postgraduate Professional License.

[~~7.~~ 5.] Pupil Personnel Services License.

[~~8.~~ 6.] Superintendent License.

[7. Vocational Evaluator License.]

§ 3.4. Dating of licenses.

All licenses will be [~~dated~~ effective] from July 1 in the year in which the application was made. [~~The only exception to this is the Probationary NTE License.~~]

§ 3.5. Additional endorsements.

One or more endorsements may be added to the license provided that specific endorsement requirements have been met. Written requests are made by the licensed professional and should be directed to the employing educational agency [; ~~college or university, or may be submitted by the individual with written notice being sent to the educational agency~~ or college/university. If the request is not acted upon by the local educational agency within 30 days, or is disputed, the license holder may make a written request for an additional endorsement directly to the Office of Professional Licensure, Virginia Department of Education] . Written requests should be submitted by January 15 to be in effect by July 1 of that year.

§ 3.6. Deletion of an endorsement.

An endorsement may be deleted from a license at the request of the licensed professional. Written requests are made by the licensed professional and should be directed to the employing educational agency [~~or may be submitted by the individual with written notice being sent to the educational agency~~] . [If the request is not acted upon by the local educational agency within 30 days, or is disputed, the license holder may make a written request for the deletion of an endorsement directly to the Office of Professional Licensure, Virginia Department of Education.] Written requests should be submitted by January 15 to be in effect by July 1 of that year. Individuals who wish to later add an endorsement which has been deleted must meet requirements for that endorsement at the time the endorsement is requested.

§ 3.7. National Teacher Examinations.

All candidates who hold at least a bachelor's degree and who seek an initial Virginia teaching license must obtain passing scores on the National Teacher Examinations (NTE) including the three tests of the Core Battery [~~Examination~~ Examinations] and an appropriate Specialty Area test. Candidates seeking a Technical Professional License [~~and the School Nurse License~~ and the Vocational Evaluator License] are not required to take the NTE. Individuals who have completed a minimum of two years of full-time, successful teaching experience in an accredited public or nonpublic school (kindergarten through 12th grade) will be exempted from the NTE requirement.

§ 3.8. Alternate route to licensure.

A. Alternative programs developed by institutions of higher education (i) recognize the unique strengths of prospective teachers from nontraditional backgrounds, and (ii) prepare these individuals to meet the same standards that are established for others who are granted a

provisional license.

B. [~~The~~ An] alternate route is available to those individuals employed by an educational agency seeking teaching endorsements Kindergarten through Grade 12. Endorsements at the elementary or middle school level may require the individual to take courses that are consistent with content and other unique practices for working with students at these levels.

[~~C.~~ 1.] Guidelines.

[~~1.~~ a.] An individual seeking a Provisional License through the alternate route must have:

[~~a.~~ (1)] Earned a baccalaureate degree in the arts and sciences from an accredited institution of higher education;

[~~b.~~ (2)] Completed course work, or its equivalency, in the following:

General Studies: 46 semester hours.

[~~(1)~~ (a)] Arts and humanities-9 semester hours;

[~~(2)~~ (b)] Written and oral communication skills-6 semester hours;

[~~(3)~~ (c)] Mathematics-6 semester hours;

[~~(4)~~ (d)] Literature-3 semester hours;

[~~(5)~~ (e)] History-6 semester hours;

[~~(6)~~ (f)] Social sciences-6 semester hours;

[~~(7)~~ (g)] Sciences-6 semester hours;

[~~(8)~~ (h)] Computer science-1 semester hour; and

[~~(9)~~ (i)] Health and physical education-3 semester hours.

Those persons who have an undergraduate degree other than arts and sciences wishing to teach at the NK-8 levels must meet the equivalent requirements for courses in the arts and sciences prior to employment.

[~~c.~~ (3)] Met endorsement requirements for subject areas; and

[~~d.~~ (4)] Successfully completed the National Teacher Examinations (NTE). (If the individual has not satisfied the NTE requirement, a [~~one-year, nonrenewable probationary license~~ two-year Provisional License] may be issued upon the request of the employing educational agency.)

[~~2.~~ b.] The following requirements shall be satisfied within the validity period of the Provisional License:

[~~a.~~ (1)] Professional Studies: 15 semester hours.

A minimum of 15 semester hours of professional studies in Areas I, II, III, and IV which must include the following competencies: subject area content indicating depth and breadth of subject, organization, classroom management, understanding of the various patterns of human growth and development, individual differences, evaluation, multicultural differences, and reading.

[~~(1)~~ (a)] Area I - Human Growth and Development: 3 semester hours.

Skills in this area shall contribute to an understanding of the physical, social, emotional, and intellectual development of children and the ability to use this understanding in guiding learning experiences. The self-esteem and interaction of children with individual differences should be included.

[~~(2)~~ (b)] Area II - Curriculum and Instructional Procedures: 6 semester hours.

Skills in this area shall contribute to an understanding of the principles of learning; the application of skills in discipline-specific methodology; communication processes; classroom management; selection and use of materials, including media and computers; and evaluation of pupil performance. In addition, teaching methods appropriate for exceptional students, including the gifted and talented and those with disabling conditions, shall be included. Course work will include field experiences at the appropriate level(s).

[~~(3)~~ (c)] Area III - Foundations of Education: 3 semester hours.

Skills in this area shall be designed to develop an understanding of the historical, philosophical, and sociological foundations underlying the role, development and organization of public education in the United States. Attention should be given to the legal status of students and teachers, including federal and state laws and regulations, school as an organization/culture, and contemporary issues in education.

[~~(4)~~ (d)] Area IV - Reading: 3 semester hours.

NK-3 [~~Developmental~~ Teaching of] Reading

3-6 Diagnostic or Content Area.

6-8 Reading in Content Area.

8-12 Adult Literacy or Content Area.

[~~b.~~ (2)] Complete one year of successful, full-time experience in the appropriate teaching area [~~under the direct supervision of a mentor teacher fully licensed in the same specialty area, trained in a program that complies with established Board of Education guidelines~~] . [A fully licensed, experienced teacher in the school building must be available to assist the beginning teacher employed through the alternative route.]

[C. A Virginia educational agency may submit to the Superintendent of Public Instruction for his approval an alternative program for licensure. Requirements for the Provisional License include:

1. A baccalaureate degree and the course work for the teaching area sought.

2. Training (seminar, internship, course work, etc.) in curriculum, methodology, and learning styles.

3. A fully licensed teacher in the school building available to assist the beginning teacher employed through the alternative route.]

§ 3.9. Requirements for renewing a license.

A. The Superintendent, Postgraduate Professional, Collegiate Professional, Technical Professional, [~~School Nurse, and~~] Pupil Personnel Services [, and Vocational Evaluator] licenses may be renewed upon the completion of 180 professional development points within a five-year validity period based on an individualized professional development plan. Professional development points can be accrued by the completion of activities drawn from one or more of the following options: college credit, professional conference, peer observation, educational travel, curriculum development, publication of article, publication of book, mentorship/supervision, educational project, employing educational agency professional development activity.

B. A minimum of 90 points (three semester hours in a content area) in the license holder's endorsement area(s) shall be required of license holders without a master's degree and may be satisfied at the undergraduate (two- or four-year institution) or at the graduate level. Special education course work designed to assist classroom teachers and other school personnel in working with students with disabilities may be completed to satisfy the content course requirement. Technical Professional License [~~or School Nurse License~~] holders without baccalaureate degrees may satisfy the requirement through vocational education workshops, vocational education institutes, or through undergraduate course work at two- or four-year institutions.

C. Content area course work is defined as courses at the undergraduate level (two- or four-year institution) or at the graduate level that will not duplicate previous courses taken in the humanities, history and the social sciences, the sciences, mathematics, health and physical education, and the fine arts. These courses are usually available through the college or department of arts and sciences. License holders with elementary education, middle education, special education, or reading endorsement(s) must satisfy the 90-point requirement through content course work in one of the areas listed above. Courses available through the college or department of education may be used to satisfy the content requirement for those license holders with endorsements in health and physical education, vocational education, and library science education.

D. With prior approval of the division superintendent, the 90 points in a content area may also be satisfied through: (i) course work taken to obtain a new teaching endorsement or (ii) course work taken because of a particular need of a particular teacher.

E. The remaining 90 points may be accrued by activities drawn from one or more of the 10 options described in The Virginia Renewal Manual. Renewal work is designed to provide licensed personnel with opportunities for professional development relative to the grade level(s) or teaching field(s) to which they are assigned or for which they seek an added endorsement. Such professional development encompasses both (i) responsible remediation of any area of an individual's knowledge or skills that fails to meet the standards of competency and (ii) responsible efforts to increase one's knowledge of new developments in one's field and to respond to new curricular demands within one's area of professional competence.

F. The proposed work toward renewal in certain options must be approved by the chief executive officer or designee of the employing educational agency prior to taking the renewal work. Persons who are not employed by an educational agency may renew or reinstate their license by submitting to the Office of Professional Licensure, Department of Education, their Individualized Renewal Record and official student transcripts verifying course work taken from an accredited two- or four-year college or university.

[~~G. Persons who have completed an earned doctorate degree in the area in which they are employed, with the approval of the chief executive officer or designee of the employing educational agency, may submit their completed Individualized Renewal Record to the Office of Professional Licensure, Department of Education~~] .

[~~H.~~ G.] Accrual of professional development points shall be determined by the criteria set forth [~~in The Virginia Renewal Manual~~ by the Virginia Department of Education] .

[H. Effective July 1, 1993, Virginia school divisions and private schools will renew licenses using the Recertification Point System.]

PART IV.
REVOCATION, CANCELLATION, SUSPENSION, DENIAL AND REINSTATEMENT OF TEACHING LICENSES.

§ 4.1. Revocation.

A. A teaching license may be revoked for the following reasons:

1. Obtaining or attempting to obtain such license by fraudulent means or through misrepresentation of material facts;

2. Falsification of school records, documents, statistics, or reports;

3. Conviction of any felony;

4. Conviction of any misdemeanor involving moral turpitude;

5. Conduct, such as immorality, or personal condition detrimental to the health, welfare, discipline, or morale of students or to the best interest of the public schools of the Commonwealth of Virginia;

6. Misapplication of or failure to account for school funds or other school properties with which the licensee has been entrusted;

7. Other good and just cause of a similar nature.

B. Procedures.

1. Submission of complaints. A complaint may be filed by anyone, but it shall be the duty of a division superintendent, principal or other responsible school employee to file a complaint in any case in which he has knowledge that a holder of a teaching license is guilty of any offense set forth in subsection A of this section. The person making the complaint shall submit it in writing to the appropriate division superintendent.

2. Action by division superintendent. Investigation: Upon receipt of the complaint against the holder of a teaching license, a division superintendent or his duly authorized representative shall investigate the charge.

If, on the basis of such investigation, the division superintendent finds the complaint to be without merit, he shall so notify the complaining party or parties in writing and then close his file on the matter. This action shall be final unless the local school board, on its own motion, votes to proceed to a hearing on the complaint or unless circumstances are present making this section of the regulations applicable.

C. Petition for revocation.

Should the division superintendent or local school board conclude that there is reasonable cause to believe that a complaint against the holder of a teaching license is well-founded, the teacher shall be notified of the complaint by a written "petition for revocation of a license" signed by the division superintendent. A copy of such petition shall be sent by registered mail, return receipt requested, to the teacher's last known address. If not otherwise known, the last known address shall be the address shown in the records of the Department of Education.

D. Form of petition.

The petition for the revocation of a license shall set forth:

1. The name and last known address of the person against whom the petition is being filed;

2. The social security number of and the type of license held by the person against whom the petition is being filed;

3. The offenses which are alleged and the specific actions which comprise the alleged offenses;

4. The name and address of the party filing the original complaint against the license holder;

5. A copy of the regulations which contain a statement of the rights of the person charged under these regulations; and

6. Any other pertinent information.

E. Filing of petition.

The original petition shall be entered in the files of the local school board where the license holder is employed.

F. Response to petition.

The license holder shall present his written answer, if any, to the petition within 14 days after the date of service of the petition as certified by the United States Postal Service.

1. If the teacher in his answer to the petition states that he does not wish to contest the charges, he may voluntarily return his license to the division superintendent with a written and signed statement requesting cancellation. The Superintendent of Public Instruction is authorized, upon receipt of the license holder's written and signed request from the division superintendent, to cancel the teaching license.

2. If the license holder files a written answer admitting the charges, or refuses to accept the copy of the petition from the postal authorities, or fails to file a written answer within 14 days after service of the petition upon him, or has failed to provide postal authorities with a forwarding address so that the

petition can be delivered, the local school board shall proceed to a hearing as described in this section.

3. If the license holder files his written answer denying the charges in the petition, the local school board shall provide a hearing at the time and place of its regular meeting or at such other reasonable time and place it may specify. The license holder or his representative, if any, shall be given at least 14 days notice of the hearing.

4. Following its hearing, the local school board shall receive the recommendation of the division superintendent and then either dismiss the charges or make such recommendations relative to revocation of a license as it deems appropriate. A decision to dismiss the charges shall be final (except as specified in § 4.1 G), and the investigative file on the charges shall be closed forthwith, and destroyed or maintained as a separate sealed file under provision of the Code of Virginia. Any record or material relating to the charges in any other file will be removed or destroyed. Should the local school board recommend the revocation or suspension of a license, this recommendation, along with the investigative file, shall promptly be forwarded by the division superintendent to the Superintendent of Public Instruction.

G. Revocation on motion of Board of Education.

The Board of Education reserves the right, in situations not covered by the foregoing regulations, to act directly in revoking a license. No such revocation will be ordered without the involved license holder being given the opportunity for the hearing specified in § 4.6 B.

H. Reinstatement of license.

A license that has been revoked may be reinstated by the Board of Education after five years, if the board is satisfied that reinstatement is in the best interest of the former license holder and the public schools of the Commonwealth of Virginia. The license holder must apply to the board for reinstatement. Notification to all appropriate parties will be communicated in writing by the state agency.

§ 4.2. Cancellation.

A. A teaching license may be cancelled by voluntary return by the individual, or for reasons listed under § 4.1 A, or for the following reason:

The teacher in his answer to the petition as described in [§ ~~4.2 D~~ § 4.1 F] states that he does not wish to contest the charges. Reasons for cancellation are the same as those listed under § 4.1 A.

B. Procedures.

The individual may voluntarily return the license to the division superintendent with a written and signed statement requesting cancellation. The Superintendent of Public Instruction is authorized, upon receipt of the license holder's written and signed request from the division superintendent, to cancel the license.

However, no such cancellation will be made without the involved license holder being given the opportunity for a hearing as specified in § 4.6 B.

C. Reinstatement of license.

A license that has been returned for cancellation may be reissued using the normal procedure for application, if the board is satisfied that reinstatement is in the best interest of the former license holder and the public schools of the Commonwealth of Virginia. The license holder must apply to the board for reinstatement. Notification to all appropriate parties will be communicated in writing by the state agency.

§ 4.3. Suspension.

A. A teaching license may be suspended for the following reasons:

1. Physical, mental, or emotional incapacity as shown by a competent medical authority;

2. Incompetency or neglect of duty;

3. Failure or refusal to comply with school laws and regulations, including willful violation of contractual obligations; or

4. Other good and just cause of a similar nature.

B. Procedures.

1. Submission of complaints. A complaint may be filed by anyone, but it shall be the duty of a division superintendent, principal or other responsible school employee to file a complaint in any case in which he has knowledge that a holder of a teaching license is guilty of any offense set forth in § 4.3 A of these regulations. The person making the complaint shall submit it in writing to the appropriate division superintendent.

2. Action by division superintendent. Investigation: Upon receipt of the complaint against the holder of a teaching license, a division superintendent or his duly authorized representative shall investigate the charge.

a. If, on the basis of such investigation, the division superintendent finds the complaint to be without merit, he shall so notify the complaining party or parties in writing and then close his file on the matter. This action shall be final unless the local school board, on its own motion, votes to proceed to a hearing on the complaint or unless circumstances

are present making § 4.3 B 2 b of the regulations applicable.

b. Petition for suspension. Should the division superintendent or local school board conclude that there is reasonable cause to believe that a complaint against the holder of a teaching license is well-founded, the teacher shall be notified of the complaint by a written "petition for suspension of a license form" signed by the division superintendent. A copy of such petition shall be sent by registered mail, return receipt requested, to the teacher's last known address. If not otherwise known, the last known address shall be the address shown in the records of the Department of Education.

c. Form of petition. The petition for the suspension of a license shall set forth:

(1) The name and last known address of the person against whom the petition is being filed;

(2) The social security number of and the type of license held by the person against whom the petition is being filed;

(3) The offenses which are alleged and the specific actions which comprise the alleged offenses;

(4) The name and address of the party filing the original complaint against the license holder;

(5) A statement of the rights of the person charged under these regulations; and

(6) Any other pertinent information.

C. Filing of petition.

The original petition shall be entered in the files of the local school board where the license holder is employed.

D. Response to petition.

The license holder shall present his written answer, if any, to the petition within 14 days after the date of service of the petition as certified by the United States Postal Service.

1. If the teacher in his answer to the petition states that he does not wish to contest the charges, he may voluntarily return his license to the division superintendent with a written and signed statement requesting suspension. The Superintendent of Public Instruction is authorized, upon receipt of the license holder's written and signed request from the division superintendent, to cancel the teaching license.

2. If the license holder files a written answer admitting the charges, or refuses to accept the copy of the petition from the postal authorities, or fails to file a written answer within 14 days after service of the petition upon him, or has failed to provide postal authorities with a forwarding address so that the petition can be delivered, the local school board shall proceed to a hearing as described in this section.

3. If the license holder files his written answer denying the charges in the petition, the local school board shall provide a hearing at the time and place of its regular meeting or at such other reasonable time and place it may specify. The license holder or his representative, if any, shall be given at least 14 days notice of the hearing.

4. Following its hearing, the local school board shall receive the recommendation of the division superintendent and then either dismiss the charges or make such recommendations relative to suspension of a license as it deems appropriate. A decision to dismiss the charges shall be final, except as specified in § 4.3 E, and the file on the charges shall be closed forthwith and all materials expunged. Should the local school board recommend the suspension of a license, this recommendation, along with supporting evidence, shall promptly be forwarded by the division superintendent to the Superintendent of Public Instruction.

E. Suspension on motion of Board of Education.

The Board of Education reserves the right, in situations not covered by the foregoing regulations, to act directly in suspending a license. No such suspension will be ordered without the involved license holder being given the opportunity for the hearing as specified.

F. Reinstatement of license.

A license may be suspended for a period of time not to exceed five years. The license may be reinstated by the Department of Education upon request with verification that all requirements for license renewal have been satisfied. The license holder must apply to the board for reinstatement. Notification to all appropriate parties will be communicated in writing by the state agency.

§ 4.4. Denial.

A. A teaching license may be denied for the following reasons:

1. Attempting to obtain such license by fraudulent means or through misrepresentation of material facts;

2. Falsification of records or documents;

3. Conviction of any felony;

4. Conviction of any misdemeanor involving moral turpitude;

5. Conduct, such as immorality, or personal condition detrimental to the health, welfare, discipline, or morale of students or to the best interest of the public schools of the Commonwealth of Virginia;

6. Revocation of the license by another state; and

7. Other good and just cause of a similar nature.

B. Expired license.

The holder of a teaching license which has expired may be denied renewal or reinstatement by the Superintendent of Public Instruction for any of the reasons specified in § 4.1 A of these regulations. No such denial will be ordered unless the license holder is given the opportunity for the hearing specified in § 4.6 B.

§ 4.5. Right to counsel and transcript.

A license holder shall have the right, at his own expense, to be represented by counsel of his choice at the local school board hearing provided for in § 4.5 or in the proceedings before the Board of Education as specified in § 4.6 A. Counsel may, but need not, be an attorney. Any such hearing before a local school board and any hearing before the Board of Education shall be recorded, and the party charged shall be provided, upon written request, a hearing transcript without charge.

§ 4.6. Action by the State Superintendent of Public Instruction and the Board of Education.

A. Upon receipt of the complaint from the local school division, the Superintendent of Public Instruction will ensure that an investigative panel at the state level reviews the petition. The panel shall consist of three to five members selected by the Division Chief, Compliance Coordination, Virginia Department of Education. The license holder should be notified within 14 days of the receipt of the complaint to the Department of Education as to the date, time and location of this hearing. Both parties, the local school division and the license holder, are entitled to be present with counsel if so desired. The recommendation of the state level panel is made to the state superintendent, for presentation to the State Board of Education. He shall then present his report to the Board of Education or its duly designated committee at one of its duly scheduled meetings. The license holder shall be given at least 14 days notice, in the manner specified in § 4.1 F, of the date on which the Superintendent of Public Instruction's report will be continued, where necessary, from one Board of Education or committee meeting to another.

B. Hearing.

The Board of Education, or its duly designated committee, shall receive and consider the report of the Superintendent of Public Instruction and such relevant and material evidence as the license holder may desire to present at the hearing. At the conclusion of the hearing, the Superintendent of Public Instruction may make his recommendation as to what revocation or suspension action should be taken by the Board of Education. The Board of Education will then enter its order within 14 days after the hearing has concluded. This order will contain findings of fact either sustaining or dismissing the complaint.

C. Decision not to revoke or suspend.

If the decision of the Board of Education is not to revoke or suspend the license, the license holder and the principal complainants will be so notified and the Board of Education's file and any other record or material will be removed or destroyed.

D. Decision to revoke or suspend.

If the decision of the Board of Education is to revoke or suspend the license, a written order will be entered in the minutes of the meeting at which the matter was decided. A copy of this order will be sent to the license holder and the principal complainants.

§ 4.7. Right of license holder to appear at hearing.

A license holder shall have the right to appear in person at local school board, Board of Education, or Board of Education committee hearings described herein unless he is confined to jail or a penal institution. The local school board or Board of Education, at its discretion, may continue such hearings for a reasonable time, if the license holder is prevented from appearing in person for such reasons as documented medical or mental impairment.

§ 4.8. Notification.

Notification of the revocation, denial, or reinstatement of a teaching license shall be made by the Superintendent of Public Instruction, or by his designee, via registered or certified mail, to division superintendents in Virginia and to chief state school officers of the other states, and territories of the United States.

PART V.
ADVISORY BOARD ON TEACHER EDUCATION AND LICENSURE.

§ 5.1. Advisory Board on Teacher Education and Licensure.

A. As set forth in § 22.1-305.2 in the Code of Virginia, the Advisory Board on Teacher Education and Licensure advises the Board of Education on policies applicable to the licensure of school personnel.

B. Of the members who are classroom teachers of the advisory board, one may represent accredited private schools, one shall be a teacher of special education, and

one shall be a teacher of vocational education.

C. The Board of Education may appoint the members of the advisory board from nominations submitted by state societies or incorporated associations with statewide membership representing teachers, principals, superintendents, school personnel administrators, school boards, parents, teacher preparation programs and others.

D. The Advisory Board on Teacher Education and Licensure shall undertake such studies related to licensure as the Board of Education may request or the Advisory Board on Teacher Education and Licensure may recommend to the Board of Education.

E. The Board of Education shall make a timely response to recommendations from the advisory board.

F. The Advisory Board on Teacher Education and Licensure shall make at least one annual presentation to the Board of Education, and shall make additional presentations on the call of the members of the Advisory Board on Teacher Education and Licensure.

PART VI.
GENERAL AND PROFESSIONAL STUDIES REQUIREMENTS.

§ 6.1. General studies requirements.

A. Prospective candidates for licensure, with the exception of those seeking the Technical Professional License, in the Commonwealth of Virginia must provide evidence of the completion of a general education program that meets the standards.

B. The general education background for all students shall include a minimum of 46 semester credit hours of course work to include the following requirements. General studies course work may be applied to an endorsement unless otherwise noted.

Arts and humanities ..... 9 semester hours.
(art, music, philosophy, and foreign language).

Written and oral communication skills
(including but not limited to
English grammar and composition).
..... 6 semester hours.

Literature ..... 3 semester hours.

Mathematics ..... 6 semester hours.
(algebra or calculus equivalent).

History ..... 6 semester hours.
(must include American History).

Social sciences ..... 6 semester hours.

Sciences ..... 6 semester hours.
(one course must include laboratory).

Computer sciences ..... 1 semester hour.

Health and physical education .... 3 semester hours.
(may include course work designated.
as health, physical education,
wellness, recreation, physical.
fitness, and related descriptors).

§ 6.2. Professional studies requirements.

A. An applicant for licensure, with the exception of those applying for the Technical Professional License, shall have completed a professional education program with a minimum of 15 semester hours with the distribution of semester hour requirements as stipulated in the following areas.

1. Human growth and development (birth through adolescence): 3 semester hours.

Skills in this area shall contribute to an understanding of the physical, social, emotional, and intellectual development of children and the ability to use this understanding in guiding learning experiences. The self-esteem and interaction of children with individual differences–economic, social, racial, ethnic, religious, physical, and mental–should be incorporated to include skills contributing to an understanding of developmental disabilities and developmental issues related to and not limited to substance abuse, child abuse, family disruptions.

2. Curriculum and instructional procedures: 6 semester hours.

Skills in this area shall contribute to an understanding of the principles of learning; the application of skills in discipline-specific methodology; communication processes; classroom management; selection and use of materials, including media and computers; and evaluation of pupil performance. In addition, teaching methods appropriate for exceptional students, including gifted and talented and those with disabling conditions, methods appropriate for the level of endorsement sought, shall be included. Pre-student teaching experiences (field experiences) should be evident within these skills. For NK-12 field experiences must be at the elementary, middle, and secondary levels.

3. Foundations of education: 3 semester hours.

Skills in this area shall be designed to develop an understanding of the historical, philosophical, and sociological foundations underlying the role, development and organization of public education in the United States. Attention should be given to the legal status of teachers and students, including federal and state laws and regulations, school as an organization/culture, and contemporary issues in

education.

4. Reading: 3 semester hours.

NK-3 [~~Developmental~~ Teaching of] Reading.

3-6 Diagnostic or Content Area.

6-8 Reading in Content Area.

8-12 Adult Literacy or Content Area.

B. Supervised classroom experience.

The student teaching experience should provide for the prospective teacher to be in classrooms full-time for a minimum of 200 clock hours. At least 150 hours shall be in direct teaching activities (providing direct instruction) at the level of endorsement. If an NK-12 endorsement is sought, teaching activities must be at the elementary and middle or secondary levels. Individuals seeking the endorsement in library media must complete the supervised experience in a library media setting. Individuals seeking an endorsement in an area of special education must complete the supervised classroom experience requirement in the area of disability the endorsement is sought. Two years of successful full-time teaching experience in an appropriate area in any accredited public or nonpublic school may be accepted in lieu of the supervised teaching experience.

PART VII.
TEACHING ENDORSEMENT AREAS.

§ 7.1. Adult education.

The applicant seeking an endorsement in adult education shall complete the following:

1. Hold a baccalaureate degree from an accredited college or university or hold a Collegiate Professional License;

2. Individuals not holding a Collegiate Professional License must satisfy the NTE requirement (three Core Battery tests);

3. 15 semester hours of course work distributed in the following areas:

a. The adult learner: 3 semester hours;

Experiences shall include the nature or psychology of the adult learner, or adult development.

b. Methods and materials: 3 semester hours;

Experiences shall include methods and materials for adult basic skills.

c. Reading for adults: 3 semester hours; and

d. Electives: 6 semester hours.

Experiences shall include course work selected from the following areas:

(1) Curriculum development in adult basic education or GED instruction;

(2) Beginning reading for adults;

(3) Reading comprehension for adult education;

(4) Beginning mathematics for adults;

(5) Foundations of adult education; and

(6) Other adult basic skills instruction.

5. Teaching experience. All applicants shall complete one year of supervised successful full-time or an equivalent number of hours of part-time teaching of adults.

§ 7.2. Adult English as a second language.

The applicant seeking an endorsement in adult English as a second language shall complete the following:

1. Hold a baccalaureate degree from an accredited college or university or hold a Collegiate Professional License.

2. Individuals not holding a Collegiate Professional License must satisfy the NTE requirement (three Core Battery tests).

3. 21 semester hours of course work distributed in the following areas:

a. Methods for Teaching ESL to Adults: 3 semester hours;

b. English Linguistics: 3 semester hours;

c. Cross-cultural education: 3 semester hours;

d. Modern foreign language: 3 semester hours; and

e. Electives: 6 semester hours:

(1) Cross-cultural communication;

(2) Second language acquisition;

(3) General linguistics;

(4) Teaching reading to adults;

(5) Adult ESL instruction;

(6) Adult ESL curriculum development.

4. Teaching experience. All applicants shall complete one year of supervised successful full-time or an equivalent number of hours of part-time teaching of adults.

Individuals holding a Virginia Professional License with an endorsement in English as a Second Language NK-12 may add the Adult English as a Second Language endorsement by completing three semester hours of Methods of Teaching English as a Second Language to Adults.

§ 7.3. Agriculture.

The applicant seeking an endorsement in agricultural education shall have on-the-job experience in agribusiness and shall complete a minimum of 45 semester hours of course work in the following technical agriculture areas:

1. Plant science: 3 semester hours.

2. Animal science: 3 semester hours.

3. Agricultural Mechanics: 3 semester hours.

4. Agricultural Economics and Management: 3 semester hours.

5. Microcomputers: 3 semester hours.

Experiences shall include application in agriculture.

6. Electives: 30 semester hours.

Course work selected from areas 1-4 above.

[Endorsements may be granted in the following agricultural education specialized programs: agriculture machinery service and horticulture. Occupational and professional studies requirements are specified under the Technical Professional License.]

§ 7.4. Art.

The applicant seeking endorsement in art shall complete a major in art, or the equivalent to a major in art, that includes a minimum of 36 semester hours of course work. Of these semester hours, a minimum of 9 semester hours must be in upper level courses.

1. Two-dimensional media and concepts: 12 semester hours.

Experiences shall include those basic and complex techniques and concepts in two dimensional design, drawing, painting, printmaking, and electronic imagery.

2. Three-dimensional media and concepts: 12 semester hours.

Experiences shall include basic and complex techniques and concepts in three-dimensional design, sculpture, ceramics, and crafts (such as fiber arts and jewelry making).

3. History of art: 9 semester hours.

Experiences shall include history of art, past and present, including aesthetics and criticism with emphasis on the relationship of art and culture.

4. Related areas of art: 3 semester hours.

Experiences may include related fields such as architecture, dance, music, theater, photography, and other communication arts.

§ 7.5. Biology.

The applicant seeking an endorsement in biology shall complete a major in biology, or the equivalent to a major in biology that includes a minimum of 44 semester hours of course work in the following areas:

1. Biology: 32 semester hours.

Experiences shall include zoology and botany.

2. Background requirements:

a. General chemistry: 3 semester hours.

b. Organic chemistry: 3 semester hours.

3. Mathematics: 6 semester hours.

Experiences shall include college algebra and statistics.

§ 7.6. Business education: accounting.

The applicant seeking an endorsement in accounting shall complete the following:

Accounting: 12 semester hours.

Experiences shall include principles of accounting.

§ 7.7. Business education: basic business.

The applicant seeking endorsement in basic business shall complete a minimum of 18 semester hours of course work in business principles and management which shall include a minimum of four areas selected from the following:

1. Business law;

2. Business principles;

3. Management;

4. Marketing;

5. Finance or business mathematics;

6. Insurance;

7. Policy;

8. Production; and

9. Economics.

§ 7.8. Business education: business.

The applicant seeking the comprehensive endorsement in business shall complete a minimum of 45 semester hours of course work in the following:

1. Accounting: 6 semester hours.

Experiences shall include principles of accounting.

2. Economics: 6 semester hours.

3. Business principles and management: 12 semester hours.

Experiences shall include a minimum of four selected from the following areas:

a. Business law;

b. Business principles;

c. Management;

d. Marketing;

e. Finance or business mathematics;

f. Insurance;

g. Policy; [and]

h. Production [~~;and~~ .]

[~~i. Economics.~~]

4. Administrative systems: 9 semester hours.

Experiences shall include instruction in office communications, office systems and procedures, computer applications, and software.

5. Information systems: 6 semester hours.

Experiences may include programming courses.

6. Keyboarding and word processing applications: 6 semester hours.

§ 7.9. Business education: keyboarding (add-on endorsement).

The applicant seeking an add-on endorsement in keyboarding shall complete the following:

1. An endorsement in a secondary or NK-12 subject area.

2. Keyboarding: 6 semester hours.

Experiences shall include keyboarding and word processing applications. Semester-hour requirements will be reduced when the applicant demonstrates previously acquired proficiency in typewriting by verifying successful completion of the most advanced course in typewriting offered by a college or university approved for the preparation of business education teachers.

[Endorsements may be granted in the following business education specialized areas: data processing, medical office procedures, and legal office procedures. Occupational and professional studies requirements are specified under the Technical Professional License.]

§ 7.10. Chemistry.

The applicant seeking an endorsement in chemistry shall complete a major in chemistry or the equivalent to a major in chemistry that includes a minimum of 53 semester hours of course work in the following:

1. Chemistry: 32 semester hour.

Experiences shall include physical chemistry.

2. Background requirements:

a. Biology: 3 semester hours.

b. Physics: 6 semester hours.

c. Mathematics: 12 semester hours.

Experiences shall include calculus and statistics.

§ 7.11. Computer science.

The applicant seeking an endorsement in computer science shall complete a minimum of 15 semester hours of course work in the following:

1. Data structures or algorithm analysis [or both] : 3 semester hours.

2. Introduction to computer systems: 3 semester hours.

3. Application of computer technology: 3 semester hours.

4. Computer science: 6 semester hours.

Two sequential courses.

§ 7.12. Dance NK-12.

The applicant seeking an endorsement in dance NK-12 shall complete a minimum of 24 semester hours in the following areas:

1. Development of movement language: 12 semester hours.

a. Experiences shall include a course in each of the following dance areas for a total of six semester hours:

(1) Ballet;

(2) Folk;

(3) Jazz; and

(4) Modern.

b. Area of concentration. A minimum of 3 semester hours of course work beyond entry level in one of the following dance areas:

(1) Ballet;

(2) Folk;

(3) Jazz; and

(4) Modern.

c. A minimum of 3 semester hours to include:

(1) Composition;

(2) Improvisation; and

(3) Dance production.

May include: stage lighting, stage costuming, or stage makeup.

2. Scientific foundations: 9 semester hours. Must include each of the following areas:

a. Human anatomy;

b. Kinesiology; and

c. Injury prevention and care for dance–may include exercise physiology, athletic training, or injury prevention and care.

3. Cultural Understanding: 3 semester hours.

Must include history of dance.

§ 7.13. Dance NK-12 (add-on endorsement).

The applicant seeking an add-on endorsement in dance NK-12 shall complete the following for a total of 15 semester hours:

1. An endorsement in physical education.

2. Development of movement language: 12 semester hours.

a. Experiences shall include at least a course in each of the following dance areas for a total of 6 semester hours:

(1) Ballet;

(2) Folk;

(3) Jazz; and

(4) Modern.

b. Area of concentration. A minimum of 3 semester hours of course work beyond entry level in one of the following dance areas:

(1) Ballet;

(2) Folk;

(3) Jazz; or.

(4) Modern.

c. Composition or improvisation. A minimum of 3 semester hours in one or more of the following:

(1) Composition;

(2) Improvisation; or

(3) Dance production.

May include: stage lighting, stage costuming, or stage makeup.

3. Cultural understanding: 3 semester hours.

Must include history of dance.

§ 7.14. Driver education (add-on endorsement).

The applicant seeking an add-on endorsement in driver education shall complete the following:

1. An endorsement in a secondary or NK-12 subject area.

2. Basic laboratory driver education: 3 semester hours.

Experiences shall include both classroom instruction and supervised experience in actual practice driving (behind-the-wheel) instruction.

3. Methods of teaching driver education: 3 semester hours.

Experiences shall include supervised experiences in behind-the-wheel instruction, including emergency procedures (steering, off-road recovery, stopping distance, and reaction time).

§ 7.15. Early education NK-3.

The applicant seeking the Early Education NK-3 endorsement shall complete the following:

1. An interdisciplinary study consisting of 36 semester hours in courses composed of 12 hours each in three of the following areas:

a. Arts and humanities: foreign language, fine arts, or philosophy/religion;

b. Social studies: psychology, sociology, anthropology, political science, history, economics, or geography;

c. Sciences: life sciences or physical sciences;

d. Mathematics and technology; or

e. Language arts.

2. Field experiences: 400 clock hours, at least 300 hours of which shall be in direct teaching activities (providing direct instruction). Field work should include observation of young children and adults and varying degrees of participation with children and adults in early childhood settings. Student teaching should include seminar meetings, experience in working with parents, and experience in working with interdisciplinary teams of professionals. Applicants should have student teaching placements in two different grades (200 clock hours each), at least one of which is a pre-primary experience.

Individuals seeking an endorsement in both the early childhood and elementary areas must complete requisite course work in each concentration area. Four hundred clock hours in three placements (prekindergarten or kindergarten–200 hours, first or second grade–100 hours, and third, fourth or fifth grade–100 hours), with a minimum of 200 clock hours per endorsement, must be completed.

§ 7.16. Earth science.

The applicant seeking an endorsement in earth science shall complete an interdisciplinary earth science major that includes a minimum of 42 semester hours of course work in the following:

1. Earth science: 36 semester hours.

Experiences shall include a minimum of six semester hours each of geology, oceanography, meteorology, astronomy, and an elective of 3 semester hours.

2. Background requirements: Chemistry, physics, or biology: 6 semester hours.

At least one laboratory experience shall be included.

§ 7.17. Economics.

The applicant seeking an endorsement in economics shall complete the following requirements:

Economics: 30 semester hours. Experiences shall include consumer economics.

§ 7.18. Economics (add-on endorsement).

The applicant seeking an add-on endorsement in economics shall complete the following:

1. An endorsement in history;

2. Economics: 12 semester hours;

Course work must be above the level of the original history endorsement.

3. Political science: 6 semester hours; and

4. Geography: 6 semester hours.

§ 7.19. Elementary grades 3-6.

An applicant seeking the Elementary Grades 3-6 endorsement shall complete the following:

1. Interdisciplinary study consisting of 36 semester hours in courses composed of 12 hours each in three of the following areas:

a. Arts and humanities: foreign language, fine arts, or philosophy/religion;

b. Social studies: psychology, sociology, anthropology, political science, history, economics, child development, or geography;

c. Sciences: life sciences or physical sciences;

d. Mathematics and technology;

e. English and language arts.

2. Field experiences: 400 clock hours, at least 300

hours of which shall be in direct teaching activities (providing direct instruction). Field work should include observation of young children and adults in elementary settings. Student teaching should include seminar meetings, experience in working with parents, and experience in working with interdisciplinary teams of professionals.

Individuals seeking an endorsement in both the early childhood and elementary areas must complete requisite course work in each concentration area. Four hundred clock hours in three placements (prekindergarten or kindergarten–200 hours, first or second grade–100 hours, and third, fourth or fifth grade–100 hours), with a minimum of 200 clock hours per endorsement, must be completed.

§ 7.20. English.

The applicant seeking an endorsement in English shall complete a major or its equivalent in English, including a minimum of 33 semester hours in course work in addition to the general studies requirement.

1. Literature: 18 semester hours.

Course work from each of the following areas:

a. Survey of English literature;

b. Survey of American literature;

c. World literature;

d. Ethnic/minority literature;

e. Adolescent literature; and

f. Literary theory/criticism.

2. Language: 3 semester hours.

Experiences shall include the development and nature of English, including some attention to comparative English grammar.

3. Composition: 3 semester hours.

Experiences shall include the teaching of writing, based on current knowledge and most effective practices, including the use of computers for this purpose.

4. Oral Language: 3 semester hours.

Experiences shall include the teaching of oral language in groups, as well as attention to oral language as used in both formal and informal presentations.

5. Electives: 6 semester hours.

Course work selected from any of the four areas above.

§ 7.21. English as a second language (ESL).

The applicant seeking an endorsement in English as a second language shall complete a minimum of 24 semester hours of course work in the following:

1. Teaching of development reading: 3 semester hours.

2. English linguistics: 3 semester hours.

Experiences shall include phonology, morphology and syntax of English.

3. Cross-cultural education: 3 semester hours.

4. Modern foreign language: 6 semester hours.

If applicant's primary language is other than English, all 6 hours must be in English.

5. Electives: 6 semester hours.

Course work may be selected from any of the following topics:

a. Second language acquisition;

b. General linguistics;

c. Applied linguistics;

d. Psycholinguistics;

e. Sociolinguistics;

f. ESL assessment; or

g. ESL curriculum development, including cross-cultural communication.

6. Methods for teaching ESL: 3 semester hours.

§ 7.22. Foreign language: modern (grades 6-12).

The applicant seeking an endorsement in a modern foreign language for Grades 6-12 shall complete a major or its equivalent in a modern foreign language, including a minimum of 30 semester hours of language course work above the intermediate level. Endorsement in a second foreign language endorsement may be obtained with 24 semester hours of course work above the intermediate level.

A. Option one.

First endorsement: 30 semester hours.

Experiences shall include course work in advanced

grammar and composition, conversation, culture and civilization, and literature.

B. Option two.

Added endorsement in a second modern foreign language: 24 semester hours.

Experiences shall include course work in advanced grammar and composition, conversation, culture and civilization, and literature.

C. Option three.

Native speakers or applicants who have learned the foreign language by nonacademic means.

Native speakers or applicants who have learned a foreign language without formal academic credit in a college or university must:

1. Achieve a minimum score of 600 on the Test of English as a Foreign Language, if English is not the native language. Native speakers of English are exempt from this test.

2. Achieve a composite score at or above the 50th percentile on the listening, speaking, reading, writing, civilization and culture sections of the Modern Language Association Proficiency Test for Teachers and Advanced Students. No individual section score shall be below the 25th percentile.

3. Present three semester hours of methods of teaching foreign languages from an accredited college or university in the United States.

§ 7.23. Foreign languages in elementary schools grades NK-6 (FLES) (add-on endorsement).

The applicant seeking endorsement in a modern foreign language for Grades NK-6 shall satisfy all endorsement requirements for Grades 6-12 and shall meet the specific requirements for immersion or FLES programs noted below:

A. Option one; immersion programs.

The applicant must have native or near-native proficiency in the target language and meet all requirements for an elementary teaching endorsement.

1. Achieve a minimum score of 600 on the Test of English as a Foreign Language, if English is not the native language. Native speakers of English are exempt from this test.

2. Achieve a composite score at or above the 50th percentile on the listening, speaking, reading, writing, civilization and culture sections of the Modern Language Association Proficiency Test for Teachers and Advanced Students. No individual section score shall be below the 25th percentile.

B. Option two; nonimmersion (FLES): 3 semester hours.

Experiences shall include course work in elementary teaching methods.

§ 7.24. Foreign language: Latin.

The applicant seeking an endorsement in Latin shall complete a major or its equivalent in Latin, including a minimum of 24 semester hours of Latin course work above the intermediate level.

A. Option one - Latin grades 6-12.

First endorsement: 24 semester hours.

Experiences may include up to 6 semester hours of Roman history, Roman life, mythology, or archaeology.

B. Option two - Latin grades 6-12.

Endorsement added to a modern foreign language: 15 semester hours.

Experiences may include up to 3 semester hours of Roman history, Roman life, mythology, or archaeology.

C. Option three - Latin NK-12.

The applicant seeking an endorsement in Latin for Grades NK-6 shall:

1. Hold an endorsement in Latin 6-12.

2. Elementary teaching methods: 3 semester hours.

§ 7.25. General mathematics.

The applicant seeking endorsement in general mathematics (including general, consumer and applications of mathematics) shall complete a minimum of 18 semester hours of course work which includes the following:

1. Algebra;

2. Geometry;

3. Probability and statistics;

4. Applied mathematics; and

5. Computer science.

[§ 7.26. General science.

The applicant seeking an endorsement in general science shall complete a minimum of 30 semester hours which must include the following:

1. Biology: 6 semester hours.

2. Chemistry: 6 semester hours.

3. Physics: 6 semester hours.

4. Earth and space science: 12 semester hours.]

§ [~~7.26.~~ 7.27.] Geography.

The applicant seeking an endorsement in geography shall complete a minimum of 36 semester hours of course experiences which include the following:

1. Geography: 30 semester hours.

Experiences shall include physical, cultural, or historical geography.

2. Economics: 6 semester hours.

Must include experiences in consumer economics.

§ [~~7.27.~~ 7.28.] Geography (add-on endorsement).

The applicant seeking an add-on endorsement in geography shall complete the following:

1. An endorsement in history.

2. Economics: 6 semester hours.

3. Geography: 12 semester hours.

Experiences shall include physical, cultural or historical geography.

§ [~~7.28.~~ 7.29.] Gifted education (add-on endorsement).

The applicant seeking an endorsement in gifted education shall complete the following:

1. An endorsement in an elementary, middle, secondary, or NK-12 subject.

2. 12 semester hours of graduate-level course work in gifted education to include each of the following areas:

a. Integration of the gifted student into the total school environment;

b. Characteristics of gifted students;

c. Specific techniques of identifying gifted, and diagnostic and prescriptive approaches to instruction;

d. Educational models, teaching methods and strategies, selection of resources and materials;

e. Curriculum development and program evaluation;

f. Contemporary issues and research in gifted education; and

g. Practicum experience in gifted education.

§ [~~7.29.~~ 7.30.] Health NK-12.

The applicant seeking an endorsement in health education NK-12 shall complete a minimum of 33 semester hours of course work distributed in the following:

1. Scientific background: 12 semester hours.

Human anatomy and physiology, biology, chemistry, and microbiology.

2. Behavior or social science: 6 semester hours.

Sociology/philosophy of man.

3. Health education: 3 semester hours.

Administration of the health program including health instruction, health services, healthy school environment, evaluation and health counseling, and school-community relationships related to health.

4. Basic health content: 12 semester hours.

Personal and community problems, including drugs, smoking, nutrition, fitness, consumer health, environmental health, health careers, disease prevention, safety, first aid, CPR, Heimlich Maneuver, mental and emotional health, and family life education.

§ [~~7.30.~~ 7.31.] Health education NK-12 (add-on endorsement).

The applicant seeking an add-on endorsement in health NK-12 shall complete the following:

1. An endorsement in physical education.

2. Basic health content: 12 semester hours.

Personal and community problems, including drugs, smoking, nutrition, fitness, consumer health, environmental health, health careers, disease prevention, safety, first aid, CPR, Heimlich Maneuver, mental and emotional health, and family life education.

3. Methods of teaching health: 3 semester hours.

§ [~~7.31.~~ 7.32.] Health occupations.

The applicant seeking an endorsement in health occupations education must complete the requirements in one of the following options:

A. Option one (Collegiate Professional License).

1. Hold a baccalaureate degree from an approved program of study preparing health care professionals;

2. Be licensed or certified as a professional practitioner in the area in which one is to be teaching;

3. Completed two years of occupational experience in an area related to the program to be taught; and

4. Complete a minimum of 12 semester hours of college credit in the specialized vocational education courses listed below. The courses may be completed under a Provisional License if the individual is employed as a teacher in a public or nonpublic school in Virginia.

a. Teaching methods;

b. Curriculum development; and

c. Program management.

B. Option two (Technical Professional License).

1. Be licensed or certified as a professional practitioner in the area in which one is to be teaching;

2. Completed two years of occupational experience in an area related to the program to be taught;

3. Completed a health occupations program equivalent to a two-year associate degree program; and

4. Complete a minimum of 12 semester hours of college credit in the specialized vocational education courses listed below. The course work may be taken under a provisional license if the individual is employed as a teacher in a Virginia public or nonpublic school.

a. Teaching methods;

b. Curriculum development; and

c. Program management.

§ [~~7.32.~~ 7.33.] History.

The applicant seeking an endorsement in history shall complete a minimum of 36 semester hours of course work in the following:

1. History: 30 semester hours.

Experiences shall include Virginia and American history, world history, English history, and at least one of the following: ancient history, European history, nonwestern history, or contemporary affairs.

2. Economics: 6 semester hours.

To obtain information regarding the requirements to add endorsements in economics, geography, and political science to the history endorsement, refer to these areas listed [~~alphabetically in this document~~ in §§ 7.18, 7.28, and 7.48 of this regulation] .

§ [~~7.33.~~ 7.34.] Home economics [: ~~consumer and homemaking~~ education] .

The applicant seeking an endorsement in [~~consumer and homemaking~~ home economics education] shall complete a minimum of 36 semester hours of course work in the following:

1. The development of the individual and the family: 9 semester hours.

2. Management, family finance, and consumer economics: 6 semester hours.

3. Food and nutrition: 6 semester hours.

4. Housing, home furnishings, and equipment: 6 semester hours.

5. Clothing and textiles: 3 semester hours.

6. Electives: 6 semester hours.

Course work selected from areas 1-5.

[Endorsements may be granted in the following home economics specialized areas: child care occupations, clothing occupations, food occupations, home furnishings occupations, and home and institutional services. Occupational and professional studies requirements are specified under the Technical Professional License.]

§ [~~7.34.~~ 7.35.] Industrial cooperative training (add-on endorsement).

The applicant seeking an add-on endorsement in industrial cooperative training (ICT) shall complete the following:

1. A Virginia Collegiate Professional or Postgraduate Professional License.

Experiences shall include a minimum of two years of successful full-time teaching experience.

2. Trade and industrial education: 15 semester hours.

Experiences shall include each of the following areas:

a. Administration and coordination of ICT;

b. Methods and development of related instructional materials for ICT;

c. Vocational student organizations;

d. Implementation of a competency based (CBE) curriculum; and

e. Development and utilization of directly related occupational materials.

3. Occupational experience: 4,000 clock hours.

Experiences shall include a minimum of 4,000 clock hours, or two years, of acceptable employment in the trade, technical, or industrial field in the last 10 years.

§ [~~7.35.~~ 7.36.] Journalism.

The applicant seeking an endorsement in journalism shall complete the following:

Journalism: 24 semester hours.

§ [~~7.36.~~ 7.37.] Journalism (add-on endorsement).

The applicant seeking an add-on endorsement in journalism shall complete the following:

1. An endorsement in any area.

2. Journalism: 15 semester hours.

§ [~~7.37.~~ 7.38.] Library media NK-12.

The applicant seeking an endorsement in library media NK-12 shall complete a minimum of 24 semester hours which includes the following:

1. Professionalism. Experiences shall include the philosophy and objectives of the school library and its increased responsibilities for new services; past and present role of the library media center in the school and the relationship of the school library to all types of libraries, information agencies, and appropriate local, state regional, and national professional organizations and publications.

2. Communication. Experiences shall include techniques to interpersonal skills needed to communicate effectively with students, staff, administration and the general public.

3. Collection management. Experiences shall include the application of basic principles critical to the evaluation, selection, and weeding of appropriate media resources, and the acquisition of new and traditional technologies.

4. Organization. Experiences shall include the description, classification, and subject assignment of materials, and management and automation of library technical operations.

5. Administration. Experiences shall include the identification, evaluation, planning, and management of a school library media program.

6. Instructional leadership. Experiences shall include history, development, and content of children's and young adult's media; evaluation, selection, and utilization of media and instructional equipment for children and young adults; teaching of media, reference, research, and production skills to enable student use of resources; provision of reference, referral and retrieval services; reading, listening, and viewing guidance; and the role of the library media specialist as a teacher, information specialist, and instructional consultant.

7. Access. Experience shall include the physical access, intellectual freedom, privacy and the rights of the school library media center users, and the use of computer networks for accessing resources within and outside the school.

8. Design and production. Experiences shall include the design and production of resources to use in the teaching/learning process.

§ [~~7.38.~~ 7.39.] Marketing.

The applicant seeking an endorsement in marketing shall complete a major in marketing education or the equivalent to a major in marketing education which includes a minimum of 30 semester hours in the following:

1. The marketing process: 3 semester hours.

2. Economics: 3 semester hours.

3. Specific technical areas: 9 semester hours.

Experiences shall include a minimum of three areas selected from the following:

a. Personnel;

b. Sales process;

c. Merchandising;

d. Product/service technology;

e. Operations and organization; or

f. Promotion.

4. Electives: 15 semester hours.

5. Occupational experiences: 1,000 clock hours.

Experiences shall include a minimum of 1,000 clock hours in a marketing occupation within the last five years, 500 hours of which must have been university-supervised at an approved marketing education program, or the applicant whose baccalaureate degree is in an area other than marketing education must complete a minimum 4,000 clock-hour occupational experience within the last five years in one or more marketing occupations in addition to requirements 1-4 above.

[Endorsements may be granted in the following marketing education specialized programs: apparel and accessories; financial services; hotel/motel operations; international marketing; real estate; restaurant; sports, entertainment, and recreation; and travel and tourism. Occupational and professional studies requirements are listed under the Technical Professional License.]

§ [~~7.39.~~ 7.40.] Mathematics.

The applicant seeking an endorsement in mathematics shall complete a minimum of 36 semester hours of course work in the following:

1. Algebra. Experiences should include linear and abstract algebra;

2. Geometry. Experiences should include Euclidean and other geometries;

3. Probability and statistics;

4. Applied mathematics;

5. Computer science and computer programming; and

6. Calculus. Experiences should include basic through multivariate calculus.

§ [~~7.40.~~ 7.41.] Middle education grades 6-8.

An applicant seeking the Middle Education 6-8 endorsement shall complete the following:

1. Interdisciplinary study consisting of 18 semester hours in at least two of the following concentration areas:

a. English and language arts. A minimum of 18 semester hours. The combination of the two must include course work in: language (history, structure, or grammar), literature, adolescent literature, advanced composition, and interpersonal communication or speech.

b. Social studies. A minimum of 18 semester hours. The combination of the two must include course work in: American history, world history, basic economics, geography, and international affairs. c. Mathematics and technology.

A minimum of 18 semester hours. The combination of the two must include course work in: algebra, geometry, probability and statistics, computer science, and applications of mathematics.

d. Science. A minimum of 18 semester hours. The combination of the two must include a minimum of two courses in each of the following: biology, chemistry, physics, and earth and space science. A laboratory course is required in each of the four areas.

§ [~~7.41.~~ 7.42.] Music-choral grades NK-12.

The applicant seeking an endorsement in music-choral shall complete a minimum of 42 semester hours of course work in the following:

1. Basic music knowledge: 18 semester hours.

Experiences shall be related to music theory, music history, and literature.

2. Musical performance: 18 semester hours.

Experiences shall consist of developing competency in a primary and secondary medium, selected from voice or keyboard, and in teaching, rehearsing, and conducting ensembles.

3. Electives: 6 semester hours.

Course work selected from either of the two areas above.

§ [~~7.42.~~ 7.43.] Music-instrumental grades NK-12.

The applicant seeking an endorsement in music-instrumental shall complete a minimum of 42 semester hours of course work in the following:

1. Basic music knowledge: 18 semester hours.

Experiences shall be related to music theory, music history, and literature.

2. Musical performance: 18 semester hours.

Experiences shall consist of developing competency in a primary performance medium (band or orchestral instrument), and in a secondary performance medium (band, orchestral, or keyboard instrument), and in teaching, rehearsing, and conducting ensembles.

3. Electives: 6 semester hours.

Course work selected from either of the two areas above.

§ [~~7.43.~~ 7.44.] Physical education NK-12.

The applicant seeking an endorsement in physical education NK-12 shall complete a minimum of 33 semester hours in the following:

1. Scientific background: 9 semester hours. Must include human anatomy, physiology, and kinesiology.

2. General theory in physical education: 9 semester hours.

History and principles of physical education, administration of physical education, motor learning/development, adapted physical education, and measurement and evaluation in physical education.

3. Health and safety, personal health: 6 semester hours.

First aid, CPR, Heimlich Maneuver, and safety. Personal health and lifestyle choices.

4. Physical education activities: 6 semester hours.

Movement education, individual and dual sports, games, rhythms and dance, tumbling, gymnastics, and outdoor education are optional.

5. Electives: 3 semester hours.

Course work selected from areas 1 through 4.

§ [~~7.44.~~ 7.45.] Physical education NK-12 (add-on endorsement).

The applicant seeking an add-on endorsement in physical education NK-12 shall complete the following:

1. An endorsement in health education.

2. General theory in physical education: 6 semester hours.

History and principles of physical education, administration of physical education, motor learning/development, adapted physical education, and measurement and evaluation in physical education.

3. Physical education activities: 6 semester hours.

Movement education, individual and dual sports, games, rhythms and dance, tumbling, gymnastics, and outdoor education are optional.

4. Kinesiology: 3 semester hours.

§ [~~7.45.~~ 7.46.] Physics.

The applicant seeking an endorsement in physics shall complete a major in physics or the equivalent to a major in physics that includes a minimum of 53 semester hours of course work in the following:

1. Physics: 32 semester hours.

2. Background requirements.

a. Chemistry: 6 semester hours.

b. Biology: 3 semester hours.

c. Mathematics: 12 semester hours.

Experiences shall include calculus and statistics.

§ [~~7.46.~~ 7.47.] Political science.

The applicant seeking an endorsement in political science shall complete a minimum of 36 semester hours in the following:

1. Political science: 24 semester hours.

2. Economics: 6 semester hours.

Must include experiences in consumer economics.

3. History or geography or both: 6 semester hours.

§ [~~7.47.~~ 7.48.] Political science (add-on endorsement).

The applicant seeking an endorsement in political science shall complete the following:

1. An endorsement in history.

2. Economics: 6 semester hours.

Experiences shall include consumer economics.

3. Political science: 12 semester hours.

Experiences shall include American government and comparative government.

4. Geography: 6 semester hours.

Experiences shall include physical, cultural, or historical geography.

§ [~~7.48.~~ 7.49.] Psychology.

The applicant seeking an endorsement in psychology shall complete the following:

Psychology: 30 semester hours.

[§ 7.50. Social studies.

The applicant seeking an endorsement in social studies shall complete a minimum of 42 semester hours in the following:

1. History: 18 semester hours.

2. Political science: 12 semester hours.

3. Geography: 6 semester hours.

4. Economics: 6 semester hours.]

§ [~~7.49.~~ 7.51.] Sociology and cultural anthropology.

The applicant seeking an endorsement in sociology and cultural anthropology shall complete a minimum of 30 semester hours in the following:

Sociology and cultural anthropology: 30 semester hours.

§ [~~7.50.~~ 7.52.] Special education: early childhood special education.

The applicant seeking an endorsement in early childhood special education shall complete a minimum of 27 semester hours of upper-level or graduate course work to include each of the following:

1. Foundations. Experiences shall include an overview of early childhood special education and the nature and characteristics of major disabling and at-risk conditions [to include legal aspects and trends for service delivery to the birth through age five population] .

2. Assessment. Experiences shall include knowledge in the selection, administration, and interpretation of formal and informal assessment techniques for young children with disabling and at-risk conditions [and their families] .

3. Instructional programming. Methods for providing early intervention to include service delivery options, development of individualized education programs (IEPs) and individualized family service plans (IFSPs) and curriculum development and implementation to ensure developmentally appropriate intervention techniques in the areas of self-help, motor, cognitive, social/emotional, and language.

4. Speech and language development [and intervention] . Experiences shall include the effects of disabling and at-risk conditions on the [~~speech and language~~] development of young children [and methods of intervention] .

5. Medical aspects. Experiences shall include the medical aspects of young children with disabling and at-risk conditions and the management of neurodevelopmental and motor disabilities [including emergency care and the role of health care professionals in the lives of individuals with disabilities] .

6. Behavior management. Experiences shall include [the application of principles of learning and child development to] individual and group management using a variety of techniques [that are appropriate to the age of that child] .

7. Consultation. Experiences shall include communication, collaboration, and consultation techniques to work with children, educators, families, and other human service professionals [to include: service coordination, interagency coordination, integration in the least restrictive environment (LRE), and transition facilitation] .

8. Child growth and development. Experiences shall include normal child growth and development from birth through age [~~eight~~ five] .

9. Theories and techniques of [~~early~~ family] centered intervention.

§ [~~7.51.~~ 7.53.] Special education: emotional disturbance grades NK-12.

The applicant seeking an endorsement in emotional disturbance shall complete 27 semester hours of course work to include each of the following:

[1. Overview of exceptional children. Theories, characteristics and needs of the different types of exceptionalities. This includes general practices for instructional programming and program evaluation.]

[~~1.~~ 2.] Characteristics of individuals with emotional disturbances. Concepts, theories and characteristics of individuals with disabilities and persons with emotional disturbance, including an examination of the impact of the disability on the individual and family, diverse socio-cultural influences, and health aspects.

[~~2.~~ 3.] Psychoeducational assessment. Educational, academic, and behavioral diagnosis and assessment of individuals with emotional disturbance.

[~~3.~~ 4.] Instructional programming for individuals with emotional disturbances. Instructional programming for students with disabilities and modifications of curriculum to facilitate integration of students with emotional disturbance into the continuum of programs and services.

[~~4.~~ 5.] Language development. Speech and language development and the effects of disabling conditions and cultural diversity on language development.

[~~5.~~ 6.] Research [/policies]. Research and technology trends and legal aspects in special education.

[~~6.~~ 7.] Behavior management [/social skills development] . Specific techniques of behavior management with emphasis on crisis intervention.

[~~7.~~ 8.] Career education. Career, transition, and

vocational programming for individuals with disabilities in society.

[~~8.~~ 9.] Consultation. Collaborative consultation techniques to work with teachers, parents, paraprofessionals and other professionals.

§ [~~7.52.~~ 7.54.] Special education: hearing impairment grades NK-12.

The applicant seeking an endorsement in hearing impairment shall complete a minimum of 27 semester hours of course work to include each of the following:

1. Characteristics of individuals with hearing impairments. Experiences shall include socio-cultural aspects, effects of diverse socio-cultural influences, and health-related aspects, and foundations of education and culture of persons with hearing impairments.

2. Psychoeducational assessment. Experiences shall include psychoeducational assessment of disabled persons, including individuals who are hearing impaired.

3. Instructional programming. Experiences shall include methods and procedures for teaching persons with hearing impairments, including instructional programming and modifications of curriculum to facilitate integration of students with disabilities into the continuum of programs and services.

4. Speech and language development. [Speech and language development and the effects of disabling conditions and cultural diversity on typical language development.] Experiences shall include the effects of hearing impairments and cultural diversity on language development.

5. Research [/policies] . Experiences shall include research and technology trends and legal aspects in special education.

6. Behavioral management. Experiences shall include individual and group behavior management techniques.

7. Career education. Experiences shall include career and vocational aspects of individuals with disabilities, including persons with hearing impairments, in society.

8. Consultation. Experiences shall include consultation techniques to work with parents and other professionals.

9. Speech and hearing science. [Anatomy of speech structures, auditory and visual mechanisms, production, transmission and pyschophysical characteristics of sound, general and specific effects of hearing impairment on production and reception of speech.]

10. Audiology. [Diagnosis in hearing evaluation, testing procedures and characteristics of amplification devices and their application to the instructional processes.] Experiences shall include individual and group amplification systems with emphasis upon classroom utilization.

11. Communication modalities. [Experiences with various modalities of communication including various sign language systems, cued speech, speechreading and verbal communication. ~~Experiences shall include sign language.~~]

§ [~~7.53.~~ 7.55.] Special education: mental retardation grades NK-12.

The applicant seeking an endorsement in mental retardation shall complete a minimum of [~~21~~ 27] semester hours of course work to include each of the following:

[1. Overview of exceptional children. Theories, characteristics and needs of the different types of exceptionalities. This includes general practices for instructional programming and program evaluation.]

[~~1.~~ 2.] Characteristics of individuals with mental retardation. Experiences shall include socio-cultural aspects, effects of diverse socio-cultural influences, health-related aspects, and characteristics of individuals who are mentally retarded.

[~~2.~~ 3.] Psychoeducational assessment. Experiences shall include psychoeducational assessment and its interpretation for students who are mentally retarded.

[~~3.~~ 4.] Instructional programming. Experiences shall include instructional programming for students with disabilities and modifications of curriculum to facilitate integration of students who are disabled into the continuum of programs and services.

[~~4.~~ 5.] Language development. Experiences shall include the effects of disabling conditions and cultural diversity on typical language development.

[~~5.~~ 6.] Research [/policies] . Experiences shall include research and technology trends and legal aspects in special education.

[~~6.~~ 7.] Behavior management. Experiences shall include individual and group behavior management techniques.

[~~7.~~ 8.] Career education. Experiences shall include career and vocational exploration, as well as leisure and social skills training, for the mentally retarded.

[~~8.~~ 9.] Consultation. Experiences shall include consultation techniques to work with parents and other professionals.

§ [~~7.54.~~ 7.56.] Special education: severe disabilities grades NK-12.

The applicant seeking an endorsement in severe disabilities shall complete 27 semester hours of course work to include each of the following:

1. Characteristics of individuals with severe disabilities. Characteristics of individuals with disabilities, including socio-cultural aspects, effects of diverse socio-cultural influences, health related aspects, and characteristics of students with severe disabilities, including medical aspects and their implications for instruction.

2. Psychoeducational assessment. Appropriate procedures and instruments used to identify students with severe disabilities and evaluate their progress.

3. Instructional programming. Philosophy and methods of best practice to educate students with severe disabilities with their nondisabled, age appropriate peers.

4. Speech and language development. [Speech and] language development and the effects of disabling conditions and cultural diversity on typical language development, including communication development (e.g., nonverbal systems and electronic communication devices).

5. Research [/policies] . Research and technology trends and legal aspects in special education.

6. Methods for teaching individuals with severe disabilities. Methods for teaching individuals with severe disabilities, including self-care, social and leisure skills development, and occupational and physical therapy techniques with application for use with students with severe disabilities.

7. Behavior management. Advanced techniques of behavior management.

8. Career education. Vocational factors in the education and training of students with severe disabilities.

9. Consultation. Consultation techniques to work with parents, and other professionals.

§ [~~7.55.~~ 7.57.] Special education: specific learning disabilities grades NK-12.

The applicant seeking an endorsement in specific learning disabilities grades NK-12 shall complete 27 semester hours of course work to include each of the following:

[~~1. Characteristics of individuals with specific learning disabilities. Concepts, theories and characteristics of disabled individuals and persons with specific learning disabilities, including socio-cultural aspects, effects of diverse socio-cultural influences, and health aspects with a focus on children at the elementary level.~~

~~2. Psychoeducational assessment. Educational diagnosis and assessment of individuals with specific learning disabilities with a focus on the developmental level of children.~~

~~3. Instructional programming for specifically learning disabled. Instructional programming for disabled students and modifications of curriculum to facilitate integration of learning disabled students into the continuum of programs and services.~~

~~4. Language development. Language development and the effects of disabling conditions and cultural diversity on typical language development.~~

~~5. Research. Current research and technology trends and legal aspects in special education.~~

~~6. Behavior management for specifically learning disabled. Individual and group behavior management techniques.~~

~~7. Career education. Career and vocational aspects of disabled individuals in society.~~

~~8. Consultation. Collaborative consultation techniques to work with parents, teachers, and other professionals.~~

1. Overview of exceptional education. Theories, characteristics, and needs of the different types of exceptionalities. The characteristics should be considered in light of specific age-span/developmental issues related to cognitive functioning, multi-cultural influences, social development and medical interventions. This includes general practices for instructional programming and program evaluation of these individuals.

2. Characteristics of individuals with a specific learning disability. Theories, characteristics and needs of individuals with a specific learning disability. The characteristics should be considered in light of specific age-span/developmental issues related to cognitive functioning, multi-cultural influences, emotional adjustment, social development and medical interventions.

3. Psychoeducational assessment. Educational diagnosis and assessment of students using both individual and group standardized tests, curriculum based assessments, and informal assessment techniques. This should include various techniques to collect and analyze information from classroom observations and from practical experience assessing and diagnosing early childhood, pre-adolescents and adolescents suspected of having a specific learning disability.

4. Instructional programming for individuals with a specific learning disability. Instructional programming and program evaluation for individuals with a specific learning disability to facilitate integration of these students into the continuum of services. This includes methods for teaching academics, study skills, and learning strategies which include a multi-sensory approach specific to these students.

5. Remedial strategies and methods for individuals with a specific learning disability. Remedial strategies and methods for individuals with a specific learning disability which include a multi-sensory approach for remediation and improvement of basic skills in the areas of reading, written expression, listening comprehension, oral language, pragmatic language, and mathematics.

6. Language development. Speech and language development and the effects of disabilities, especially a specific learning disability, and cultural diversity on typical language development, including the nature and history of the English language, the process of acquiring English language skills, and the structure of the English language.

7. Research/policies. Current research, technology trends, and laws related to the education and employment of persons with disabilities (e.g., P.L. 101-476, Section 504 of the Rehabilitation Act of 1973). This should include current regulations and procedures governing special education, including Individual Education Program (IEP) development.

8. Behavior management/social skills development. Specific techniques addressing management of behavior, remediation of inappropriate social skills and development of appropriate social behavior using techniques based upon behavioral, cognitive, and affective psychological theories. This includes an understanding of the psychosocial aspects effecting self-esteem, behavior and academic progress of the individuals with a specific learning disability.

9. Consultation. Collaborative/consultation techniques to work with parents, teachers, related service personnel, administrators, service community agencies, and other professionals in providing services and in planning for further education, careers, transition, or vocational programming.]

§ [~~7.56.~~ 7.58.] Special education: speech/language disorders grades NK-12.

The applicant seeking an endorsement in Speech/Language Disorders shall complete the requirements through one of the following options:

A. Option one.

1. An earned master's degree in speech-language pathology from an accredited institution.

2. Complete 60 semester hours of course work, 30 semester hours of which must be earned at the graduate level, and shall include:

a. 12 semester hours of course work providing fundamental knowledge of anatomy an physiology of speech and auditory mechanisms and the normal development and the use of speech, voice, hearing, and language.

b. 24 semester hours of course work to include each of the following:

(1) current principals, procedures, techniques, and instruments used in evaluating speech, language, voice, ad hearing;

(2) Various types of disorders of speech, language, voice and hearing classifications, causes and manifestations;

(3) Principles, remedial procedures and instrumentation used in the habilitation, prevention and rehabilitation of disorders of articulation, language, fluency, voice and resonance;

(4) Relationships among speech, language, voice and hearing problems, especially multiply disabling conditions;

(5) The evaluation and treatment of disorders of the oral and pharyngeal mechanisms as they relate to communication, including but not limited to dysphagia.

(6) The use of alternative communication devices and appliances facilitating communication;

(7) Organization and administration of public school programs designed to provide direct service for speech/language impaired persons;

(8) Services available from related fields for those with disorder of communication;

(9) Effective use of information obtained from related disciplines about the sensory, physical, emotional, social, or intellectual status of a child or an adult, including psychoeducational assessment.

(10) Research, trends and legal issues in the field of special education.

c. 6 semester hours in audiology, to include hearing measurement, aural rehabilitation, and manual communication.

d. A maximum of 3 semester hours of credit in courses for thesis or dissertation.

e. A minimum of 300 clock hours of direct client contact, of which 100 shall be in a supervised educational setting. This experience must have been sponsored by the college or university attended and shall include no more than six semester hours. A minimum of 200 clock hours must be in speech-language pathology. These 300 clinical clock hours shall be appropriately distributed in each of the following areas:

(1) Diagnosis (evaluation of speech and language).

(2) Management of language disorders.

(3) Management of voice disorders.

(4) Management of articulation disorders.

(5) Management of fluency disorders.

(6) Audiology (measurement of hearing and aural rehabilitation).

B. Option two.

1. A current license in speech pathology issued by the Virginia Board of Audiology and [~~Speech~~ Speech-Language] Pathology.

2. Course work which includes the following:

a. Psychoeducational assessment;

b. Manual communication; and

c. Research trends and legal issues in the field of special education.

[§ ~~7.57.~~ 7.59.] Special education: visual impairment grades NK-12.

The applicant seeking an endorsement in Visual Impairment shall complete 27 semester hours of course work to include each of the following:

1. Characteristics of individuals with visual impairments. Experiences shall include characteristics of individuals with disabilities, and impact of visual impairment on infant and children's growth and development, and on child and adolescent psycho-social development including family interaction patterns.

2. Assessment for visual impairment. Experiences shall include low vision practices and procedures, to include assessment and instructional programming for functional vision.

3. Language development. Experiences shall include language development an the effects of disabling conditions and cultural diversity on language development.

4. Research [/policies] . Experiences shall include current research and technology trends and legal aspects in special education, including national, state and community resources for students who are blind and skill in using technological devices and equipment.

5. Daily living skills. Experiences shall include social and recreational skills and resources for individuals who are blind to include methods and materials for assessing and teaching activities of daily living.

6. Braille reading and writing. Experiences shall include teaching reading and writing of grade 2 Braille on both a Braille writer and a "slate and stylus," and knowledge of other codes to include Nemeth, music code, computer Braille.

7. Behavior management. Experiences shall include individual and group behavior management techniques.

8. Career education. Experiences shall include career/vocational and transition programming for individuals who are disabled in society, including knowledge of careers, vocational opportunities, and transition from school to work.

9. Consultation. Experiences shall include consultation techniques to work with parents, and other professionals.

10. Anatomy, physiology, and diseases of the eye. Experiences shall include anatomy, physiology, and diseases of the eye and the educational implications.

§ [~~7.58.~~ 7.60.] Speech communication.

The applicant seeking an endorsement in speech communications shall complete the following:

Speech Communication: 24 semester hours.

Including competencies in analytical, organizational, vocal, physical, and social skills.

§ [~~7.59.~~ 7.61.] Speech communication (add-on endorsement).

The applicant seeking an add-on endorsement in speech communication shall complete the following:

1. An endorsement in any area.

2. Speech communication: 15 semester hours.

Including competencies in analytical, organizational, vocal, physical, and social skills.

§ [~~7.60.~~ 7.62.] Technology education.

The applicant seeking an endorsement in technology education shall complete a minimum of 39 semester hours in the following:

1. Technology and culture: 6 semester hours.

Experiences shall include the historical development of technology and its present and future impact on the individual, society and environment.

2. Technological foundations: 12 semester hours.

Experiences shall include drafting, electronics, materials science and energy, and power.

3. Technological processes: 12 semester hours.

Experiences shall include material processes, manufacturing, constructing, designing, and graphic communications.

4. Technological systems: 9 semester hours.

Experiences shall include communication, production, and transportation.

§ [~~7.61.~~ 7.63.] Theater arts.

The applicant seeking an endorsement in theater arts shall complete the following:

Theater arts: 24 semester hours.

§ [~~7.62.~~ 7.64.] Theater arts (add-on endorsement).

The applicant seeking an add-on endorsement in theater arts shall complete the following:

1. An endorsement in any area.

2. Theater arts: 15 semester hours.

§ [~~7.63.~~ 7.65.] Trade and industrial education.

The applicant seeking an endorsement in trade and industrial education shall meet the requirements through one of the following options:

A. Option one – Approved Program (Collegiate Professional License).

A baccalaureate degree in an approved vocational industrial education or trade and industrial education program from a regionally accredited institution.

B. Option two (Collegiate Professional License).

An applicant who has earned a baccalaureate degree in a technical field related to a trade and industrial area must complete the following:

1. National Occupational Competency Test.

Occupational competency shall be demonstrated by [~~an acceptable score~~ a score at or above the 40th percentile] on the appropriate National Occupational Competency Testing Institute Test (NOCTI) or the equivalent, or through current state licensure.

2. Occupational Experience Requirements.

a. Candidates shall be required to provide evidence of two years or 4,000 hours of satisfactory occupational experience beyond the learning period, at the journeyman level of the trade or occupation, or at an equivalent level in the occupation during the last five years (not applicable to Trade and Industrial Education candidates). Experience shall be related to the teaching specialty or the area of endorsement.

b. If the candidate's occupational experience has not been within the last five years, the candidate must participate in a supervised technical update related to the teaching specialty or area of endorsement or complete a supervised internship of work experience of not less than six weeks related to the area of endorsement or teaching specialty.

[~~3. New teacher orientation. An orientation workshop.~~]

[~~4.~~ 3.] Specialized professional studies core: 9 semester hours.

The professional studies core, which may be completed under a Provisional License, shall consist of course work in the following vocation industrial education course areas:

a. Teaching strategies: 3 semester hours.

b. Curriculum design and development: 3 semester hours.

c. Program/classroom/laboratory management: 3 semester hours:

C. Option three (Technical Professional License).

An applicant who has not earned a baccalaureate degree in a trade and industrial education area must complete the following requirements:

[~~1. Basic academic skills test. An acceptable score on the Pre-Professional Skills Test (PPST) shall be required of all teaching candidates that do not have at least an associate's degree.~~]

[~~2.~~ 1.] National Occupational Competency Test. Occupational competency shall be demonstrated by [~~an acceptable score~~ a score at or above the 40th

percentile] on the appropriate National Occupational Competency Testing Institute Test (NOCTI) or the equivalent, or through current state licensure.

[~~3.~~ 2.] Occupational Experience Requirements.

a. Candidates shall be required to provide evidence of two years or 4,000 hours of satisfactory occupational experience beyond the learning period, at the journeyman level of the trade or occupation, or an equivalent level in the occupation during the last five years). Experience shall be related to the teaching specialty or the area of endorsement.

b. If the candidate's occupational experience has not been within the last five years, the candidate must [~~participate in a supervised technical update related to the teaching specialty or area of endorsement or complete a supervised internship of~~ complete a technical update course related to the teaching specialty or area of endorsement or complete] work experience of not less than six weeks related to the area of endorsement or teaching specialty.

[~~4. New teacher orientation. An orientation workshop.~~]

[~~5.~~ 3.] Specialized professional studies core: 9 semester hours.

The specialized professional studies core, which may be completed under a provisional license, shall consist of course work in the following vocation industrial education course areas:

a. Teaching strategies: 3 semester hours.

b. Curriculum design and development: 3 semester hours.

c. Program/classroom/laboratory management: 3 semester hours:

§ [~~7.64.~~ 7.66.] Trade and industrial education (add-on endorsement).

An applicant seeking an add-on endorsement in trade and industrial education shall complete the following:

1. Collegiate Professional or Postgraduate Professional License with a nonvocational endorsement.

2. Verification of demonstrated competency in the trade or technology to be taught. Verification shall be presented, prior to any teaching assignments, in one of the following ways:

a. [~~Satisfactory score~~ A score at or above the 40th percentile] on the National Occupational Competency Test (NOCT) for the occupation, and two years of satisfactory full-time employment experience at the journeyman level or an equivalent level in the occupation within the last five years.

b. Hold licensure for the trade or industrial area that requires a license; and complete two years of satisfactory full-time employment experience at the journeyman level or an equivalent level in the occupation within the last five years.

3. Completion of a minimum of 9 semester hours of course work selected at least three of the following specialized vocational industrial education areas:

a. Teaching methods;

b. Curriculum;

c. Laboratory/shop management; or

d. Vocational student organizations.

PART VIII.
SUPPORT PERSONNEL.

§ 8.1. Division superintendent license.

An individual may be a candidate for the Eligibility List of Division Superintendents and the renewable division superintendent license through the completion of the requirements in one of the following three options.

A. Option one.

1. Hold an earned doctorate degree in educational administration or educational leadership from an accredited institution.

2. Completed five years of educational experience in a public or accredited nonpublic school, two of which must be teaching experience at the NK-12 level and two of which must be in administration/supervision at the NK-12 level.

B. Option two.

1. Hold an earned master's degree from an accredited institution plus completed 30 graduate hours beyond the master's degree.

2. Completed requirements for principal endorsement which includes the demonstration of competencies in the following areas:

a. Leadership skills;

b. Development and management of budgets;

c. Knowledge of school law;

d. Human relations skills;

e. Supervision of instruction skills;

f. Personnel management and development;

g. Public relations skills; and

h. Decision making skills.

3. Completed five years of educational experience in a public or accredited nonpublic school, two of which must be teaching experience at the NK-12 level and two of which must be in administration/supervision.

C. Option three.

1. Hold an earned master's degree from an accredited institution.

2. Hold a current, valid out-of-state license with an endorsement as a division superintendent.

3. Completed five years of educational experience in a public or accredited nonpublic school, two of which must be teaching experience at the NK-12 level and two of which must be in administration/supervision.

[~~§ 8.2. Guidance counselor (elementary, middle, and secondary).~~

~~The applicant seeking an endorsement in guidance shall complete the following:~~

~~1. An earned master's degree from an approved program in school counseling or a master's degree from an accredited college or university and completed an approved school guidance and counseling program.~~

~~2. Two years of successful full-time teaching experience or two years of successful experience in guidance and counseling. (Two years of successful, full-time experience in guidance and counseling under a two-year Provisional License may be accepted to meet this requirement.)~~

~~3. 39 semester hours of graduate course work to include each of the following areas:~~

~~a. Human growth and development.~~

~~b. Social and cultural foundations.~~

~~c. Counseling relationships (individual, group, and family).~~

~~d. Lifespan career development.~~

~~e. Appraisal.~~

~~f. Research and evaluation.~~

~~g. Professional orientation.~~

~~h. Specialization studies in school counseling (school environment and program development K-12).~~

~~i. Internship in guidance and counseling: 200 clock hours in an educational setting at the level of endorsement. To add an endorsement at another level requires a 200-clock-hour internship in an educational setting or one year of successful service as a school guidance counselor at the level seeking endorsement.~~

§ [~~8.3.~~ 8.2.] Instructional and supervisory personnel.

A. The applicant seeking an endorsement in an instructional and supervisory personnel area shall complete the following:

1. An earned master's degree;

2. Possess leadership qualities and personal characteristics attested to by a division superintendent of schools, by the chief administrative officer of a private school, or by an official in an institution of higher learning who is in a position to evaluate the applicant's qualifications;

3. A minimum of 2 semester hours of graduate level course work in each of the following areas:

a. Supervision and evaluation of instructional programs;

b. Social psychology of organizations;

c. Curriculum development;

d. School administration;

e. Learning theory;

f. Child growth and development (birth through adolescence); and

g. School law, if special education is the area to be supervised, school law shall include special education law.

B. Applicants seeking an endorsement as instructional supervisor or supervisor endorsements in a specialized area or level shall complete the following requirements:

1. A minimum of three years of successful, full-time experience as a teacher or school professional certified in the area of specialization;

2. Recent successful experience as a teacher, administrator, supervisor, or school professional in the area and level endorsement sought;

3. Endorsed in the specialization or teaching area within that level;

4. Applicants seeking the general supervisor, director of instruction, or assistant superintendent for instruction endorsements shall complete the following requirements:

a. A minimum of three years of recent successful experience as a teacher, administrator, supervisor, or school professional; and

b. Formal graduate work in curriculum in at least two levels (elementary, middle, and secondary).

§ [~~8.4.~~ 8.3.] Reading specialist.

The applicant seeking an endorsement as reading specialist shall have: (i) at least three years of successful classroom teaching experience in which the teaching of reading was an important responsibility [; ~~(ii)~~ ; (ii) an earned master's degree from an accredited college or university; and (iii)] a planned graduate level program in reading that includes course experiences of a minimum of 30 semester hours in the following:

1. 18 semester hours of graduate course work in the following:

a. Foundations or survey of reading instruction;

b. Language development;

c. Reading in the content areas;

d. Organization and supervision of reading program development;

e. Diagnosis and remediation of reading difficulties; and

f. Practicum in the diagnosis and remediation of reading difficulties.

2. 12 semester hours of graduate or undergraduate course work selected from any of the following areas:

a. Measurement or evaluation;

b. Child or adolescent psychology or both;

c. Psychology, including personality and learning behaviors;

d. Literature for children, adolescents, and adults with limited reading ability;

e. Language arts instruction;

f. Learning disabilities; and

g. Contemporary issues in the teaching of reading.

[§ 8.4. School counselor (elementary, middle, and secondary).

The applicant seeking an endorsement in school counseling shall complete the following:

1. An earned master's degree from an approved program in school counseling or a master's degree from an accredited college or university and completed an approved school guidance and counseling program.

2. Two years of successful full-time teaching experience or two years of successful experience in guidance and counseling. (Two years of successful, full-time experience in guidance and counseling under a two-year Provisional License may be accepted to meet this requirement.)

3. 39 semester hours of graduate course work to include each of the following areas:

a. Human growth and development.

b. Social and cultural foundations.

c. Counseling relationships (individual, group, and family).

d. Lifespan career development.

e. Appraisal.

f. Research and evaluation.

g. Professional orientation.

h. Specialization studies in school counseling (elementary, middle, or secondary counseling).

i. Internship in guidance and counseling: 200 clock hours in an educational setting at the level of endorsement. To add an endorsement at another level requires a 200-clock-hour internship in an educational setting or one year of successful service as a school guidance counselor at the level seeking endorsement.]

[§ ~~8.5. School nurse license.~~

~~The applicant seeking the school nurse license shall complete the following requirements:~~

~~1. Licensed as a registered nurse (RN) in the Commonwealth of Virginia;~~

~~2. A minimum of one-year, full-time experience in nursing (child health or community health preferred);~~

~~3. A minimum of 12 semester hours of undergraduate/graduate credit distributed in the following areas:~~

~~a. Nursing: 6 semester hours.~~

~~(1) Health assessment of school-aged children;~~

~~(2) Theory and methods of planning and implementing, and evaluating effective school health/community health services programs;~~

~~(3) Application of the nursing process to the unique needs of the individual child and groups of school-aged children; and.~~

~~(4) Community health nursing principles.~~

~~b. Related support courses: 6 semester hours.~~

~~(1) Theory and practice of laws and policies which affect the educational program of students and the practice of school nursing;~~

~~(2) Psychology of the exceptional child;~~

~~(3) Family life education;~~

~~(4) Health education;~~

~~(5) Human growth and development;~~

~~(6) Family dynamics;~~

~~(7) Learning theory;~~

~~(8) Counseling;~~

~~(9) Substance abuse; and/or~~

~~(10) Epidemiology.~~]

§ [~~8.6.~~ 8.5.] School principal (elementary, middle, and secondary).

An individual may become eligible for an endorsement as an elementary, middle, or secondary principal or assistant principal through the completion of the requirements in one of the following options. Individuals obtaining full licensure must have satisfied all principal endorsement requirements. Provisional licenses are issued to individuals who have satisfied the principal endorsement requirements with the exception of the internship.

A. Option one: Virginia approved program.

1. Hold a master's degree from an accredited college or university;

2. Complete three years of successful, full-time teaching experience in an accredited nonpublic or public school; and

3. Complete an approved restructured principal preparation program in Virginia which includes a full-time internship. The internship must be a minimum of 90 days in length under the joint supervision of a university faculty member and an appropriate school administrator, preferably the building principal, and shall be inclusive of a full range of administrative experiences [, including contact with students in ongoing instructional programs] .

Individuals who have completed all requirements in this option except the full-time 90-day internship will qualify for a Provisional License. These individuals must complete the full-time, 90-day internship during their first year of employment as an assistant principal or principal to be eligible for the full license.

B. Option two: Out-of-state approved program in administration.

1. Hold a master's degree from an accredited college or university;

2. Complete three years of successful, full-time teaching experience in an accredited nonpublic or public school; and

3. Complete an out-of-state approved program in elementary, middle, or secondary administration which includes a full-time internship, or complete an out-of-state approved program in elementary, middle, or secondary administration and have a minimum of one year of successful, full-time experience as a principal or assistant principal.

Individuals who have completed all requirements in this option except the full-time internship or one year of successful full-time experience as a principal or assistant principal may be issued a Provisional License in Virginia. During the first year of employment in Virginia as an assistant principal or principal, the individual must work cooperatively with a practicing administrator.

C. Option three: Out-of-state administration license.

1. Hold a master's degree from an accredited college or university;

2. Hold a current, valid out-of-state license with endorsements as an elementary, middle, or secondary principal; and

3. Have a minimum of one year of successful, full-time experience as a principal or assistant principal in an accredited nonpublic or public school.

Individuals who have completed all requirements in this option except the one year of successful, full-time

experience as an assistant principal/principal may be issued a Provisional License upon employment as an assistant principal or principal. During the first year of employment as an assistant principal or principal, the individual must work cooperatively with a practicing administrator.

§ [~~8.7.~~ 8.6.] School psychologist.

The applicant seeking the school psychologist endorsement shall complete the following:

1. 60 graduate hours which culminate in at least a master's degree from an approved program in school psychology or hold a certificate issued by the National School Psychology Certification Board;

[~~2. A passing score on the National Teacher Examinations School Psychology Specialty Area Examination;~~]

[~~3.~~ 2.] Course work shall include the following competencies:

a. Assessment:

(1) Cognitive;

(2) Academic; and

(3) Personality/social.

b. Intervention (direct and indirect):

(1) Counseling;

(2) Consultation; and

(3) Behavior management;

c. Psychological Foundations:

(1) Biological bases of behavior;

(2) Cultural diversity;

(3) Infant, child and adolescent development (normal/abnormal);

(4) Personality theory;

(5) Human learning; and

(6) Social bases of behavior.

d. Educational foundations:

(1) Education of exceptional learners;

(2) Instructional and remedial techniques; and

(3) Organization and operation of schools.

e. Statistics and research design.

f. Professional school psychology:

(1) History and foundations of school psychology;

(2) Legal and ethical issues;

(3) Professional issues and standards; and

(4) Role and function of the school psychologist.

[~~4.~~ 3.] An internship which is documented by the degree granting institution. No more than 12 hours of internship can be counted toward the 60 graduate semester hours required for certification. The internship experience shall occur on a full-time basis over a period of one year or on a half-time basis over a period of two consecutive academic years. The internship shall occur under conditions of appropriate supervision, i.e., school based supervisor shall hold a valid credential as a school psychologist and nonschool based supervisor shall be an appropriately credentialed psychologist. The internship shall include experiences at multiple age levels, at least one half of which shall be in an accredited school setting.

§ [~~8.8.~~ 8.7.] School social worker.

The applicant seeking the school social worker endorsement shall complete the following:

1. An earned master's of social work from an accredited school of social work with a minimum of 60 graduate hours;

2. Supervised practicum or field experience of a minimum of 400 clock hours in an accredited school discharging the duties of a school social worker or completion of a minimum of one year full-time supervised successful experience as a school social worker in an accredited school;

3. School social work practice: 3 semester hours at the graduate level;

4. A minimum of six graduate semester hours distributed in at least two of the following:

a. School law;

b. School administration;

c. Assessment and evaluation; and

d. Education of the exceptionalities.

§ [~~8.9.~~ 8.8.] Visiting teacher.

The applicant seeking the visiting teacher endorsement shall complete the following:

1. An earned master's degree from an accredited college or university;

2. Two years of experience:

a. One year of successful full-time experience in an accredited educational setting either as a teacher or as a pupil personnel professional; and

b. One year of full-time supervised experience as a visiting teacher in an accredited school.

3. A minimum of 30 graduate hours which shall include a course in each of the following:

a. School social work practice;

b. Community organization;

c. Casework practice;

d. Group process;

e. Family dynamics;

f. Abnormal psychology;

g. Human growth and development (Birth through adulthood);

h. Assessment/evaluation;

i. Education of exceptionalities; and

j. School law.

§ [~~8.10.~~ 8.9.] Vocational Evaluator [~~(add-on endorsement)~~ License] .

An applicant seeking [~~an add-on endorsement as~~] a Vocational Evaluator [License] must complete the following:

[~~1. Purposes and practices of vocational evaluation: 3 semester hours.~~

~~2. Characteristics of special populations: 3 semester hours.~~

~~3. Purposes and practices of vocational education: 3 semester hours.~~

~~4. Career/life planning, transitioning, and occupational information: 3 semester hours.~~

~~5. Minimum of 150 clock hours of orientation to vocational evaluation under the supervision of a practicing, certified, school-based vocational evaluator.~~

~~Such orientation may be concurrent with employment and must be completed by December 1 or no later than the third month of employment.~~

~~PERSONS CERTIFIED IN VOCATIONAL EVALUATION (CVE) THROUGH THE COMMISSION ON CERTIFICATION OF VOCATIONAL EVALUATION AND WORK ADJUSTMENT SPECIALISTS (CCWAVES) WOULD BE EXEMPTED FROM THESE REQUIREMENTS.~~

1. A minimum of 150 clock hours or orientation to vocational evaluation under the supervision of a practicing, certified, school-based vocational evaluator. Such orientation may be concurrent with employment and must be completed by December 1 or not later than the third month of employment.

2. Completion of one of the following options:

a. Option one: Certified in Vocational Evaluation (CVE) and has met all standards and criteria of the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists (CCWAVES).

b. Option two: Hold a master's degree in vocational evaluation, vocational education, special education, or rehabilitation counseling.

c. Option three: Hold a bachelor's degree in vocational evaluation, vocational education, special education, or rehabilitation service and complete a minimum of 30 semester hours from among the following with at least six credit hours in each of the following areas:

(1) Client services.

(a) Education for exceptional children;

(b) Medical aspects of disabling conditions or medication information for counselors;

(c) Introduction to vocational rehabilitation or rehabilitation techniques;

(d) Counseling theory or human services counseling;

(e) Statistics or research methodology or educational statistics;

(f) Individual counseling or counseling techniques and practices;

(g) Human service organizations; or

(h) English composition or report writing.

(2) Vocational aspects.

(a) Purposes/practices of vocational education;

(b) Occupational information;

(c) Work hardening;

(d) Individual program planning; or

(e) Career/life planning.

(3) Vocational evaluation.

(a) Tests and measurements or psychology testing;

(b) Educational psychology;

(c) Work samples in vocational evaluation;

(d) Job analysis;

(e) Purposes/practices of vocational evaluation; or

(f) Transition services.

(4) Psychology.

(a) Psychology of learning or learning theory;

(b) Psychology of personality or developmental psychology;

(c) Psychology of adolescence; or

(d) Introduction to psychology.]

§ [~~8.11.~~ 8.10.] Vocational special needs (add-on endorsement).

The applicant seeking the vocational special needs endorsement shall complete the following:

1. A baccalaureate degree in special education, vocational education, or teaching license with endorsement in one area of vocational education or special education.

2. A minimum of 15 semester hours of course work that includes:

a. Overview of vocational special needs programs and services: philosophy; development; learning characteristics of all students including those who are disadvantaged; disabled, and gifted; program implementation; and evaluation: 3 semester hours.

b. Instructional methods and curriculum and resources in career-vocational, community based and transition programs for special populations in vocational education: 3 semester hours.

c. Planning and delivery of cooperative education programs: training site evaluation marketing, planning, and evaluation: 3 semester hours.

d. Career/life planning, transitioning, and occupational information: 3 semester hours.

e. Purposes and practices, characteristics of special populations: 3 semester hours.

3. 4,000 clock hours of employment experience in business or industry or complete a work experience internship under the supervision of an institution of higher education.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulations: **State Plan for Medical Assistance Relating to Discontinuing Coverage of Certain Optional Drugs and Fertility Services.**
VR 460-01-79.7. Pharmacy Services Rebate Agreement Terms.
VR 460-02-3.1100. Amount, Duration and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy.
VR 460-02-3.1200. Amount, Duration and Scope of Services Provided Medically Needy Groups: All.
VR 460-03-3.1100. Amount, Duration and Scope of Services.
VR 460-03-3.1105. Drugs or Drug Categories Which are not Covered.
VR 460-02-4.1920. Methods and Standards Used for Establishing Payment Rates–Other Types of Care.

Statutory Authority: § 32.1-324 of the Code of Virginia.

Effective Date: April 1, 1993.

Summary:

The purpose of these regulations is to (i) conform with federal requirements for rebates on certain drugs; (ii) redefine family planning services to exclude the coverage of certain fertility drugs and services; (iii) discontinue coverage of certain optional drugs; and (iv) modify the method of the payment of pharmaceutical dispensing fees to allow for more or less frequent dispensing as is appropriate per drug.

The sections of the State Plan for Medical Assistance which are affected by this regulatory action are the preprinted page 79g providing for drug rebates, Attachment 3.1 A pertaining to services covered for the Categorically Needy, Attachment 3.1 B pertaining to services covered for the Medically Needy, Supplement 1 to Attachment 3.1 A & B and Attachment 4.19 B pertaining to Methods and Standards Used for Establishing Payment Rates–Other Types of Care. Moreover, this regulation adds a new supplement, Supplement 5, to Attachment 3.1 A & B.

Drug Rebates

OBRA 90, provides federal matching payment for drugs covered under a rebate agreement. This section mandates that the Secretary of Health and Human Services enter into agreements with drug manufacturers to provide specified rebates to state Medicaid programs on a quarterly basis in order for a state to receive federal matching dollars for those drugs. Payment for covered outpatient drugs of a manufacturer must be covered in a rebate agreement in effect between the manufacturer and the Secretary on behalf of all states. Payment may also be made if the rebate agreement is between the manufacturer and the state, if the Secretary has delegated authority to the state to enter into such agreements.

Once this regulation (page 79g) is adopted as a permanent regulation, it will supersede the existing identical emergency regulation.

Each state is required to report to each manufacturer and to the Health Care Financing Administration (HCFA) the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter. Drug manufacturers must also make price reports to the Secretary each quarter.

Fertility Services and Drugs

In addition, as directed by the Board of Medical Assistance Services (BMAS), the Department is excluding from Medicaid coverage agents used to promote fertility.

Fertility and infertility services can be divided into two categories which include surgical interventions and drug treatments. Previously, DMAS included the coverage of both fertility (family planning services such as surgical sterilizations and birth control pills) and infertility services (such as penile implants and reversals of tubal ligations) under the broad category of family planning services. BMAS approved the revision of the DMAS' definition of family planning services to include only those services and drugs directed towards the prevention of pregnancy or planning of contraception.

Optional Drugs

OBRA 90 also allows the states to exclude any or all of 11 categories of drugs regardless of whether a rebate agreement is in effect with the manufacturer. These categories of drugs, known as "optional drugs," are generally considered not medically necessary or are drugs with a very high potential for abuse. The Department is reviewing these 11 categories for the purpose of determining whether coverage will continue or the drugs will be excluded. The categories currently excluded from coverage are anorexiants when used for weight loss, over-the-counter medications for non-nursing home residents, products when used for topical hair growth, and drugs determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness (DESI drugs).

The BMAS also directed the Department to exclude from coverage drugs when their purpose is for cosmetic reasons or to promote hair growth. Therefore, DMAS is excluding from coverage Minoxidil, when it has been prescribed for hair growth and agents containing hydroquinone or its derivatives, which have been prescribed solely for the depigmentation of skin.

Technical changes have been made to move existing policy language from Supplement 1 to the newly established Supplement 5.

Expired Drugs

OBRA 90 also required that Medicaid programs not reimburse for drugs which had been determined to be expired by their manufacturers. This policy must be included in the State Plan to conform with federal law and policies of HCFA.

Pharmaceutical Dispensing Fees

Certain drugs have unique federally mandated dispensing and patient monitoring requirements. The current State Plan language allows DMAS to reimburse for only one dispensing fee per month per prescription. The adopted changes will allow DMAS to modify dispensing fees to suit unique circumstances, like the requirement to dispense clozapine weekly.

New drugs are constantly entering the marketplace. The number of available drugs that are "high-tech" or have the ability to cause serious and harmful side effects in their users is increasing. One example is clozapine which is highly toxic to bone marrow and causes the depletion of the white blood cells, the cells that fight infection in individuals. Because of this, the FDA requires an extensive monitoring system for clozapine users. The monitoring system requires the drug to be dispensed in no more than a 7-day supply and only after the patient has a blood test to confirm an adequate level of white blood cells. Because of the unique dispensing requirements for this drug, a fee is paid each time this drug is dispensed.

VR 460-01-79.7. Pharmacy Services Rebate Agreement Terms.

Citation

Act § 1927(b)(2)

§ 4.36. Pharmacy Services Rebate Agreement Terms.

The Commonwealth conforms to § 1927(b)(2) with regard to the reporting of information on the total number

of dosage units of each covered outpatient drug dispensed under the plan during the quarter, and in such a manner as specified by the Secretary of Health and Human Resources and also shall promptly transmit a copy of such report to the Secretary. The Commonwealth also conforms to § 1927(b)(3)(D) with regard to assuring the confidentiality of the disclosure of the identity of a manufacturer or wholesaler and prices charged for drugs by such manufacturer or wholesaler.

VR 460-02-3.1100. Amount, Duration and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy.

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

Provided: ☐ No limitations ☒ With limitations*

2.a. Outpatient hospital services.

Provided: ☐ No limitations ☒ With limitations*

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

☒ Provided: ☐ No limitations

☒ With limitations* ☐ Not provided.

c. 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).

Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

Provided: ☒ No limitations ☐ With limitations*

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

Provided: ☒ No limitations ☐ With limitations*

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

☒ Provided: ☐ No limitations

☒ In excess of Federal requirements*

☐ Limited to Federal requirements

c. Family planning services and supplies for individuals of child-bearing age. (See Page 5 for Family Planning.)

☒ Provided: ☒ With limitations*

☐ Not provided ☐ No limitations

5. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere. (See Page 5 for Physician's Services.)

☒ Provided: ☒ With limitations*

☐ Not provided ☐ No limitations

6. Medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. (See Page 8 for Other Practitioners.)

a. Podiatrists' Services.

☒ Provided: ☒ With limitations*

☐ Not provided ☐ No limitations

b. Optometrists' Services.

☒ Provided: ☒ With limitations*

☐ Not provided ☐ No limitations

c. Chiropractors' Services.

☐ Provided ☐ No limitations ☐ With limitations*

☒ Not provided

d. Other Practitioner's Services.

☒ Provided (Identified on attached sheet with description of limitations)* ☐ Not provided

7. Home health services. (See page 9 for Home Health.)

a. 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.

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

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

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

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

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

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

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

8. Private duty nursing services.

☐ Provided ☐ No limitations ☐ With limitations*

☒ Not provided

9. Clinic services. (See Page 10, Clinic Services)

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

10. Dental Services. (See Page 11, Dental Services)

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

11. Physical therapy and related services. (See page 12 for PT and related services.)

a. Physical therapy.

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

b. Occupational therapy.

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

c. Services for individuals with speech, hearing, and language disorders. (Provided by or under supervision of a speech pathologist or audiologist) (See page 12, Physical Therapy and Related Services.)

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist. (See page 13 for Prescribed Drugs and Eyeglasses.)

a. Prescribed drugs.

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

b. Dentures.

☐ Provided ☐ No limitations ☐ With limitations*

☒ Not provided

c. Prosthetic devices.

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

d. Eyeglasses.

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan. (See page 14 for diagnostic and other services.)

a. Diagnostic services.

☐ Provided ☐ No limitations ☐ With limitations*

☒ Not provided

b. Screening services.

☐ Provided ☐ No limitations ☐ With limitations*

☒ Not provided

c. Preventive services.

☐ Provided ☐ No limitations ☐ With limitations*

☒ Not provided

d. Rehabilitative services. (See page 9, Home Health Services)

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided

14. Services for individuals age 65 or older in institutions for mental diseases. (See page 15 for IMD services for persons over 65.)

a. Inpatient hospital services.

☒ Provided ☒ No limitations ☐ With limitations*

☐ Not provided

b. Skilled nursing facility services.

☒ Provided ☒ No limitations ☐ With limitations*

☐ Not provided

c. Intermediate care facility.

☒ Provided ☒ No limitations ☐ With limitations*

☐ Not provided

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

☒ Provided ☐ No limitations ☐ With limitations*

☐ Not provided.

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

☒ Provided ☒ No limitations ☐ With limitations*

☐ Not provided.

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

☐ Provided ☐ No limitations ☐ With limitations*

☒ Not provided.

17. Nurse-midwife services.

☒ Provided ☐ No limitations ☒ With limitations*

☐ Not provided.

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

☒ Provided ☒ No limitations ☐ with limitations*

☐ Not provided.

19. Case management services as defined in, and to the group specified in, Supplement 2 to Attachment 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act)

☒ Provided ☒ With limitations

☐ Not provided

20. Extended services to pregnant women

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

☒ Provided † ☐ No limitations ☒ With limitations*

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

☒ Provided † ☐ No limitations ☒ With limitations*

☐ Not provided

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

☐ Provided † ☐ No limitations ☐ With limitations*

☒ Not provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided † ☐ No limitations ☐ With limitations*

☒ Not provided

23. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary.

a. Transportation

☒ Provided ☐ No limitations ☒ With limitations

☐ Not provided

b. Services of Christian Science nurses.

☐ Provided ☐ No limitations ☐ With limitations

☒ Not provided

c. Care and services provided in Christian Science sanitoria.

☒ Provided ☒ No limitations ☐ With limitations

☐ Not provided

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

☒ Provided ☒ No limitations ☐ With limitations

☐ Not provided

e. Emergency hospital services.

☒ Provided ☒ No limitations ☐ With limitations

☐ Not provided

f. 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.

☐ Provided ☐ No limitations ☐ With limitations

☒ Not provided

24. Private health insurance premiums, coinsurance and deductibles when cost-effective (pursuant to P.L. 101-508 § 4402).

* Descriptions provided on attached sheet. See Supplement 1 to Attachments 3.1 A and 3.1 B.

† List of major categories of services (e.g., inpatient hospital, physician, etc.) that are available as pregnancy-related services, and description of additional coverage of these services, if applicable, provided on attachment.

VR 460-02-3.1200. Amount, Duration and Scope of Services Provided Medically Needy Groups: All.

The following ambulatory services are provided.

Physicians Services
Outpatient Hospital Services
Clinic Services
Laboratory and X-Ray Services
EPSDT Services
Family Planning Services
Optometrist Services
Home Health Services
Dental Services for those under age 21
Physical Therapy and Related Services
Prescribed Drugs
Eyeglass Services
Nurse Midwives
Outpatient Rehabilitation
Extended Services to Pregnant Women

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

☒ Provided ☐ No limitations ☒ With limitations*

2.a. Outpatient hospital services.

☒ Provided ☐ No limitations ☒ With limitations*

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

☒ Provided ☐ No limitations ☒ With limitations*

c. 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).

☒ Provided ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

☒ Provided ☐ No limitations ☒ With limitations*

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

☒ Provided ☒ No limitations ☐ With limitations*

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

☒ Provided ☒ No limitations ☐ With limitations*

c. Family planning services and supplies for individuals of childbearing age.

☒ Provided: ☒ ☐ No limitations

☒ With limitations*

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

☒ Provided ☒ No limitations ☐ With limitations*

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

a. Podiatrists' Services

☒ Provided ☐ No limitations ☒ With limitations*

b. Optometrists' Services

☒ Provided ☐ No limitations ☒ With limitations*

c. Chiropractors' Services

☐ Provided ☐ No limitations ☐ With limitations*

d. Other Practitioners' Services

☒ Provided ☐ No limitations ☒ With limitations*

7. Home Health Services

a. 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.

☒ Provided ☒ No limitations ☐ With limitations*

b. Home health aide services provided by a home health

agency.

☒ Provided ☒ No limitations ☐ With limitations*

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

☒ Provided ☐ No limitations ☒ With limitations*

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

☒ Provided ☒ No limitations ☐ With limitations*

8. Private duty nursing services.

☐ Provided ☐ No limitations ☐ With limitations*

9. Clinic services.

☒ Provided ☐ No limitations ☒ With limitations*

10. Dental services.

☒ Provided ☐ No limitations ☒ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

☒ Provided ☐ No limitations ☒ With limitations*

b. Occupational therapy.

☒ Provided ☐ No limitations ☒ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

☒ Provided ☐ No limitations ☒ With limitations*

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

a. Prescribed drugs.

☒ Provided ☐ No limitations ☒ With limitations*

b. Dentures.

☐ Provided ☐ No limitations ☐ With limitations*

* Description provided on attachment.

c. Prosthetic devices.

☒ Provided ☐ No limitations ☒ With limitations*

d. Eyeglasses.

☒ Provided ☐ No limitations ☒ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

☐ Provided ☐ No limitations ☐ With limitations*

b. Screening services.

☐ Provided ☐ No limitations ☐ With limitations*

c. Preventive services.

☐ Provided ☐ No limitations ☐ With limitations*

d. Rehabilitative services.

☒ Provided ☐ No limitations ☒ With limitations*

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

a. Inpatient hospital services.

☐ Provided ☐ No limitations ☐ With limitations*

b. Skilled nursing facility services.

☐ Provided ☐ No limitations ☐ With limitations*

c. Intermediate care facility services.

☐ Provided ☐ No limitations ☐ With limitations*

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

☐ Provided ☐ No limitations ☐ With limitations*

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

☐ Provided ☐ No limitations ☐ With limitations*

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

☐ Provided ☐ No limitations ☐ With limitations*

17. Nurse-midwife services.

☒ Provided ☐ No limitations ☐ With limitations*

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

☒ Provided ☒ No limitations ☐ With limitations*

19. Case management services as defined in, and to the group specified in, Supplement 2 to ATTACHMENT 3.1-A (in accordance with § 1905(a)(19) or § 1915(g) of the Act).

☐ Provided ☐ With limitations

☐ Not provided

20. Extended services for pregnant women.

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

☐ Provided ☐ No limitations ☐ With limitations*

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

☐ Provided ☐ No limitations ☐ With limitations*

☐ Not provided

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with § 1920 of the Act).

☐ Provided ☐ No limitations ☐ With limitations*

☐ Not provided

22. Respiratory care services (in accordance with section 1902(a)(9)(A) through (C) of the Act).

☐ Provided ☐ No limitations ☐ With limitations*

☒ Not provided

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided ☐ No limitations ☒ With limitations*

b. Services of Christian Science nurses.

☐ Provided ☐ No limitations ☐ With limitations*

c. Care and services provided in Christian Science sanitorial.

☒ Provided ☒ No limitations ☐ With limitations*

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

☒ Provided ☒ No limitations ☐ With limitations*

e. Emergency hospital services.

☒ Provided ☒ No limitations ☐ With limitations*

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

☐ Provided ☐ No limitations ☐ With limitations*

* Description provided on attachment. See Supplement 1 to Attachments 3.1 A and 3.1 B.

† List of major categories of services (e.g., inpatient hospital, physician, etc.) that are available as pregnancy-related services, and description of additional coverage of these services, if applicable, provided on attachment.

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. 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 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.

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

B. Family planning services shall be defined as those services which delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

§ 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. 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 annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.

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 annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.

D. 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 annually. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

§ 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~~ *Speech-Language* 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.

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

12a. Prescribed drugs.

Drugs for which Federal Financial Participation is not available, pursuant to the requirements of § 1927 of the Social Security Act (OBRA '90 § 4401), shall not be covered except for over-the-counter drugs when prescribed for nursing facility residents.

1. ~~Nonlegend drugs, except insulin, syringes, needles, diabetic test strips for clients under 21 years of age, and family planning supplies are not covered by Medicaid. This limitation does not apply to Medicaid recipients who are in skilled and intermediate care facilities.~~ *The following prescribed, nonlegend drugs/drug devices shall be covered: (i) insulin, (ii) syringes, (iii) needles, (iv) diabetic test strips for clients under 21 years of age, (v) family planning supplies, and (vi) those prescribed to nursing home residents.*

2. Legend drugs *are covered* , with the exception of anorexiant drugs prescribed for weight loss and ~~transdermal drug delivery systems,~~ *the drugs or classes of drugs identified in Supplement 5* ~~are covered. Coverage of anorexiants for other than weight loss requires preauthorization~~ .

3. ~~The Program will not provide reimbursement for drugs determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.~~ *Repealed.*

4. ~~Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, prescriptions for Medicaid recipients for specific multiple source drugs shall be filled with generic drug products listed in the Virginia Voluntary Formulary unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written.~~ *Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, and in compliance with the provision of § 4401 of the Omnibus Reconciliation Act of 1990, § 1927(e) of the Social Security Act as amended by OBRA 90, and pursuant to the authority provided for under § 32.1-325 A of the Code of Virginia, prescriptions for Medicaid recipients for multiple source drugs subject to 42 CFR § 447.332 shall be filled with generic drug products unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written.*

5. ~~New drugs, except for Treatment Investigational New Drugs (Treatment IND), are not covered until approved by the board, unless a physician obtains prior approval. The new drugs listed in Supplement 1 to the New Drug Review Program Regulations (VR 460-05-2000.1000) are not covered.~~ *New drugs shall be covered in accordance with the Social Security Act § 1927(d) (OBRA 90 § 4401).*

6. The number of refills shall be limited pursuant to § 54.1-3411 of the Drug Control Act.

12b. Dentures.

Provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

12c. Prosthetic devices.

A. Prosthetics services shall mean the replacement of missing arms and legs. Nothing in this regulation shall be construed to refer to orthotic services or devices.

B. Prosthetic devices (artificial arms and legs, and their necessary supportive attachments) are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and preauthorized for the minimum applicable component necessary for the activities of daily living.

12d. Eyeglasses.

Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

§ 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.

Screening mammograms for the female recipient population aged 35 and over shall be covered, consistent with the guidelines published by the American Cancer Society.

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 shall 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 eight 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 five 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 shall 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 shall 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 shall 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 shall 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 shall 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 shall 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 shall 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 shall 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 shall be a licensed doctor of medicine or osteopathy.

d. Counseling services. Counseling services shall 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.

Transportation services are provided to Virginia Medicaid recipients to ensure that they have necessary access to and from providers of all medical services. Both emergency and nonemergency services are covered. The single state agency may enter into contracts with friends of recipients, nonprofit private agencies, and public carriers to provide transportation to Medicaid recipients.

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 460-03-3.1105. Drugs or Drug Categories which are not Covered.

§ 1. Agents when used for weight gain or loss.

Coverage of anorexiants for other than weight loss requires medical justification.

§ 2. Agents when used for cosmetic purposes or hair growth.

A. Minoxidil shall not be covered when prescribed for hair growth or other cosmetic purposes.

B. Agents containing hydroquinone or its derivatives which are used solely for depigmentation of the skin [shall not be covered] .

§ 3. Agents used to promote fertility.

Agents used to promote fertility shall not be covered.

§ 4. Expired drugs.

Drugs dispensed past the labeled expiration date shall not be covered.

§ 5. DESI drugs.

The program shall not provide reimbursement for drugs determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

§ 6. Nonlegend drugs.

Nonlegend drugs, with those exceptions shown in Supplement 1, shall not be covered.

VR 460-02-4.1920. Methods and Standards Used 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. 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, including those obstetric and pediatric procedures contained in Supplement 1 to Attachment 4.19 B, 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 performed 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.

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.

4. Rehabilitation agencies

5. Comprehensive outpatient rehabilitation facilities

6. 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.)

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, including those obstetric and pediatric procedures contained in Supplement 1 to Attachment 4.19 B, 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.

(m) Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by Supplement 3.

(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.~~ *Payment for pharmacy services will be as described above; however, payment for legend drugs will include the allowed cost for the drug plus only one dispensing*

fee per month for each specific drug. However, oral contraceptives shall not be subject to the one month dispensing rule. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements.

(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 two 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 12 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.

p. Dispute resolution for state-operated providers

(1) Definitions.

(a) "DMAS" means the Department of Medical Assistance Services.

(b) "Division director" means the director of a division of DMAS.

(c) "State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

(2) Right to request reconsideration.

(a) A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the

State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

(b) The appropriate DMAS division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

(3) Informal review. The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought, and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

(4) Division director action. The division director shall consider any recommendation of his designee and shall render a decision.

(5) DMAS director review. A state-operated provider may, within 30 days after receiving the informal review decision of the division director, request that the DMAS director or his designee review the decision of the division director. The DMAS director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

(6) Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after the receipt of the decision of the DMAS director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

RADFORD UNIVERSITY

The following Radford University documents are on file with the Registrar of Regulations. Those items marked with an asterisk (*) have been updated since last year.

*1. Radford University Student Handbook (1992-1993)
*2. Radford University Undergraduate and Graduate Catalog (1992-1993)
3. Radford University Classified Employee Handbook
*4. Radford University Faculty-Staff Handbook (1992-1993)
5. Radford University Heth Student Center Policies (1992)
6. Radford University Donald N. Dedmon Center General Policies and Procedures (1989)
7. Radford University Judicial System Manual (1989-1990)
8. Radford University Student Record Policy (Revised 1/82)
9. Radford University Club Leaders Manual (1990-1991)
*10. Radford University Student Activity Account Policies and Procedures (revised July 10, 1992)
11. Rules and Regulations for Admission and Attendance of Parolees and Probationers to Radford University
12. Rules and Regulations for Admissions of Inmates of Correctional Institutions to Radford University
13. Guidelines for All-Campus Programming Groups Requesting Recognition on Radford University Campus (March 28, 1979)
14. Radford University Revised Policies and Procedures for Dealing with Students Displaying Disruptive Emotional Behavior (Revised 11/86)
*15. Radford University Student Publications (Revised Spring 1992)
*16. Radford University Statement on AIDS
*17. Radford University College of Education & Human Development Undergraduate Advisee Handbook (1992-1993)
*18. Radford University Student Teacher Handbook, College of Education and Human Development (7/92)
19. Radford University Undergraduate Academic Advising Manual (1990-1991)
*20. Radford University Internal Governance Document (Revised January 1993)
*21. Radford University Intramural Handbook (1992-1993)
*22. Radford University Parking and Traffic Regulations (1992-1993)
*23. Radford University School of Nursing Graduate Student Handbook (Fall, 1992)
*24. Radford University School of Nursing Undergraduate Student Handbook (1992-1993)
*25. Radford University Residential Student Agreement and Construction of Lofts Policy (10/92)
*26. Radford University Registration Policies (1992) (as outlined in the printed course schedules)
*27. Health Insurance for International Students (1993)

DEPARTMENT OF WASTE MANAGEMENT (VIRGINIA WASTE MANAGEMENT BOARD)

Title of Regulation: **VR 672-30-1. Regulations Governing the Transportation of Hazardous Materials.**

Statutory Authority: §§ 10.1-1402 and 10.1-1450 of the Code of Virginia.

Effective Date: March 24, 1993.

Summary:

On January 8, 1993, the Virginia Waste Management Board adopted Amendment 11 to the Virginia Regulations Governing the Transportation of Hazardous Materials. Amendment 11 incorporated changes made by the United States Department of Transportation (USDOT) between July 1, 1991, and June 11, 1992, to the federal hazardous materials transportation regulations. To the extent possible, where USDOT subsequently changed the incorporated rules in a minor way, Amendment 11 includes the subsequent federal corrections, editorial changes, clarifications, extensions, delays in effective dates, and other changes. The amendments address the following areas:

1. Classification and packaging of certain hazardous materials;

2. Required controlled substances testing;

3. Hazard communication standards;

4. Descriptions on shipping papers;

5. Communication of hazards of materials in liquid phase, solid phase, and flammable liquid materials in a liquid phase; and

6. Incorporation of Federal Railroad Administration changes to conform to the mandate of § 19 of the Uniform Materials Transportation Uniform Safety Act of 1990.

VR 672-30-1. Regulations Governing the Transportation of Hazardous Materials.

PART I.
DEFINITIONS.

§ 1.1. Definitions.

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

"Explosive" means any chemical compound, mixture, or device, the primary or common purpose of which is to function by explosion, i.e., with substantially instantaneous release of gas and heat, unless such compound, mixture, or device is otherwise specifically classified in 49 Code of Federal Regulations (CFR) Parts 170 through 177.

"Hazardous material" means a substance or material in a form or quantity which may pose an unreasonable risk to health, safety or property when transported, and which the Secretary of Transportation of the United States has so determined by regulation or order.

"Transport" or *"transportation"* means any movement of property by any mode, and any packing, loading, unloading, identification, marking, placarding, or storage incidental thereto.

PART II.
GENERAL INFORMATION AND LEGISLATIVE AUTHORITY.

§ 2.1. Authority for regulation.

A. These regulations are issued under authority of Article 7 (§ 10.1-1450 et seq.) of Chapter 14 of Title 10.1 of the Code of Virginia, Transportation of Hazardous Materials.

B. Section 10.1-1450 of the Code of Virginia assigns the Virginia Waste Management Board the responsibility for promulgating regulations governing the transportation of hazardous materials.

C. The board is authorized to promulgate rules and regulations designating the manner and method by which hazardous materials shall be loaded, unloaded, packed, identified, marked, placarded, stored and transported, such rules to be no more restrictive than applicable federal regulations.

§ 2.2. Purpose of regulations.

The purpose of these regulations is to regulate the transportation of hazardous materials in Virginia.

§ 2.3. Administration of regulations.

A. The Director of the Department of Waste Management is designated by the Virginia Waste Management Board with the responsibility to carry out these regulations.

B. The Department of Waste Management is responsible for the planning, development and implementation of programs to meet the requirements of Article 7 (§ 10.1-1450 et seq.) of Chapter 14 of Title 10.1 of the Code of Virginia.

§ 2.4. Application of regulations.

Notwithstanding the limitations contained in Title 49, Code of Federal Regulations, § 171.1(a)(3), and subject to the exceptions set forth in § 2.5 below, these regulations apply to any person who transports hazardous materials, or offers such materials for shipment.

§ 2.5. Exceptions.

Nothing contained in these regulations shall apply to regular military or naval forces of the United States, nor to the duly authorized militia of any state or territory thereof, nor to the police or fire departments of this Commonwealth, providing the same are acting within their official capacity and in the performance of their duties; nor to the transportation of hazardous radioactive materials in accordance with § 44-146.30 of the Code of

Virginia.

§ 2.6. Regulations not to preclude exercise of certain regulatory powers.

Pursuant to § 10.1-1452 of the Code of Virginia, the provisions of these regulations shall not be construed so as to preclude the exercise of the statutory and regulatory powers of any agency, department or political subdivision of the Commonwealth having statutory authority to regulate hazardous materials on specified highways or portions thereof.

§ 2.7. Transportation under United States Regulations.

Pursuant to § 10.1-1454 of the Code of Virginia, any person transporting or offering for shipment hazardous materials in accordance with regulations promulgated under the laws of the United States, shall be deemed to have complied with the provisions of these regulations, except when such transportation is excluded from regulation under the laws or regulations of the United States.

§ 2.8. Enforcement.

A. Law-enforcement officers.

The Department of State Police and all other law-enforcement officers of the Commonwealth who have satisfactorily completed the course in Hazardous Materials Compliance and Enforcement as prescribed by the U.S. Department of Transportation, Research and Special Programs Administration, Office of Hazardous Materials Transportation, in federal safety regulations and safety inspection procedures pertaining to the transportation of hazardous materials, shall enforce the provisions of this article, and any rule or regulation promulgated herein. Those law-enforcement officers certified to enforce the provisions of this article, and any regulation promulgated hereunder, shall annually receive in-service training in current federal safety regulations and safety inspection procedures pertaining to the transportation of hazardous materials. Pursuant to § 10.1-1455 of the Code of Virginia, violation of these regulations is a Class 1 misdemeanor.

B. Civil judicial enforcement of these regulations shall be governed by § 10.1-1455 of the Code of Virginia.

§ 2.9. Application of Administrative Process Act.

The provisions of the Virginia Administrative Process Act, codified as § 9-6.14:1 *et seq.* of the Code of Virginia, govern the adoption, amendment, modification, and revision of these regulations, and the conduct of all proceedings hereunder.

PART III.
COMPLIANCE WITH FEDERAL REGULATIONS.

§ 3.1. Compliance.

Every person who transports or offers for transportation hazardous materials within or through the Commonwealth of Virginia shall comply with the federal regulations governing the transportation of hazardous materials promulgated by the United States Secretary of Transportation with amendments promulgated and in effect as of ~~June 30, 1991~~ *June 1, 1992* , [*(except as otherwise specified below)*] pursuant to the Hazardous Materials Transportation Act, and located at Title 49 of the Code of Federal Regulations (CFR) as set forth below and which are incorporated in these regulations by reference:

1. Exemptions. Hazardous Materials Program Procedures in 49 CFR, Part 107, Subpart B.

2. Hazardous Materials Regulations in 49 CFR, Parts 171 through 177.

3. Shipping Container Specifications in 49 CFR, Part 178.

4. Specifications for Tank Cars in 49 CFR, Part 179.

5. Qualifications and Maintenance of Cargo Tanks in 49 CFR, Part 180.

6. Commercial Licensing Requirements in 49 CFR, Part 383.

7. Motor Carrier Safety Regulations in 49 CFR, Parts 390 through 397.

[*8. 49 CFR, Parts 107, 171, 173, 174, 176, 177, 178, 179, and 180, Federal Register, Volume 57, Number 191, Thursday, October 1, 1992, Pages 45446-45466, Docket Numbers HM-181; HM-189, Amendment Numbers 107-23, 171-111, 172-123, 173-224, 174-53, 176-30, 77-78, 178-97, 179-45, and 180-3.*]

PART IV.
HAULING EXPLOSIVES IN PASSENGER-TYPE VEHICLES.

§ 4.1. Hauling explosives in passenger-type vehicles.

Explosives shall not be transported in or on any motor vehicle licensed as a passenger vehicle or a vehicle which is customarily and ordinarily used in the transportation of passengers except upon written permission of the State Police and under their direct supervision and only in the amount and between points authorized. If the movement is intracity, the permission of the properly designated authority of such city shall be secured. Dangerous articles, including small arms ammunition, but not including other types of explosives, may be transported in passenger-type vehicles provided the maximum quantity transported does not exceed 100 pounds in weight. Such transportation shall not be subject to these rules.

PART V.
OUT OF SERVICE.

§ 5.1. Out of service.

The Department of State Police and all other law-enforcement officers of the Commonwealth who have met the qualifications set forth in § 2.8, above, shall be the agents authorized to perform inspections of motor vehicles in operation and to declare and mark vehicles "out of service" as set forth in 49 CFR § 396.9.

DIRECTOR'S ORDER NUMBER THREE (93)

VIRGINIA'S FOURTH ON-LINE GAME LOTTERY; "CASH 5," 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 fourth on-line game lottery, "Cash 5." These rules amplify and conform to the duly adopted State Lottery Board regulations for the conduct of on-line 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
January 29, 1993

GOVERNOR'S COMMENTS ON PROPOSED REGULATIONS

(Required by § 9-6.12:9.1 of the Code of Virginia)

BOARD FOR ACCOUNTANCY

Title of Regulation: **VR 105-01-2. Board for Accountancy Regulations.**

Governor's Comment:

I do not object to the initial draft of these regulations. However, I reserve the right to comment on the final package, including any changes made as a result of public hearings and comment.

/s/ Lawrence Douglas Wilder
Governor
Date: January 25, 1993

DEPARTMENT OF CORRECTIONS (STATE BOARD OF)

Title of Regulation: **VR 230-30-004:1. Standards for Community Residential Programs.**

Governor's Comment:

I concur with the comments of the Department of Planning and Budget. After the State Board of Corrections considers and addresses the comments submitted by the Department of Planning and Budget, localities and agencies impacted by this proposal, and the public, I will make my final comment on this proposal.

/s/ Lawrence Douglas Wilder
Governor
Date: January 22, 1993

DEPARTMENT OF HEALTH (STATE BOARD OF)

Title of Regulation: **VR 355-11-200. Regulations Governing the Newborn Screening and Treatment Program.**

Governor's Comment:

I concur with the form and content of this proposal. I reserve my right to comment on the final package once comments from the public have been received.

/s/ Lawrence Douglas Wilder
Governor
Date: January 22, 1993

* * * * * * * * *

Title of Regulation: **VR 355-30-000. Virginia Medical Care Facilities Certificate of Public Need (COPN) Rules and Regulations.**

Governor's Comment:

I concur with the form and content of this regulation.

/s/ Lawrence Douglas Wilder
Governor
Date: January 26, 1993

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulations: **State Plan for Medical Assistance Relating to Discontinuing Coverage of Certain Optional Drugs and Fertility Services.**
VR 460-01-79.7. Pharmacy Services Rebate Agreement Terms.
VR 460-02-3.1100. Amount, Duration and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy.
VR 460-02-3.1200. Amount, Duration and Scope of Services Provided Medically Needy Groups: All.
VR 460-03-3.1100. Amount, Duration and Scope of Services.
VR 460-03.3.1105. Drugs or Drug Categories Which are Not Covered.
VR 460-02-4.1920. Methods and Standards Used for Establishing Payment Rates–Other Types of Care.

Governor's Comment:

I do not object to the initial draft of these regulations. However, I reserve the right to comment on the final package, including any changes made as a result of public hearings and comment, before promulgation.

/s/ Lawrence Douglas Wilder
Governor
Date: January 22, 1993

DEPARTMENT OF MINES, MINERALS AND ENERGY

Title of Regulation: **VR 480-03-19. Virginia Coal Surface Mining Reclamation Regulations.**

Governor's Comment:

I do not object to the initial draft of these regulations. However, I reserve the right to comment on the final package, including any changes made as a result of public hearings and comments, before promulgation.

/s/ Lawrence Douglas Wilder
Governor
Date: January 22, 1993

DEPARTMENT OF SOCIAL SERVICES (STATE BOARD OF)

Title of Regulation: **VR 615-01-48. General Relief Program – Deeming Income from Alien Sponsors.**

Governor's Comment:

I do not object to the initial draft of these regulations. However, I reserve the right to comment on the final package, including any changes made as a result of public comments, before promulgation.

/s/ Lawrence Douglas Wilder
Governor
Date: January 22, 1993

BOARD FOR WASTE MANAGEMENT FACILITY OPERATORS

Title of Regulation: **VR 674-01-02. Waste Management Facility Operators Regulations.**

Governor's Comment:

I do not object to the initial draft of these regulations. However, I reserve the right to comment on the final package, including any changes made a a result of public hearings and comments, before promulgation.

/s/ Lawrence Douglas Wilder
Governor
Date: January 25, 1993

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.

Notice to the Public

RT Associates has published a Virginia Register Deskbook, a cumulative index of Volumes 1 through 8 (Issue 13). For more information contact RT Associates, P.O. Box 36416, Baltimore, Maryland 21286.

DEPARTMENT OF LABOR AND INDUSTRY

Notice to the Public

The Virginia State Plan for the enforcement of occupational safety and health laws (VOSH) commits the Commonwealth to adopt regulations identical to, or as effective as, those promulgated by the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA).

Accordingly, public participation in the formulation of such regulations must be made during the adoption of such regulations at the federal level. Therefore, the Virginia Department of Labor and Industry is reissuing the following Federal OSHA notice:

U.S. Department of Labor
Occupational Safety and Health Administration
29 CFR Part 1926
(Docket S-775)

Safety Standards for Steel and Other Metal and Non-Metal Erection

Agency: Occupational Safety and Health Administration (OSHA)

Action: Notice of Intent to Establish Negotiated Rulemaking Committee; Request for Representation.

Summary: The Occupational Safety and Health Administration is announcing its intent to establish a Steel Erection Negotiated Rulemaking Advisory Committee under the Negotiated Rulemaking Act (NRA) and the Federal Advisory Committee Act (FACA). The committee will negotiate issues associated with the development of a proposed revision of the existing safety provisions in its construction standards for steel erection (29 CFR part 1926, subpart R). The committee will include representatives of identified parties who would be significantly affected by the final rule. OSHA solicits interested parties to nominate representatives for membership for representation on the committee.

Nominations for membership or representation on the committee should be sent, in quadruplicate, to the Docket Office, Docket S-775, U.S. Department of Labor, Occupational Safety and Health Administration, Room N-2625, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Text: Full text of the proposed rulemaking can be found in Volume 57, No. 250, p. 61860 (December 29, 1992) of the Federal Register.

Date: OSHA must receive written comments and requests for membership or representation by March 29, 1993.

Address: Written comments should be submitted in quadruplicate to the Docket Office, Docket No. S-775, Room N-2625, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210, telephone (202) 219-7894.

An additional copy should be submitted to the Director of Enforcement Policy, Virginia Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia 23219.

For further information contact: James F. Foster, Office of Information and Consumer Affairs, OSHA, Room N-3647, 200 Constitution Avenue, N.W., Washington, D.C. 20210, telephone (202) 219-8151.

VIRGINIA CODE COMMISSION

NOTICE TO STATE AGENCIES

Mailing Address: Our 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

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Title of General Notice: **Civil Penalty Decision Matrix.**

Publication: 9:8 VA.R. 1355-1357 January 11, 1993.

Correction to Notice:

Page 1357, § 1.4 F, the dollar amount associated with 7-9 points should read "50"

DEPARTMENT OF LABOR AND INDUSTRY

Title of Regulation: **VR 425-02-91. Construction Industry Standard for Occupational Exposure to Cadmium (1926.63).**

Publication: 9:9 VA.R. 1431 January 25, 1993.

Correction to Final Regulation:

Page 1431, Summary, paragraph 2, line 1, before "industry" change "general" to "the construction"

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

BOARD FOR ACCOUNTANCY

February 23, 1993 - 2:30 p.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

The board will meet to conduct a formal hearing:

File Number 91-01928
Board for Accountancy v. Charles K. Trible, CPA

Contact: Gayle Eubank, Legal Assistant, Department of Commerce, 3600 W. Broad St., Fifth Floor, Richmond, VA 23230, telephone (804) 367-8524.

† **March 15, 1993 - 10 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, 5th Floor, Richmond, Virginia. ♿

A meeting to (i) review comments on the proposed regulations, and (ii) conduct routine board business.

Contact: Roberta L. Banning, Assistant Director, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590.

DEPARTMENT FOR THE AGING

Long-Term Care Council

March 12, 1993 - 10 a.m. – Open Meeting
Virginia Housing Development Authority, 601 South Belvidere Street, Conference Room 1, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A general business meeting.

Contact: Cathy Saunders, Director of Long-Term Care, Department for the Aging, 700 E. Franklin St., 10th Floor, Richmond, VA 23219, telephone (804) 225-2912 or toll-free 1-800-55AGING.

Long-Term Care Ombudsman Program Advisory Council

March 25, 1993 - 9:30 a.m. – Open Meeting
The Virginia Association of Homes for Adults, Inc., United Way Building, 224 West Broad Street, Suite 101, Richmond, Virginia. ♿

Business will include further discussion on the goals and objectives for the Virginia Long-Term Care Ombudsman Program and Elder Rights.

Contact: Etta V. Hopkins, Assistant State Ombudsman, Virginia Department for the Aging, 700 E. Franklin St., 10th Floor, Richmond, VA 23219-2327, telephone (804) 225-2271, toll-free 1-800-552-3402, or (804) 225-2271/TDD ☎

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES (BOARD OF)

March 15, 1993 – Written comments may be submitted through this date.

May 19, 1993 - 2 p.m. – Public Hearing
1100 Bank Street, 2nd Floor Board Room, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Agriculture and Consumer Services intends to consider amending regulations entitled **VR 115-05-01. Regulations Governing Grade "A" Milk.** The proposed regulation will continue certain authority contained in the existing regulation governing the production, processing, and sale of Grade "A" pasteurized mil

and Grade "A" pasteurized milk products and certain milk products. The purpose of the present regulatory action is to review the regulation for effectiveness and continued need. The proposed regulation has been drafted to include provisions of the existing regulation and to enhance its effectiveness. In addition, certain new provisions have been established which affect milk plants, receiving station, transfer stations, producers and industry laboratories specifying: drug screening requirements of Grade "A" raw milk for pasteurization prior to processing; minimum penalties for violation of the drug residue requirements; new standards for temperature, somatic cell counts and cryoscope test; requirements to receive and retain a permit; sanitation requirements for Grade "A" raw milk for pasteurization; and sanitation requirements for Grade "A" pasteurized milk.

Statutory Authority: § 3.1-530.1 of the Code of Virginia.

Contact: J. A. Beers, Program Manager, P.O. Box 1163, Richmond, VA 23209, telephone (804) 786-1453.

Virginia Bright Flue-cured Tobacco Board

† **March 5, 1993 - 10 a.m.** – Open Meeting
Sheldon's Restaurant, Keysville, Virginia.

The board will meet to consider funding proposals for research, promotion and education projects pertaining to Virginia flue-cured tobacco and other business that may come before the board. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes.

Contact: D. Stanley Duffer, Secretary, Department of Agriculture and Consumer Services, P.O. Box 129, Halifax, VA 24558, telephone (804) 572-4568.

Virginia Small Grains Board

March 1, 1993 - 9 a.m. – Open Meeting
Williamsburg Hilton and Conference Center, 50 Kingsmill Road, Conference Center, Room 11, Williamsburg, Virginia.

The board will meet to discuss issues related to Virginia small grains industry and to hear project proposals. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes.

Contact: Rosser Cobb, Program Director, Department of Agriculture and Consumer Services, P.O. Box 26, Warsaw, VA 22572, telephone (804) 333-3710.

Virginia Soybean Board

March 4, 1993 - 9 a.m. – Open Meeting
March 5, 1993 - 9 a.m. – Open Meeting
Williamsburg Hilton and Conference Center, 50 Kingsmill Road, Conference Center, Room 15, Williamsburg, Virginia.

The board will meet in regular session to discuss issues related to Virginia soybean industry and to hear project reports and proposals. The board will entertain public comment on March 5 at the conclusion of all other business for a period not to exceed 30 minutes.

Contact: Rosser Cobb, Program Director, Department of Agriculture and Consumer Services, P.O. Box 26, Warsaw, VA 22572, telephone (804) 333-3710.

Virginia Sweet Potato Board

† **March 10, 1993 - 7:30 p.m.** – Open Meeting
Eastern Shore Agriculture Experiment Station, Route 1, Box 133, Research Drive, Painter, Virginia.

The board will meet to discuss marketing, promotion, research and education programs for the state's sweet potato industry and to develop the board's annual budget. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes.

Contact: J. William Mapp, Program Director, Department of Agriculture and Consumer Services, Box 26, Onley, VA 23418, telephone (804) 787-5867.

BOARD FOR ARCHITECTS, PROFESSIONAL ENGINEERS, LAND SURVEYORS AND LANDSCAPE ARCHITECTS

Board for Professional Engineers

February 23, 1993 - 9 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

A meeting to (i) approve minutes from November 18, 1992 meeting; (ii) review correspondence; (iii) review enforcement files; (iv) review applications; and (v) conduct regulatory review.

Contact: Willie Fobbs, III, Assistant Director, Department of Commerce, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514.

ASAP POLICY BOARD - MOUNT ROGERS

† **April 14, 1993 - 1 p.m.** – Open Meeting
Oby's Restaurant, North Main Street, Marion, Virginia.

A meeting to conduct program business. The order of business at all regular meetings shall be as follows: (i) call to order; (ii) roll call; (iii) approval of minutes; (iv) unfinished business; (v) new business; and (vi) adjournment.

Contact: J. L. Reedy, Jr., Director, Mt. Rogers ASAP, 1102 A N. Main St., Marion, VA 24354, telephone (703) 783-7771.

ASAP POLICY BOARD - VALLEY

† **March 8, 1993 - 8:30 a.m.** – Open Meeting
Augusta County School Board Office, Fishersville, Virginia. ♿

A regular meeting of the local policy board which conducts business pertaining to the following: (i) court referrals, (ii) financial report, (iii) director's report, and (iv) statistical reports.

Contact: Mrs. Rhoda G. York, Executive Director, Holiday Court, Suite B, Staunton, VA 24401, telephone (703) 886-5616 or Waynesboro number (703) 943-4405.

AUCTIONEERS BOARD

† **March 9, 1993 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting to conduct board business and other matters which may require board action.

Contact: Geralde W. Morgan, Board Administrator, Department of Commerce, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8534.

CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

February 25, 1993 - 10 a.m. – Open Meeting
Virginia Housing Development Authority, 601 South Belvidere Street, Conference Room #2, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

The board will conduct general business, including review of local Chesapeake Bay Preservation Area programs. A tentative agenda will be available from the Chesapeake Bay Local Assistance Department by February 18, 1993.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Central Area Review Committee

† **February 24, 1993 - 9 a.m.** – Open Meeting
The Council on the Environment, 202 North 9th Street, Room 900, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

The Review 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 meeting. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Northern Area Review Committee

† **March 4, 1993 - 9 a.m.** – Open Meeting
The Council on the Environment, 202 North 9th Street, Room 900, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

The Review 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 meeting. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Southern Area Review Committee

† **February 24, 1993 - 1:30 p.m.** – Open Meeting
The Yorktown Courthouse, Corner of Ballard Street and Alexander Hamilton Boulevard, Room 14, Yorktown, Virginia. ♿ (Interpreter for the deaf provided upon request)

The Review 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 meeting. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

CHILD DAY-CARE COUNCIL

February 26, 1993 - 8 a.m. – Open Meeting
Koger Executive Center, West End, 1603 Santa Rosa Road, Tyler Building, Conference Room, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A meeting to discuss legislation affecting child care centers, camps, school age programs, and

preschool/nursery schools.

Contact: Peggy Friedenberg, Legislative Analyst, Office of Governmental Affairs, Department of Social Services, 8007 Discovery Dr., Richmond, VA 23229-8699, telephone (804) 662-9217.

COUNCIL ON CHILD DAY CARE AND EARLY CHILDHOOD PROGRAMS

† **March 2, 1993 - 10 a.m.** – Open Meeting

Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, Virginia.

A regularly scheduled bi-monthly meeting. Public comments will not be received.

Contact: Mary Ellen Verdu, Executive Director, Virginia Council on Child Day Care and Early Childhood Programs, Washington Bldg., 1100 Bank St., Suite 1116, Richmond, VA 23219, telephone (804) 371-8603.

INTERDEPARTMENTAL REGULATION OF RESIDENTIAL FACILITIES FOR CHILDREN

March 19, 1993 - 8:30 a.m. – Open Meeting

Office of Coordinator, Interdepartmental Regulation, Blair Building, Conference Room B, 8007 Discovery Drive, Richmond, Virginia. ♿

A regularly scheduled 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, Interdepartmental Regulation, Office of the Coordinator, 8007 Discovery Dr., Richmond, VA 23229-8699, telephone (804) 662-7124.

COMPENSATION BOARD

March 3, 1993 - 5 p.m. – Open Meeting

March 31, 1993 - 5 p.m. – Open Meeting

Ninth Street Office Building, 202 North Ninth Street, Room 913/913A, 9th Floor, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A routine meeting to conduct business.

Contact: Bruce W. Haynes, Executive Secretary, Compensation Board, P.O. Box 3-F, Richmond, VA 23206-0686 or (804) 786-3886/TDD ☎

BOARD FOR CONTRACTORS

Complaints Committee

† **March 17, 1993 - 9 a.m.** – Open Meeting

Department of Commerce, 3600 West Broad Street, 5th Floor, Conference Room 1, Richmond, Virginia.

A meeting to review and consider complaints filed by consumers against licensed contractors.

Contact: A.R. Wade, Complaints Administrator, 3600 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 367-8585.

Recovery Fund Committee

March 18, 1993 - 9 a.m. – Open Meeting

Department of Commerce, 3600 West Broad Street, 5th Floor, Conference Room 3, Richmond, Virginia. ♿

A meeting to consider claims filed against the Virginia Contractor Transaction Recovery Fund. This meeting is open to the public; however, a portion of the discussion may be conducted in Executive Session.

Contact: Holly Erickson, Assistant Administrator, 3600 W. Broad St., Richmond, VA 23219, telephone (804) 367-8561.

BOARD FOR COSMETOLOGY

February 22, 1993 - 9 a.m. – Open Meeting
March 29, 1993 - 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, Department of Commerce, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-0500.

DEPARTMENT FOR THE DEAF AND HARD OF HEARING

† **March 24, 1993 - 5 p.m.** – Public Hearing

The Rehabilitation Center for the Blind, 401 Azalea Avenue, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A public hearing to receive comments on the department's proposed fee increase for candidates participating in the Virginia Quality Assurance Screening Written and Performance Assessments.

Contact: Brenda Thornton, VQAS Coordinator, 1100 Bank Street, 12th Floor, Richmond, VA 23219, telephone (804) 225-2570 or toll-free 1-800-552-7917.

GOVERNOR'S COMMISSION ON DEFENSE CONVERSION AND ECONOMIC ADJUSTMENT

† **March 8, 1993 - 9 a.m.** – Open Meeting
† **March 9, 1993 - 9 a.m.** – Open Meeting
Richmond Marriott Hotel, Richmond, Virginia. ♿
(Interpreter for the deaf provided upon request)

A statewide conference to educate community leaders, affected businesses, and state agencies on the potential impact of reductions in domestic military spending in Virginia, and federal, state, and local actions necessary to reduce the negative effects and to capitalize on the positive ramifications of such actions. Individuals wishing to attend must preregister at a cost of $75 per person. Registrations are limited to 450.

Contact: Jeffrey A. Windom, Deputy Commissioner, Virginia Employment Commission, 703 E. Main St., Richmond, VA 23219, telephone (804) 786-1697 or (804) 371-8050/TDD ☎

BOARD OF DENTISTRY

† **February 26, 1993 - 1 p.m.** – Open Meeting
6606 West Broad Street, 4th Floor, Richmond, Virginia. ♿

A formal hearing.

Contact: Marcia J. Miller, Executive Director, 6606 W. Broad St., Richmond, VA 23230-1717, telephone (804) 662-9906.

DEPARTMENT OF EDUCATION (BOARD OF)

February 25, 1993 - 8 a.m. – Open Meeting
March 25, 1993 - 8 a.m. – Open Meeting
James Monroe Building, 101 North 14th Street, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

The Board of Education and the Board of Vocational Education will hold a regularly scheduled meeting. Business will be conducted according to items listed on the agenda. The agenda is available upon request.

Contact: Dr. Ernest W. Martin, Assistant Superintendent, P.O. Box 2120, Richmond, VA 23216-2120, telephone (804) 225-2073.

LOCAL EMERGENCY PLANNING COMMITTEE - CHESTERFIELD COUNTY

March 4, 1993 - 5:30 p.m. – Open Meeting
April 1, 1993 - 5:30 p.m. – Open Meeting
Chesterfield County Administration Building, 10001 Ironbridge Road, Room 502, Chesterfield, Virginia. ♿

A meeting to meet requirements of Superfund Amendment and Reauthorization Act of 1986.

Contact: Lynda G. Furr, Assistant Emergency Services Coordinator, Chesterfield Fire Department, P.O. Box 40, Chesterfield, VA 23832, telephone (804) 748-1236.

LOCAL EMERGENCY PLANNING COMMISSION - COUNTY OF MONTGOMERY/TOWN OF BLACKSBURG

March 9, 1993 - 3 p.m. – Open Meeting
Montgomery County Courthouse, Main and Franklin Streets, Board of Supervisors Room, 3rd Floor, Christiansburg, Virginia. ♿

A meeting for the development of a Hazardous Materials Emergency Response Plan for Montgomery County and the Town of Blacksburg.

Contact: Steve Via, New River Valley Planning Commission, P.O. Box 3726, Radford, VA 24143, telephone (703) 639-9313 or FAX (703) 831-6093.

LOCAL EMERGENCY PLANNING COMMITTEE - PORTSMOUTH

March 10, 1993 - 9 a.m. – Open Meeting
St. Julien's Annex, Victory Boulevard at Magazine Road, Building 307, Portsmouth, Virginia.

A general meeting.

Contact: Karen Karpowski, Secretary, Portsmouth Local Emergency Planning Committee, Fire Department, 361 Effingham Street, Portsmouth, VA 23704-2337, telephone (804) 393-8765.

VIRGINIA FIRE SERVICES BOARD

† **March 12, 1993 - 6 p.m.** – Open Meeting
† **March 13, 1993 - Unknown** – Open Meeting
† **March 14, 1993 - Unknown** – Open Meeting
Mountain Lake, Virginia.

A work session. No business will be conducted, no policy decisions will be made.

Contact: Anne J. Bales, Executive Secretary Senior, Department of Fire Programs, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

DEPARTMENT OF HEALTH (STATE BOARD OF)

March 1, 1993 - 2 p.m. – Public Hearing
1500 East Franklin Street, Suite 115, Richmond, Virginia.

March 5, 1993 – Written comments may be submitted through 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 **repeal** regulations entitled **VR 355-01-01. Public Participation Guidelines in the Development and Formation of Regulations** and **adopt** regulations entitled **VR 355-01-100. Public Participation Guidelines.** The Public Participation Guidelines outline the methods used to solicit input from the public in the formation and development of regulations.

Statutory Authority: §§ 9-6.14:7.1 and 32.1-12 of the Code of Virginia.

Contact: Susan R. Rowland, Assistant to the Commissioner, 1500 E. Main St., Suite 214, Richmond, VA 23219, telephone (804) 786-3564.

* * * * * * * *

† **April 23, 1993** – Written comments may be submitted through 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 355-28-100. Regulations for Disease Reporting and Control.** The regulations are being amended to (i) comply with current disease control policies, (ii) change the form for reporting morbidity, and (iii) comply with statutory requirements.

STATEMENT

Basis: Section 32.1-12 of the Code of Virginia empowers the Board of Health with the authority to make, adopt and promulgate regulations. Section 32.1-35 directs the board to promulgate regulations specifying which diseases occurring in the Commonwealth are to be reportable and the method by which they are to be reported.

Substance: The regulations provide detail regarding the requirements for reporting communicable diseases, toxic substances related diseases, cancer, and memory loss disorders to the Health Department for the purposes of disease surveillance and control. Included are definitions of who is required to report, which diseases are reportable, and what mechanisms are available for reporting. The two major proposed changes included in this amendment are described and other proposed changes summarized below.

1. To make lead poisoning in children a reportable condition: the goals of surveillance for childhood lead poisoning are to identify the distribution of elevated blood lead levels in children throughout Virginia, identify sources of exposure, and target prevention programs. The proposed definition of reportable lead poisoning is children age zero to 15 with confirmed venous blood lead levels of 15 ug/dL or higher. Such reports would be submitted to the local health department by all reporting sources (physicians, hospital directors, and laboratory directors).

2. To change the Confidential Morbidity Report Form: A new form is being proposed for recording information on a person having a reportable condition. One patient would be reported per form. The form would be printed as a three-part form, thereby making copies available for the reporting source, the local health department, and the state Health Department.

Other minor proposed changes include adding Escherichia coli 0157:H7 to the definition of foodborne outbreaks, adding waterborne outbreaks to the list of diseases that should be reported by rapid means, permitting directors of laboratories to report the results of any confirmatory test for the conditions they are required to report, reflecting the current immunization requirements of the Code, and making the wording of the regulations consistent with the change in the Code that now requires reporting to the Alzheimer's Disease and Related Disorders Registry where reporting was previously voluntary.

Issues: The addition of childhood lead poisoning to the list of reportable conditions is consistent with recommendations of the national Centers for Disease Control. This addition is concise and brief. Amending existing regulations was determined to be the least burdensome method of identifying populations at risk for this condition, which is the first step in intervention and prevention.

The change in the form to be used for disease reporting is meant to achieve a simplification of the paperwork necessary for disease reporting. This change would render six forms currently in use unnecessary, decrease the need for photocopying forms, reduce the time needed for health department staff to telephone reporting sources for missing information, and increase the confidentiality of the data reported.

The other proposed changes are designed to increase the internal consistency of the regulations as well as consistency with the Code, to make reporting more complete, or to allow more rapid investigation and intervention when situations arise that are a threat to the public's health.

The proposed regulations have been reviewed by the agency's assistant attorney general, members of the department's staff, and the State Board of Health. Comments received from district health directors regarding desired changes in the morbidity report form have been incorporated into the proposed form. No comments were

received during the period following the publication of the Notice of Intent to Amend.

Impact: Persons in the private sector affected by this amendment to the regulations include physicians, hospitals, and laboratory directors. The primary impact is that they would have to forward reports of children with lead poisoning to the health department. Many are testing for lead poisoning, so this would only involve mailing the information to the health department. This should not result in a significant burden, however, given that these entities are already required to forward information on persons with a variety of diagnoses to the health department.

The agency will be responsible for maintaining data on children with lead poisoning and providing education on lead poisoning prevention to the parents of these children. Local health departments will be responsible for following up on cases of lead poisoning that are reported. Such follow-up could include activities ranging from providing information to conducting inspections of homes. The extent of follow-up conducted will depend on the availability of existing resources. The agency has received a five-year grant from the federal Centers for Disease Control for childhood lead poisoning prevention. Education and training will be provided with those funds.

The agency does not anticipate that any additional costs will be incurred as a result of this amendment. If any costs unexpectedly arise, however, they will be absorbed by the current budget.

They agency will benefit from the elimination of six morbidity report forms and the creation of only one form to take their place. The design of the form in three parts and including only one patient name should save time and money by decreasing the need to photocopy the forms for distribution and/or filing purposes.

Evaluation of the effectiveness and continued need for the regulations will be accomplished through the ongoing surveillance and investigation of disease.

Statutory Authority: §§ 32.1-12 and 32.1-35 of the Code of Virginia.

Contact: C. Diane Woolard, M.P.H., Senior Epidemiologist, Virginia Department of Health, P.O. Box 2448, Room 113, Richmond, VA 23218, telephone (804) 786-6261.

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† **March 17, 1993 - 10 a.m.** – Public Hearing
Monroe Building, 101 North 14th Street, Conference Room B, Richmond, Virginia.

April 23, 1993 – Written comments may be submitted through 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 355-30-000. Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.** The purpose of the proposed amendments is to implement the Certificate of Public Need program consistent with the amended law which became effective July 1, 1992.

STATEMENT

Basis: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Summary, purpose, and issues: The regulations incorporate amendments to the certificate of public need (COPN) law that became effective on July 1, 1992. With the exception of Part VI which provides a process for expediting the review of certain types of projects, these regulations were first promulgated as emergency regulations with an effective date of July 10, 1992. The amendments expand the categories of projects that require COPN approval by the State Health Commissioner prior to initiation; allow the replacement of certain major medical equipment without the issuance of a certificate of need under certain circumstances; eliminate the current registration and data reporting requirements for certain types of medical care facility capital expenditure projects; eliminate the scheduled sunset of COPN review requirements for ambulatory surgery centers and hospitals; extend the moratorium on the issuance of COPNs for nursing home bed projects from June 30, 1993, to July 30, 1994, and provides several additional exemptions to this moratorium. The amendments to the law also allow extensions to the schedules for completion of certain previously authorized nursing home projects under certain conditions.

Estimated impact: Changes proposed at this time will bring the rules and regulations in full compliance with recent amendments to the Virginia Medical Care Facilities Certificate of Public Need Law. The proposed regulations define all of the medical care facility projects which are now subject to review and expand the application "batch" review process to include all of the reviewable projects. Projects which meet specific criteria may be considered on an expedited basis outside of the regular batch review schedule.

The changes will increase the number of projects which are submitted to the department for review. However, the batching review system enables staff to conduct a comparative review of all similar projects submitted in the same geographic area and provides even distribution of the project workload according to an established annual schedule. The process for expediting certain projects will minimize staff time and effort spent on certain uncomplicated projects. Therefore, with the "batch" review system combined with the process for expedited review, agency staff should be able to manage their time efficiently and effectively handle the increased project workload.

The regulations also establish provisions for emergency

replacement of certain major medical equipment on an expedited basis which will not require the issuance of a certificate of public need. Under this provision, equipment which is inoperable or needed to provide an essential clinical health service can be authorized for replacement within a maximum of 15 days. Such projects qualifying for emergency replacement will not be reviewed according to the standard procedure and will, therefore, require minimal staff time.

There are also additional exceptions to the current nursing home moratorium and provisions which allow additional extensions to the schedules for completion of nursing home projects which had been previously authorized. These will require additional agency staff time to review. However, with the application batching review system, staff will be able to manage their time efficiently and these additional projects are not likely to have a significant impact on the overall operation of the COPN program.

The increase in the number of projects submitted for review will bring in additional revenue through the collection of application fees. According to the statute, these fees are to be used to offset the expense of administering the COPN program and, therefore, should provide additional moneys for staff and administration of the COPN program.

There are costs associated with the completion of the application process by those health care providers not subject to COPN review requirements. However, by regulating the health care industry through the COPN process, the Commonwealth may help contain the overall cost of health care for its citizens.

The department has made efforts to ensure that the regulations are clear and concise by providing definitions of all significant terms used in the regulations and adopting the language from the COPN statute whenever possible. The department also considered comments and incorporated the advice of the regulated industry in initially drafting these regulations.

The department considered several alternative methods for the consideration of medical care facility projects which are subject to review in accordance with the COPN law. All projects are now subject to a relatively lengthy review process which enables public participation and analysis by state and local agencies. The process proposed for expediting the review of certain projects provides an alternative to the standard batch review system and will minimize the regulatory burden on sponsors of routine projects which are not expected to have a significant impact on the health care system.

Forms: There is one new application form associated with the changes to the regulations. This new form has been developed for sponsors to submit projects for consideration under the expedited review process. This new form requires a project sponsor to submit the minimum information necessary to process an application compared to the detailed information required by the application form which is used to propose a project under the standard batch review process. The forms associated with former registration and reporting requirements will no longer be used.

Statutory Authority: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Written comments may be submitted through April 23, 1993, to Paul E. Parker, Director, Division of Resources Development, Virginia Department of Health, 1500 East Main Street, Suite 105, Richmond, Virginia 23219.

Contact: Wendy Brown, Project Review Manager, Division of Resources Development, 1500 E. Main St., Suite 105, Richmond, VA 23219, telephone (804) 786-7463.

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† **March 17, 1993 - 1 p.m.** – Public Hearing
Monroe Building, 101 North 14th Street, Conference Room B, Richmond, Virginia.

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 **repeal** regulations entitled: **1987 State Medical Facilities Plan** and **adopt** regulations entitled: **VR 355-30-100 through VR 355-30-113. Virginia State Medical Facilities Plan.** The purpose of the proposed action is to revise the State Medical Facilities Plan to provide guidance for assessing the public need for projects for review according to the 1992 amendments to the Certificate of Public Need law.

STATEMENT

Basis: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Purpose: The 1992-1993 State Medical Facilities Plan (SMFP) responds to the amendments to the Certificate of Public Need (COPN) law that became effective July 1, 1992. The SMFP is identical to the SMFP which became effective in July 1992 on an emergency basis and is currently in use by the department. The statutory amendments which became effective on July 1, 1992, substantially expanded the categories of capital expenditure projects that require COPN approval by the State Health Commissioner prior to initiation. The SMFP serves as a basis for decision making on a wide range of project categories and is essential to the implementation of the COPN program.

Substance, issues, and impact: The State Medical Facilities Plan provides guidance for assessing the public need for the full range of capital expenditure project categories which require COPN review under the 1992 law amendments. Without the SMFP, the Department of Health would have no specific standards in place to review such major medical equipment categories as lithotripsy, positron emission tomography, single photon emission computed

tomography (SPECT), gamma knife surgery, or magnetic source imaging. Additionally, the SMFP is the department's only available guidance for the evaluation of service categories subject to COPN review such as medical rehabilitation and organ transplantation, and many other health service categories. Finally, under the 1992 law amendments, any capital expenditure, for whatever reason, which exceeds $1 million dollars, is subject to COPN review. The SMFP establishes specific planning guidance for the review of the many COPN proposals which will fall in this category but do not involve changes in specific clinical health services or major medical equipment specifically subject to COPN review.

The SMFP provides planning standards, allowing for informed and consistent decision making. The SMFP provides direct and concise standards for all COPN project categories. In order to assure clarity and simplicity, the standards have all been developed to address the same guiding principles. The regulated industry provided comments and assisted in developing the SMFP criteria when the document was initially drafted as an emergency regulation.

The SMFP greatly simplifies the COPN review process. Potential applicants are able to review, in a single document with a simple format, the key standards which will be used by the Department of Health in the review of their project. Department staff also have a simplified basis for organizing and focusing their analyses and evaluative reports on projects.

The department considered various alternative methods to assess the public need for the various regulated services and capital expenditures. Methods were selected which are direct and comprehensible for the regulated industry and the reviewing agency.

The SMFP does not impose additional costs on health care providers seeking the approval of projects through the COPN process. The SMFP also provides standards which will allow the department to expedite the review of certain projects which qualify for an expedited review according to the proposed COPN regulations.

The SMFP is likely to result in COPN requests that are more responsive to the health care needs of the public, because it establishes standards for determining public need, which, in some cases, are more specific than those which were in place in prior COPN planning documents. In other cases, the SMFP represents the first standards for particular project types such as SPECT and gamma knife surgery. It is impossible to quantify this impact at this early state following the 1992 legislation, since comprehensive information is not yet available.

Statutory Authority: §§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Written comments may be submitted through April 23, 1993.

Contact: Paul E. Parker, Director, Division of Resources Development, 1500 E. Main St., Suite 105, Richmond, VA 23219, telephone (804) 786-7463.

VIRGINIA HEALTH SERVICES COST REVIEW COUNCIL

February 23, 1993 - 9:30 a.m. – Open Meeting
2015 Staples Mill Road, Richmond, Virginia.

A regular monthly meeting.

Contact: Marcia A. Melton, Executive Secretary Senior, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371.

† **March 23, 1993 - 9:30 a.m.** – Open Meeting
Blue Cross/Blue Shield of Virginia, 2015 Staples Mill Road, Richmond, Virginia.

A monthly meeting.

Contact: John A. Rupp, Executive Director, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

† **March 9, 1993 - 9:30 a.m.** – Open Meeting
George Mason University, Fairfax, Virginia.

† **April 13, 1993 - 9:30 a.m.** – Open Meeting
Danville Community College, Danville, Virginia.

A general business meeting. For additional information contact the council.

Contact: Anne M. Pratt, Associate Director, Monroe Bldg., 101 N. 14th St., 9th Floor, Richmond, VA 23219, telephone (804) 225-2639.

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March 12, 1993 – Written comments may be submitted through this date.

March 18, 1993 - 1 p.m. – Public Hearing
James Monroe Building, 101 North 14th Street, 9th Floor Conference Room, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Council of Higher Education for Virginia intends to **repeal** regulations entitled **VR 380-03-02. Virginia Work-Study Program Regulations,** and **adopt** regulations entitled **VR 380-03-02:1. Virginia Work-Study Program Regulations.** Section 23-38.70 of the Code of Virginia authorizes the Council of Higher Education to develop regulations and procedures for the operation of the

Virginia-Work Study Program (VWSP). The proposed VWSP regulations, if adopted, will replace the existing regulations which are outdated and, in places, ambiguous. The major provisions are institutional application procedures, distribution of funds, student eligibility, restrictions on student placement and compensation, and responsibilities of involved parties.

Statutory Authority: § 23-38.70 of the Code of Virginia.

Contact: Stephen Merritt, Coordinator, Financial Aid Programs, Council of Higher Education for Virginia, James Monroe Bldg., 101 N. 14th St., Richmond, VA 23219, telephone (804) 225-2623.

VIRGINIA HISTORIC PRESERVATION FOUNDATION

† **March 10, 1993 - 10:30 a.m.** – Open Meeting
Petersburg City Hall, Council Chambers, Petersburg, Virginia. ♿ (Interpreter for the deaf provided upon request)

A general business meeting.

Contact: Margaret Peters, Information Director, 221 Governor St., Richmond, VA 23219, telephone (804) 786-3143 or (804) 786-1934/TDD ☎

HOPEWELL INDUSTRIAL SAFETY COUNCIL

March 2, 1993 - 9 a.m. – Open Meeting
April 6, 1993 - 9 a.m. – Open Meeting
Hopewell Community Center, Second and City Point Road, Hopewell, Virginia. ♿ (Interpreter for deaf provided upon request)

A Local Emergency Preparedness Committee meeting on emergency preparedness as required by SARA Title III.

Contact: Robert Brown, Emergency Service Coordinator, 300 N. Main St., Hopewell, VA 23860, telephone (804) 541-2298.

DEPARTMENT OF LABOR AND INDUSTRY

Apprenticeship Council

March 1, 1993 - 7 p.m. – Open Meeting
Richmond Technical Center, 2220 Westwood Avenue, Richmond, Virginia.

March 2, 1993 - 7 p.m. – Open Meeting
Norfolk Technical Vocational Center, 1330 North Military Highway, Norfolk, Virginia.

March 3, 1993 - 7 p.m. – Open Meeting
Roanoke County Administration Center, 3738 Brambleton Avenue, Community Room, Roanoke, Virginia. ♿

March 4, 1993 - 7 p.m. – Open Meeting
Fairfax City Hall, 10455 Armstrong Street, City Council Chambers, Fairfax, Virginia. ♿

A meeting to hear comments on the proposed amendment to VR 425-01-26, Regulations Governing the Administration of Apprenticeship Programs in the Commonwealth of Virginia, § 4 B 14, numeric ratio.

† **March 25, 1993 - 10 a.m.** – Open Meeting
General Assembly Building, 910 Capitol Street, House Room C, Richmond, Virginia 23219. ♿

A regular meeting.

Contact: Robert S. Baumgardner, Director of Apprenticeship, Department of Labor and Industry, 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-2381.

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April 12, 1993 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Apprenticeship Council intends to amend regulations entitled: **VR 425-01-26. Regulations Governing the Administration of Apprenticeship Programs in the Commonwealth of Virginia.** This amendment provides new minimum numeric ratios for program sponsors performing Davis-Bacon work.

Statutory Authority: § 40.1-118 of the Code of Virginia.

Contact: Robert S. Baumgardner, Director of Apprenticeship, Department of Labor and Industry, 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-2381.

Migrant and Seasonal Farmworkers Board

† **March 3, 1993 - 10 a.m.** – Open Meeting
State Capitol Building, Capitol Square, House Room 1, Richmond, Virginia. ♿

A general meeting of the board. Election of officers will be held. The subcommittee on the Complaint Resolution Process will meet immediately following the board meeting.

Contact: Marilyn Mandel, Director, Office of Planning and Policy Analysis, Powers-Taylor Bldg., 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-2385.

LIBRARY BOARD

March 15, 1993 - 10 a.m. – Open Meeting
The Virginia State Library and Archives, 3rd Floor,

Supreme Court Room, Richmond, Virginia.

A meeting to discuss administrative matters of the Virginia State Library and Archives.

Contact: Jean H. Taylor, Secretary to State Librarian, Virginia State Library and Archives, 11th St. at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

STATE COUNCIL ON LOCAL DEBT

March 17, 1993 - 11 a.m. – Open Meeting
† **April 21, 1993 - 11 a.m.** – Open Meeting
James Monroe Building, 101 North 14th Street, 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: Gary Ometer, Debt Manager, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-4928.

COMMISSION ON LOCAL GOVERNMENT

March 1, 1993 - 1 p.m. – Open Meeting
Bedford County Board of Supervisors, 122 East Main Street, County Administration Building, Meeting Room, Bedford, Virginia.

Oral presentations regarding the City of Bedford - County of Bedford voluntary settlement agreement. Persons desiring to participate in the commission's proceedings and requiring special accommodations or interpreter services should contact the commission's offices by Friday, February 19, 1993.

March 1, 1993 - 7 p.m. – Public Hearing
Bedford County Board of Supervisors, 122 East Main Street, County Administration Building, Meeting Room, Bedford, Virginia.

Public hearing regarding the City of Bedford - County of Bedford voluntary settlement agreement. Persons desiring to participate in the commission's proceedings and requiring special accommodations or interpreter services should contact the commission's offices by Friday, February 19, 1993.

March 2, 1993 - 9 a.m. – Open Meeting
Bedford City Council Chambers, Bedford Municipal Building, 215 East Main Street, Bedford, Virginia.

A regular meeting to consider such matters as may be presented. Persons desiring to participate in the commission's proceedings and requiring special accommodations or interpreter services should contact the commission's offices by Friday, February 19, 1993.

Contact: Barbara W. Bingham, Administrative Assistant, Commission on Local Government, 702 8th Street Office Bldg., Richmond, VA 23219, telephone (804) 786-6508 or (804) 786-1860/TDD

STATE LOTTERY BOARD

February 22, 1993 - 10 a.m. – Open Meeting
2201 West Broad Street, Richmond, Virginia.

A regular monthly meeting of the board. 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, 2201 W. Broad St., Richmond, VA 23220, telephone (804) 367-9433.

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March 22, 1993 - 11 a.m. – Public Hearing
Fairfax Regional Office, 8550 Arlington Boulevard, Fairfax, Virginia.

March 22, 1993 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Lottery Board intends to consider adopting regulations entitled **VR 447-02-2. On-Line Game Regulations.** The purpose of the proposed amendment is to reduce the potential of the purchase of large blocks of on-line lottery tickets by stipulating that all playslips used must be manually marked.

Statutory Authority: § 58.1-4007 of the Code of Virginia.

Contact: Barbara L. Robertson, Lottery Staff Officer, State Lottery Department, 2201 W. Broad St., Richmond, VA 23220, telephone (804) 367-9433.

ADVISORY COMMITTEE ON MAPPING, SURVEYING AND LAND INFORMATION SYSTEMS

† **March 4, 1993 - 10 a.m.** – Open Meeting
1100 Bank Street, Suite 901, Richmond, Virginia.

A regular business meeting.

Contact: Chuck Tyger, Computer Systems Chief Engineer, Council on Information Management, 1100 Bank St., Suite 901, Richmond, VA 23219, telephone (804) 225-3622 or (804) 225-3624/TDD .

MARINE RESOURCES COMMISSION

† **February 23, 1993 - 9:30 a.m.** – Open Meeting
2600 Washington Avenue, 4th Floor, Room 403, Newport News, Virginia. ♿ (Interpreter for the deaf provided upon request)

The commission will hear and decide marine environmental matters at 9:30 a.m.: (i) permit applications for projects in wetlands, bottom lands, coastal primary sand dunes and beaches; (ii) appeals of local wetland board decisions; (iii) policy and regulatory issues.

The commission will hear and decide fishery management items at approximately 12 noon. Items to be heard are as follows: (i) regulatory proposals; (ii) fishery management plans; (iii) fishery conservation issues; (iv) licensing; (v) 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: Sandra S. Schmidt, Secretary to the Commission, P.O. Box 756, Newport News, VA 23607, telephone (804) 247-8088, toll-free 1-800-541-4646 or (804) 247-2292/TDD ☎

MARY WASHINGTON COLLEGE

Board of Visitors

February 27, 1993 - 9 a.m. – Open Meeting
† **April 17, 1993 - 9 a.m.** – Open Meeting
Woodard Campus Center, Red Room, Fredericksburg, Virginia. ♿

A regularly scheduled meeting.

Contact: Vicki Campbell, Clerk, Board of Visitors, Mary Washington College, 1301 College Avenue, George Washington Hall 103, Fredericksburg, VA 22401-5358, telephone (703) 899-4621.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

† **April 23, 1993** – Written comments may be submitted through 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 EPSDT and Inpatient Psychiatric Services: VR 460-01-22, Services; VR 460-03-3.1100, Amount, Duration and Scope of Services; VR 460-02-3.1300, Standards Established and Methods Used to Assure High Quality of Care; and VR 460-02-4.1920, Methods and Standards for Establishing Payment Rates-Other Types of Care.** The purpose of this proposal is to promulgate permanent regulations to supersede the current emergency regulations which provide for the same policies. The sections of the State Plan for Medical Assistance (the Plan) affected by this proposed regulation are: preprinted page 22; the Amount, Duration, and Scope of Services narrative (Supplement 1 to Attachment 3.1 A and B); Standards Established and Methods Used to Assure High Quality of Care (Attachment 3.1 C); and Methods and Standards for Establishing Payment Rates - Other Types of Care (Attachment 4.19 B).

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) requires that state Medicaid programs provide to recipients any and all necessary services permitted to be covered under federal law, when the need for those services are identified as a result of screenings through the Early and Periodic Screening, Diagnosis, and Treatment Program. Such services must be provided even if they are not otherwise covered under the Plan, and are thus not available to recipients independent of EPSDT referral.

The EPSDT program provides for screening and diagnostic services to determine physical and mental defects in recipients up to age 21, and health care, treatment, and other services to correct or ameliorate any defects or chronic conditions discovered. EPSDT is a mandatory program which must be provided for all Medicaid-eligible recipients who are 18 years old or younger and, at the state's option, up to age 21. The Commonwealth provides EPSDT for recipients to age 21.

One service now required to be covered for recipients because of EPSDT is inpatient psychiatric services in psychiatric hospitals. These regulations reflect the definition of covered services and the fee-for-service reimbursement methodology.

During the development of the department's policy concerning EPSDT, the Health Care Financing Administration (HCFA) provided guidance to the states. DMAS incorporated this guidance into its emergency regulations which HCFA subsequently approved. DMAS has tightened its definition of covered psychiatric services to be those provided in psychiatric hospitals when the services are the result of EPSDT.

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.

Impact: Prior to the changes mandated by OBRA 89, states only covered those services (detected by screening programs) that were included in their Medicaid plans. The law now requires that Medicaid programs pay for all health care services authorized under the federal Medicaid program whether or not those services are covered in a state's plan subject to the limitations of Pereira v. Kozlowski. The costs of these EPSDT-related services are accounted for in the current appropriation.

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

Written comments may be submitted until 5 p.m. on April 23, 1993, to Betty Cochran, Director, Division of Quality Care Assurance, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

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† **April 23, 1993** – Written comments may be submitted through 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 460-02-4.1810, VR 460-02-4.1830, and VR 460-02-4.1920. Outpatient Rehab Services and Removing the Medicare Cap on Fees.** The purpose of this proposal is (i) to promulgate permanent regulations which will provide for equitable application of recipient cost sharing policies for outpatient rehabilitative services and the elimination of the Medicare cap on all services' fees; and (ii) to replace emergency regulations currently in effect.

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 emergency adoption actions, 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 (i) to promulgate permanent regulations which will provide for equitable application of recipient cost sharing policies for outpatient rehabilitative services and the elimination of the Medicare cap on all services' fees; and (ii) to replace emergency regulations currently in effect.

Summary and analysis: The sections of the plan which are affected by this action are: Recipient Cost Sharing Obligations (Attachments 4.18 A and C); and Methods and Standards for Establishing Payment Rates-Other Types of Care (Attachment 4.19 B). Recipient cost sharing for outpatient rehabilitative services and the elimination of the Medicare cap on all services' fees are discussed below.

Recipient Cost Sharing for Outpatient Rehabilitative Services

The 1992 Appropriations Act (Appropriations Act) directed the DMAS to impose copayments on home health services. These services were intended to mean health services rendered in the home setting regardless of the kind of provider. Home health services include nursing, home health aide, speech and language services, physical therapy, and occupational therapy. The only agencies delivering nursing and home health aide services in the home setting are home health agencies. However, therapy services (speech, physical and occupational) are also offered in the home by rehabilitative agencies. Therefore, it was necessary to place a copayment on the in-home therapy services offered by rehabilitation agencies as well as those offered by home health agencies.

In developing the implementation plans for complying with the Appropriations Act mandate, DMAS identified that while rehabilitation agencies offer therapy services in the homes of recipients, they also offer these in their offices. If Medicaid imposes a copayment on in-home services then there will be an incentive for rehabilitation agencies to shift the location of services from the home to their offices. If this occurs then DMAS will not achieve the savings directed in the Appropriations Act. In order to ensure that the projected savings are achieved, DMAS proposes to impose a copayment on therapy services offered by rehabilitation agencies regardless of whether those services are offered in the home or in the office.

Moreover, an issue of equitable treatment of recipients is created if copayments are not imposed on therapy treatments in the offices of rehabilitation agencies. Individuals who are homebound and unable to leave their homes for treatment and people who go to hospital outpatient departments will be required to pay copayments, while individuals who are able to go to the offices of the rehabilitation agencies will not be required

to pay a copayment. In order to resolve this inequity, it is proposed that copayments be imposed on therapy visits rendered by rehabilitation agencies regardless of the place of treatment.

Because the Appropriations Act directed DMAS to impose copayments on home health services effective July 1, 1992, and because it is necessary to apply these copayments equitably to all recipients of outpatient therapy services, an emergency regulation was issued. Without the emergency regulation, DMAS could not meet the requirement of the Appropriations Act nor could it apply the copayment equitably until after a public comment period. Since emergency regulations are time limited in their effectiveness, these proposed permanent regulations, once adopted in their final form, will supersede the existing emergency regulation.

This proposed regulation varies from the emergency regulation by the exclusion of emergency services and all services delivered in emergency rooms from the application of the copay policy. Federal regulations exclude the imposition of recipient cost sharing for emergency services and define how such services are to be interpreted (Code of Federal Regulations § 447.53(b)(4)). Moreover, DMAS has determined that nonemergency services, as identified by the Reimbursement Adjustment for Non-Emergency Care in Emergency Rooms programs, provided in emergency rooms should not be subject to recipient copayment. The administrative cost and complexity of providers attempting to collect the copayment from the recipient after the service has been delivered was determined to be an unneccessary, costly burden to providers and, therefore, was excluded from the copayment policy.

Elimination of Medicare Cap on All Services' Fees

Effective January 1, 1992, Medicare implemented a major revision of its fee schedule for physician services. This new fee schedule was not intended to change total Medicare expenditures for physician services but did change amounts paid for many individual services significantly. Many kinds of surgical and diagnostic services are being reimbursed at a lower rate than before, while the services of primary care physicians are being reimbursed at a higher rate.

Although on average, Virginia Medicaid fees are lower than those of Medicare, there are some instances where the new Medicare fees have been reduced so sharply that they are now lower than those of Virginia Medicaid for the same services. For example, Medicare allows a payment of $670 for routine obstetrical care, including antepartum care, vaginal delivery, and postpartum care. The Medicaid allowed payment is $1,200 which is still well below payments made by other third party payers. To simply follow the language of the current state plan would mean reducing payment, sometimes significantly, for many physician services.

DMAS has used the payment rates set by the Medicare program for a number of years. It was voluntary on DMAS' part and not related to any federal policy or law. After further study and experience with the current emergency regulation, DMAS determined that removing the Medicare cap on all services was appropriate and consequently has reflected this policy in this proposed regulation.

Also in this proposed regulation, the numbering scheme of Attachment 4.19 B is being revised. This is a technical change and has no policy or fiscal impact.

Impact: The issues are discussed in the same order as established above.

Recipient Cost Sharing for Outpatient Rehabilitative Services

This initiative is not expected to result in any new General Fund expenditures by DMAS. The Appropriations Act estimated total savings of $600,000 for the biennium by the imposition of copayments on home health services. This regulation will ensure that those anticipated savings are realized.

Elimination of Medicare Cap on all Services' Fees

This proposed amendment has no fiscal or budgetary impact. It does not change Medicaid's payments to providers, but assures that payment levels currently in place are not found to be in violation of the State Plan as a result of changes in federal Medicare reimbursement policy.

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

Written comments may be submitted until 5 p.m. on April 23, 1993, to Jerome W. Patchen, Director, Division of Policy and Research, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

BOARD OF MEDICINE

Informal Conference Committee

February 24, 1993 - 10:30 a.m. – Open Meeting
Roanoke Marriott, 2801 Hershberger Road, N.W., Roanoke, Virginia.

February 26, 1993 - 9 a.m. – Open Meeting
† **March 2, 1993 - 9 a.m.** – Open Meeting
Sheraton-Fredericksburg, I-95 and Route 3, Fredericksburg, Virginia.

† **March 5, 1993 - 9 a.m.** – Open Meeting
Williamsburg Hilton, 50 Kingsmill Road, Williamsburg, Virginia. ♿

A meeting to inquire into allegations that certain practitioners may have violated laws and regulations governing the practice of medicine and other healing arts in Virginia. The committee will meet in open and closed sessions pursuant to § 2.1-344 of the Code of Virginia. Public comment will not be received.

Contact: Karen W. Perrine, Deputy Executive Director, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9908 or (804) 662-9943/TDD ☎

Advisory Board of Physical Therapy

March 12, 1993 - 9 a.m. – Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 1, Richmond, Virginia. ♿

A meeting to (i) review the traineeship forms for the American and foreign trained physical therapists; (ii) develop regulations to require an examination for inactive physical therapists applying for licensure by endorsement or reinstatement of a lapsed license; (iii) establish regulations for number of traineeships of foreign and American graduates which may be supervised by a licensed P.T.; (iv) receive reports; (v) review § 6.1 of regulations regarding the physical therapist and physical therapist assistant's first visit to determine if amendments are required; and (vi) such other business as may come before the advisory board. The chairman may entertain public comments on any agenda item.

Contact: Eugenia K. Dorson, Deputy Executive Director, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923.

Advisory Board of Occupational Therapists

March 24, 1993 - 10 a.m. – Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 2, Richmond, Virginia. ♿

A meeting to discuss the certified Occupational Therapy Assistant, review the regulation VR 465-08-01, continuing education, and such other business which comes before the advisory board. The chairman may entertain public comments on any of the agenda items noticed.

Contact: Eugenia K. Dorson, Deputy Executive Director, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923.

Advisory Committee on Certification of Optometrists

March 19, 1993 - 9 a.m. – Public Hearing
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 2, Richmond, Virginia. ♿

The advisory committee will conduct a public hearing pursuant to § 54.1-2957.2 of the Code of Virginia on regulation VR 465-09-01, § 4.3, Therapeutical Pharmaceutical Agents which a certified Doctor of Optometry may administer and prescribe for certain diseases and abnormal conditions of the human eye, and its adnexa. The committee will receive written comments until Friday, February 26, 1993. The committee will review all public and written comments and provide recommendations to the full board that may be deemed to be reasonable and necessary to ensure an appropriate standard of medical care for the patient.

Contact: Eugenia K. Dorson, Deputy Executive Director, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923.

April 9, 1993 - 10 a.m. – Open Meeting
6606 West Broad Street, Board Room 1, 5th Floor, Richmond, Virginia. ♿

A meeting to review all written and public comments received by the Board on Regulation VR 465-09-01, § 4.3, Therapeutic Pharmaceutical Agents, and make recommendations to full board.

Contact: Eugenia K. Dorson, Deputy Executive Director, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923.

Advisory Board on Respiratory Therapy

March 26, 1993 - 1 p.m. – Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Richmond, Virginia. ♿

A meeting to elect officers, review the regulation VR 465-04-01 for certification of R.T.s, and such other business which may come before the advisory board. The chairman may entertain public comments on any of the agenda items noticed.

Contact: Eugenia K. Dorson, Deputy Executive Director, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923.

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

February 24, 1993 - 10 a.m. – Open Meeting
Department of Mental Health, Mental Retardation and Substance Abuse Services, James Madison Building, 109 Governor Street, Richmond, Virginia. ♿

A regular monthly board meeting. Agenda to be published on February 17. Agenda can be obtained by

calling Jane Helfrich.

Tuesday: Informal session – 8 p.m.
Wednesday: Committee meetings – 9 a.m.
Regular session – 10 a.m.

See agenda for locations.

† **March 24, 1993 - 10 a.m.** – Open Meeting
Southeastern Virginia Training Center, 2100 Steppingstone Square, Community Services Meeting Room, Chesapeake, Virginia. ♿

A regular monthly board meeting. Agenda to be published on March 17. Agenda can be obtained by calling Jane Helfrich.

Tuesday: Informal session – 8 p.m.
Wednesday: Committee meetings – 9 a.m.
Regular session – 10 a.m.

See agenda for locations.

Contact: Jane V. Helfrich, Board Administrator, State MHMRSAS Board, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3921.

State Human Rights Committee

† **March 24, 1993 - 9 a.m.** – Open Meeting
Southeastern Virginia Training Center, 2100 Steppingstone Square, Community Services Meeting Room, Chesapeake, Virginia. ♿

A regular meeting to discuss business relating to human rights issues. Agenda items are listed for the meeting.

Contact: Elsie D. Little, State Human Rights Director, Department of Mental Health, Mental Retardation and Substance Abuse Services, Office of Human Rights, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3988.

MIDDLE VIRGINIA BOARD OF DIRECTORS AND THE MIDDLE VIRGINIA COMMUNITY CORRECTIONS RESOURCES BOARD

March 4, 1993 - 7 p.m. – Open Meeting
502 South Main Street #4, Culpeper, Virginia.

From 7 p.m. until 7:30 p.m. the Board of Directors will hold a business meeting to discuss DOC contract, budget, and other related business. Then the CCRB will meet to review cases before for eligibility to participate with the program. It will review the previous month's operation (budget and program related business).

Contact: Lisa Ann Peacock, Program Director, 502 S. Main St. #4, Culpeper, VA 22701, telephone (804) 825-4562.

DEPARTMENT OF MINES, MINERALS AND ENERGY

† **February 25, 1993 - 1 p.m.** – Open Meeting
Department of Mines, Minerals and Energy, off U.S. Route 23 adjacent to Mountain Empire Community College Campus, Conference Room 116, Big Stone Gap, Virginia. ♿ (Interpreter for the deaf provided upon request)

The purpose of the public meeting is to give interested persons an opportunity to be heard in regard to the FY93 Abandoned Mine Land Consolidated Grant Application to be submitted to the federal Office of Surface Mining. Special accommodations for disabled people are available on request.

Contact: Roger L. Williams, Abandoned Mine Land Manager, P.O. Drawer 900, Big Stone Gap, VA 24219, telephone (703) 523-8208 or toll-free 1-800-552-3831/TDD ☎

BOARD OF NURSING

Special Conference Committee

February 22, 1993 - 8:30 a.m. – Open Meeting
Department of Health Professions, 6606 West Broad Street, Conference Room 1, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

March 4, 1993 - 8:30 a.m. – Open Meeting
March 5, 1993 - 8:30 a.m. – Open Meeting
Department of Health Professions, 6606 West Broad Street, Conference Room 4, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A meeting to conduct informal conference with licensees to determine what, if any, action should be recommended to the Board of Nursing. Public comment will not be received.

Contact: M. Teresa Mullin, R.N., Assistant Executive Director, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9909 or (804) 662-7197/TDD ☎

POLYGRAPH EXAMINERS ADVISORY BOARD

March 23, 1993 - 10 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting to administer the Polygraph Examiners Licensing Examination to eligible polygraph examiner interns and to consider other matters which may require board action.

Contact: Geralde W. Morgan, Board Administrator, Department of Commerce, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8534.

BOARD OF PSYCHOLOGY

† **March 23, 1993 - 8:30 a.m.** – Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Room #4, Richmond, Virginia. ♿

An informal fact finding conference to review application for licensure of Cheryl R. Hussey, Ed.D.

† **March 23, 1993 - 10:30 a.m.** – Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Room #2, Richmond, Virginia. ♿

A meeting to conduct general board business, and review regulations to consider fee adjustments.

Contact: Evelyn B. Brown, Executive Director, or Jane Ballard, Administrative Assistant, Department of Health Professions, 6606 W. Broad St., Richmond, VA 23230-1717, telephone (804) 662-9913.

REAL ESTATE BOARD

† **March 11, 1993 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A meeting to conduct board business including review of applications for licensure, disciplinary cases, correspondence, etc.

Contact: Joan L. White, Assistant Director, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8552.

REAL ESTATE APPRAISER BOARD

March 16, 1993 - 10 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

A general business meeting.

Contact: Demetra Y. Kontos, Assistant Director, Department of Commerce, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-0500.

Complaints Committee

† **March 10, 1993 - 10 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

A meeting to review complaints.

Contact: Demetra Y. Kontos, Assistant Director, Department of Commerce, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-0500.

SEWAGE HANDLING AND DISPOSAL APPEALS REVIEW BOARD

† **March 10, 1993 - 10 a.m.** – Open Meeting
Ramada Inn, 1130 Motel Drive, Allegheny Room, Woodstock, Virginia. ♿

A meeting to hear all administrative appeals of denials of onsite sewage disposal system permits pursuant to §§ 32.1-166.1 et seq. and 9-6.14:12 of the Code of Virginia, and VR 355-34-02.

Contact: Constance G. Talbert, Secretary to the Board, 1500 E. Main St., Suite 117, P.O. Box 2448, Richmond, VA 23218, telephone (804) 786-1750.

DEPARTMENT OF SOCIAL SERVICES (STATE BOARD OF)

March 1, 1993 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Social Services intends to adopt regulations entitled **VR 615-01-43. Aid to Families with Dependent Children (AFDC) Program - Fifth Degree Specified Relative.** The purpose of the proposed regulation is to revise the AFDC policy to expand the definition of specified relative to include caretakers who are of fifth degree kinship to the dependent child.

Statutory Authority: §§ 63.1-25 and 63.1-110 of the Code of Virginia.

Written comments may be submitted through March 1, 1993, to Guy Lusk, Director, Division of Benefit Programs, 8007 Discovery Drive, Richmond, Virginia 23229-8699.

Contact: Peggy Friedenberg, Legislative Analyst, 8007 Discovery Dr., Richmond, VA 23229-8699, telephone (804) 662-9217.

DEPARTMENT OF TAXATION

† **March 1, 1993 - 10 a.m.** – Public Hearing
General Assembly Building, 910 Capitol Square, House Room C, Richmond, Virginia.

† **April 23, 1993** – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Taxation intends to amend regulations entitled: **VR 630-3-414. Corporation Income Tax: Sales Factor.** This regulation sets forth the proper method for including receipts from installment sales in the sales factor. The basis portion is included in the sales factor in the

year of sale. The net gain portion and interest income are included in the sales factor in the year recognized for federal income tax purposes. The regulation also clarifies when such receipts should be included in the numerator of the sales factor.

STATEMENT

Substance: The amendment sets forth the proper method for including receipts from installment sales in the sales factor. The regulation also clarifies when such receipts should be included in the numerator of the sales factor.

Issues: The major issue under consideration involves the treatment of receipts in years subsequent to the year of sale and whether they should be included in the numerator based on the situs of property when sold or based on the income producing activity in the year of receipt.

Basis: The regulation is issued under the authority granted by § 58.1-203 of the Code of Virginia.

Purpose: This regulation is being adopted to provide guidance concerning when installment sales proceeds should be included in the numerator and denominator of the sales factor and reflects established policy.

Estimated impact: This regulation will affect multistate corporations reporting sales under the installment method and which are required to apportion income between Virginia and other states.

Statutory Authority: § 58.1-203 of the Code of Virginia.

Contact: Michael S. Melson, Tax Policy Analyst, Department of Taxation, P.O. Box 1880, Richmond, VA 23282-1880, telephone (804) 367-0033.

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† **March 1, 1993 - 10 a.m.** – Public Hearing
General Assembly Building, 910 Capitol Square, House Room C, Richmond, Virginia.

† **April 23, 1993** – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Taxation intends to amend regulations entitled: **VR 630-3-419. Corporation Income Tax: Construction Corporation; Apportionment.** This regulation clarifies that the "completed contract method" mentioned in § 58.1-419 of the Code of Virginia does not include any of the "percentage of completion" methods available under federal law. In addition, the regulation clarifies which apportionment formula should be used when a construction corporation reports income under two or more accounting methods. Other nonsubstantive changes are made to conform to the style of The Virginia Register.

STATEMENT

Substance: This regulation clarifies the scope of the definition of "completed contract method" under § 58.1-419 of the Code of Virginia and clarifies the proper apportionment formula when a corporation's income is reported under two or more accounting methods.

Issues: The major issue under consideration involves the proper apportionment formula to be used when a corporation's income is reported under two or more accounting methods and no one method is used to report a majority of the taxpayer's business.

Basis: The regulation is issued under the authority granted by § 58.1-203 of the Code of Virginia.

Purpose: This regulation is being adopted to provide clarification for apportioning income of Virginia corporation income tax purposes in light of the multitude of changes under federal law relating to the accounting methods available to construction corporations to report income.

Estimated impact: This regulation will affect multistate corporations reporting income under the completed contract method of accounting and other percentage of completion methods and which are required to apportion income between Virginia and other states.

Statutory Authority: § 58.1-203 of the Code of Virginia.

Contact: Michael S. Melson, Tax Policy Analyst, Department of Taxation, P.O. Box 1880, Richmond, VA 23282-1880, telephone (804) 367-0033.

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† **March 1, 1993 - 10 a.m.** – Public Hearing
General Assembly Building, 910 Capitol Square, House Room C, Richmond, Virginia.

† **April 23, 1993** – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Taxation intends to amend regulations entitled: **VR 630-10-73. Retail Sales and Use Tax: Newspapers, Magazines, Periodicals and Other Publications.** The purpose of the proposed amendment is to clarify what constitutes taxable/exempt publications for purposes of the retail sales and use tax.

STATEMENT

Basis: The regulation is issued under the authority granted by § 58.1-203 of the Code of Virginia. The department periodically reviews and revises regulations to reflect

current policy and practice. Since this regulation has not been revised since January 1985 and was not reflective of current policy, it is being revised.

Purpose: This regulation clarifies what constitutes a taxable/exempt publication for purposes of the retail sales and use tax in order to provide guidance to the private sector as well as department personnel.

Substance: The regulation clarifies that publications devoted primarily to matters of specialized interest, such as legal, mercantile, political, religious or sporting matters, as well as those which are issued under a subscription basis, are exempt. Taxable publications include shopping guides, real estate guides and other publications of which the advertising portion, including product publicity, exceeds 90% of the printed area of the entire issue; crossword puzzle magazines; and newsletters and other printed materials available to a limited audience only and not to the general public. Back issues of any type of publication are taxable.

Issues: Regulatory provisions should be revised periodically to reflect current policy with respect to issues. This regulation clarifies the department's current policy with respect to publications.

Impact: This proposed regulation should have minimal impact as it merely reflects current department policy.

Statutory Authority: § 58.1-203 of the Code of Virginia.

Contact: Terry M. Barrett, Policy Analyst, Department of Taxation, P.O. Box 1880, Richmond, VA 23282-1880, telephone (804) 367-0010.

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† **March 1, 1993 - 10 a.m.** – Public Hearing
General Assembly Building, 910 Capitol Square, House Room C, Richmond, Virginia.

† **April 23, 1993** – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Taxation intends to amend regulations entitled: **VR 630-10-74. Retail Sales and Use Tax: Nonprofit Organizations.** The purpose of the proposed amendment is to clarify the sales and use tax treatment of sales and purchase transactions made by nonprofit organizations.

STATEMENT

Basis: The regulation is issued under the authority granted by § 58.1-203 of the Code of Virginia. The department periodically reviews and revises regulations to reflect current policy and practice. Since this regulation has not been revised since January 1985 and was not reflective of current policy, it is being revised.

Purpose: This proposed regulation clarifies the sales and use tax treatment of sales and purchase transactions made by nonprofit organizations.

Substance: This proposed regulation removes the list of exemptions shown in § 58.1-608 of the Code of Virginia and addresses the treatment of sales and purchase transactions made by nonprofit organizations. Specifically, this proposed regulation includes information on criteria for the exemption, strict construction, exempt transactions, purchases for resale, intercompany sales and transfer, occasional sale transactions.

Issues: Regulatory provisions should be revised periodically to reflect current policy with respect to issues. This proposed regulation clarifies the department's current policy with respect to nonprofit organizations.

Impact: This proposed regulation should have minimal impact as it merely reflects current department policy.

Statutory Authority: § 58.1-203 of the Code of Virginia.

Contact: Lonnie T. Lewis, Jr., Tax Policy Analyst, Department of Taxation, P.O. Box 1880, Richmond, VA 23282-1880, telephone (804) 367-0962.

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† **March 1, 1993 - 10 a.m.** – Public Hearing
General Assembly Building, 910 Capitol Square, House Room C, Richmond, Virginia.

† **April 23, 1993** – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Taxation intends to amend regulations entitled: **VR 630-10-80. Retail Sales and Use Tax: Penalties and Interest.** The purpose of the proposed amendment is to reflect recent law changes in the area of civil and criminal penalties in light of Virginia's 1990 Tax Amnesty Program and clarify the application of penalty to audit assessments.

STATEMENT

Basis: The regulation is issued under the authority granted by § 58.1-203 of the Code of Virginia. The 1991 General Assembly enacted legislation (1991 Acts of Assembly, Chapters 316 and 333) requiring the department to increase civil penalties and the interest rate regarding delinquent taxes. The 1992 General Assembly enacted legislation (1992 Acts of Assembly, Chapter 763) establishing certain criminal penalties.

Purpose: The regulation sets forth the increase in penalty and interest rates regarding delinquent tax payments while

also explaining criminal penalties under existing law. Additionally, the regulation explains the application of penalty to audit assessments.

Issues: Regulatory provisions are required in order to carry out the intent of the General Assembly in providing more stringent requirements regarding delinquent taxpayers. These increases are consistent with the spirit of Virginia's 1990 Tax Amnesty Program.

Substance: Civil penalties - late filing and payment penalties for the individual, fiduciary, and corporation income taxes, income tax withholding, soft drink excise tax, all sales and use taxes administered by the department (retail, aircraft, watercraft, and northern Virginia motor vehicle fuel taxes), and the tire tax were increased from 5% per month up to a maximum of 25% to 6% per month up to a maximum of 30%.

Generally, Virginia conforms to the quarterly interest rates set by the Internal Revenue Service for tax underpayment and overpayment. As the result of the law change, which retained conformity to the federal interest rates, the interest rate is now the federal rate plus 2% in relation to delinquent taxes.

Criminal penalties - any dealer who engages in the following shall be guilty of a Class 1 misdemeanor:

1. Fails to collect the tax;

2. Fails to keep proper records;

3. Fails to file returns or files a fraudulent return; and

4. Gives or receives a fraudulent exemption certificate.

Any dealer who conducts business without the proper certificate of registration shall be guilty of a Class 2 misdemeanor.

Any dealer engaged in business who converts trust taxes to some use other than remittance to the department shall be guilty of a Class 6 felony.

Audits - compliance ratios for second audits have been increased from 75% to 85% for sales tax and from 50% to 60% for use tax. Compliance ratios for subsequent audits have increased from 75% for sales tax and 75% for use tax to 85% for both taxes.

The increase in civil penalties became effective July 1, 1991, and the criminal penalty involving Class 6 felony became effective July 1, 1992.

Impact: This regulation will affect all dealers in the Commonwealth. If the dealer properly complies with the tax laws, policies and procedures required by the department, then no cost will be incurred by the regulated dealers. However, should a dealer fail to comply, the cost to the dealer could be substantial. It is unknown how much revenue this regulation may generate.

Statutory Authority: § 58.1-203 of the Code of Virginia.

Contact: Valerie H. Marks, Tax Policy Analyst, Department of Taxation, P.O. Box 1880, Richmond, VA 23282-1880, telephone (804) 367-0964.

COMMONWEALTH TRANSPORTATION BOARD

† **March 17, 1993 - 2 p.m.** – Open Meeting
Department of Transportation, 1401 East Broad Street, Board Room, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A work session of the Commonwealth Transportation Board and the Department of Transportation staff.

† **March 18, 1993 - 10 a.m.** – Open Meeting
Department of Transportation, 1401 East Broad Street, Board Room, Richmond, Virginia. ♿ (Interpreter for the 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, 1401 E. Broad St., Richmond, VA 23219, telephone (804) 786-6670

TREASURY BOARD

March 17, 1993 - 9 a.m. – Open Meeting
† **April 21, 1993 - 9 a.m.** – Open Meeting
James Monroe Building, 101 North 14th Street, Treasury Board Room, 3rd Floor, Richmond, Virginia. ♿

A regular meeting of the board.

Contact: Linda F. Bunce, Administrative Assistant to the Treasurer, Department of the Treasury, 101 N. 14th St., 3rd Floor, Richmond, VA 23219, telephone (804) 225-2142.

VIRGINIA RESOURCES AUTHORITY

March 9, 1993 - 9:30 a.m. – Open Meeting
The Mutual Building, 909 East Main Street, Suite 607, Board Room, Richmond, Virginia.

The board will meet to approve minutes of its prior meeting; to review the authority's operations for the prior months; and to 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: Shockley D. Gardner, Jr., Virginia Resources Authority, The Mutual Bldg., 909 E. Main St., Suite 707, Richmond, VA 23219, telephone (804) 644-3100 or FAX (804) 644-3109.

VIRGINIA VOLUNTARY FORMULARY BOARD

March 12, 1993 - 10 a.m. – Public Hearing
James Madison Building, 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 1, 1992, 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 12, 1993, will be made a part of the hearing record.

† **April 22, 1993 - 10:30 a.m.** – Open Meeting
Washington Building, 1100 Bank Street, 2nd Floor Board Room, Richmond, Virginia.

A meeting to consider 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 St., Room B1-9, Richmond, VA 23219, telephone (804) 786-4326.

DEPARTMENT OF WASTE MANAGEMENT (VIRGINIA WASTE MANAGEMENT BOARD)

March 10, 1993 - 2 p.m. – Public Hearing
James Monroe Building, 101 North 14th Street, Conference Room C, Richmond, Virginia.

Pursuant to the requirements of Part VII, Virginia Solid Waste Management Regulations (SWMR), Permitting of Solid Waste Management Facilities, the Department of Waste Management will hold a public hearing on the draft permit for a solid waste industrial landfill located at 3220 Deepwater Terminal Road, in the southeastern section of the corporate limits of the City of Richmond, Virginia. The permit was drafted by the Department of Waste Management for Peck Iron and Metal Company, Inc., in accordance with Part VII of the SWMR. The purpose of the public hearing will be to solicit comments regarding the technical merits of the permit issues. The public comment period will extend until March 22, 1993. Copies of the proposed draft permit may be obtained from Rebecca Clark, Department of Waste Management. Comments concerning the draft permit must be in writing and directed to Aziz Farahmand, Department of Waste Management, Monroe Building, 101 North 14th Street, 11th Floor, Richmond, Virginia 23219.

† **March 15, 1993 - 9 a.m.** – Open Meeting
Smithfield Town Hall, 310 Institute Street, Council Chambers, Smithfield, Virginia.

A general business meeting of the board. Staff will seek approval of the proposed Infectious Waste Regulations for public comment. Staff will seek approval to hold public meetings and public hearings on the proposed Amendment 12 to the Hazardous Waste Regulations. Staff will discuss the Coal Ash Regulations. The Virginia Waste Management Board will tour the Surry Power Station, Route 650 (off Route 10), Surry, Virginia, at 1 p.m.

† **March 16, 1993 - 9 a.m.** – Open Meeting
Airfield Conference Center, Southeast 4-H Educationa. Center, Inc., 15189 Airfield Road, Wakefield, Virginia.

The Virginia Waste Management Board will hold a workshop. This is a working session only. No formal action will be taken. The public is welcome to attend.

Contact: Loraine Williams, Executive Secretary, Monroe Bldg. 101 N. 14th St., 11th Floor, Richmond, VA 23219, telephone (804) 225-2998 or (804) 371-8737/TDD ☎

† **March 24, 1993 - 7 p.m.** – Public Hearing
Central High School, Route 14 at King and Queen Courthouse, King and Queen County, Virginia.

Pursuant to the requirements of Part VII of the Virginia Solid Waste Management Regulations (Permitting of Solid Waste Management Facilities), the draft Solid Waste Disposal Facility Permit for the development of a sanitary landfill in King and Queen County, Virginia, proposed by Browning-Ferris Industries, is available for public review and comment. The permit allows the proposed facility to accept only authorized, nonhazardous wastes as listed in the draft permit. The proposal incorporates design elements for a single composite liner system and a high density polyethylene leachate collection pipe system, which are not provided for in the regulations. Browning-Ferris Industries petitioned for these features pursuant to the requirements of Part IX of th

regulations (Rulemaking Petitions and Procedures), and the Department of Waste Management has granted tentative approval.

Contact: Dean E. Starook, Environmental Engineer Senior, Monroe Bldg., 101 N. 14th St., 11th Floor, Richmond, VA 23219, telephone (804) 371-0517.

† **March 26, 1993 - 2 p.m.** – Public Hearing
County Administration Building, 4301 East Parham Road, Henrico County Supervisors Board Room, Richmond, Virginia.

Pursuant to the requirements of the Virginia Solid Waste Management Regulations (Permitting of Solid Waste Management Facilities), the draft Solid Waste Disposal Facility Permit for the development of a sanitary landfill and resource management facility proposed by Browning-Ferris Industries of South Atlantic, Inc., is available for public review and comment. The permit allows the proposed facility to accept only authorized, nonhazardous solid waste, and will be open to all municipal, government, commercial, and industrial customers in accordance with the conditions of Henrico County Use Permit 41-90.

Contact: Donald H. Brunson, III, Environmental Engineer Senior, Monroe Bldg., 101 N. 14th St., 11th Floor, Richmond, VA 23219, telephone (804) 371-0515.

STATE WATER CONTROL BOARD

February 22, 1993 - 7 p.m. – Public Hearing
Route 208 at Spotsylvania Courthouse, County Administration Building, Spotsylvania County Board of Supervisors Room, Spotsylvania, Virginia.

February 23, 1993 - 7 p.m. – Public Hearing
101C Mounts Bay Road, Building C, James City County Board of Supervisors Room, Williamsburg, Virginia.

February 24, 1993 - 7 p.m. – Public Hearing
Eastern Shore Community College, Route 13, Lecture Hall, Melfa, Virginia.

March 15, 1993 – Written comments may be submitted through 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 repeal regulations entitled **VR 680-13-01. Rules of the Board and Standards for Water Wells.** The purpose of the proposed action is to repeal the Rules of the Board and Standards for Water Wells concurrently with the adoption of new regulations implementing the Ground Water Act of 1992.

An informal question and answer period has been scheduled before each hearing. At that time staff will answer questions from the public on the proposal. The question and answer period will begin 1/2 hour before the scheduled public hearing. The hearings are being held at public facilities believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facilities should contact Ms. Jackson at the address below or by telephone at (804) 527-5163 or (804) 527-4261/TDD. Persons needing interpreter services for the deaf must notify Ms. Jackson no later than Monday, January 25, 1993. The board seeks comments on the proposal and the costs and benefits of the proposal. In addition, the agency has performed certain analyses on the proposed amendments related to the purpose, need, impacts and alternatives which are available to the public upon request.

Statutory Authority: § 62.1-44.92 (Repealed) of the Code of Virginia.

Contact: Terry Wagner, State Water Control Board, P.O. Box 11143, Richmond, VA 23230, telephone (804) 527-5203.

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February 23, 1993 - 2 p.m. – Public Hearing
McCourt Building, 4850 Davis Ford Road, 1 County Complex, Prince William County Board Room, Prince William, Virginia.

March 15, 1993 – Written comments may be submitted through 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 consider amending regulations entitled **VR 680-13-03. Petroleum Underground Storage Tank Financial Responsibility Requirements.** The purpose of the proposed amendment is to incorporate the new sliding scale for financial responsibility established by the 1992 General Assembly, establish a simplified test for self-insurance and revised compliance dates, and delete requirements for the Fund.

An informal question and answer period has been scheduled before each hearing. At that time staff will answer questions from the public on the proposal. The question and answer period will begin 1/2 hour before the scheduled public hearing. The hearings are being held at public facilities believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facilities should contact Ms. Doneva Dalton at the address below or by telephone at (804) 527-5162 or (804) 527-4261/TDD. Persons needing interpreter services for the deaf must notify Ms. Dalton no later than Monday, January 25, 1993. The board seeks comments on the proposal and the costs and benefits of the proposal. In addition, the agency has performed certain analyses on the

proposed amendments related to the purpose, need, impacts and alternatives which are available to the public upon request.

Written comments may be submitted through March 15, 1993, to Doneva Dalton, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Statutory Authority: §§ 62.1-44.34:10, 62.1-44.34:11, 62.1-44.34:12, and 62.1-44.15 (10) of the Code of Virginia.

Contact: Mary-Ellen Kendall, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5195.

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February 23, 1993 - 2 p.m. – Public Hearing
McCourt Building, 4850 Davis Ford Road, 1 County Complex, Prince William County Board Room, Prince William, Virginia.

March 15, 1993 – Written comments may be submitted through 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 680-13-06. Virginia Petroleum Storage Tank Fund.** The purpose of the proposed regulation is to describe the requirements for the Virginia Petroleum Storage Tank Fund.

An informal question and answer period has been scheduled before each hearing. At that time staff will answer questions from the public on the proposal. The question and answer period will begin 1/2 hour before the scheduled public hearing. The hearings are being held at public facilities believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facilities should contact Ms. Doneva Dalton at the address below or by telephone at (804) 527-5162 or (804) 527-4261/TDD. Persons needing interpreter services for the deaf must notify Ms. Dalton no later than Monday, January 25, 1993. The board seeks comments on the proposal, the issues including specifically the appropriateness of July 1, 1992, or December 22, 1989, being the effective date for access to the Fund for UST releases, and the costs and benefits of the proposal. In addition, the agency has performed certain analyses on the proposed amendments related to the purpose, need, impacts and alternatives which are available to the public upon request.

Written comments may be submitted through March 15, 1993, to Doneva Dalton, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Statutory Authority: §§ 62.1-44.34:10, 62.1-44.34:11, 62.1-44.34:12, and 62.1-44.15(10 of the Code of Virginia.

Contact: Mary-Ellen Kendall, State Water Control Board, P.O. Box 11143, Richmond, VA 23230, telephone (804) 527-5195.

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February 22, 1993 - 7 p.m. – Public Hearing
Route 208 at Spotsylvania Courthouse, County Administration Building, Spotsylvania County Board of Supervisors Room, Spotsylvania, Virginia.

February 23, 1993 - 7 p.m. – Public Hearing
101C Mounts Bay Road, Building C, James City County Board of Supervisors Room, Williamsburg, Virginia.

February 24, 1993 - 7 p.m. – Public Hearing
Eastern Shore Community College, Route 13, Lecture Hall, Melfa, Virginia.

March 15, 1993 – Written comments may be submitted through 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 680-13-07. Ground Water Withdrawal Regulations.** The purpose of the proposed regulation is to establish procedures for the declaration of ground water management areas and the subsequent issuance of ground water withdrawal permits and special exceptions within those areas.

An informal question and answer period has been scheduled before each hearing. At that time staff will answer questions from the public on the proposal. The question and answer period will begin 1/2 hour before the scheduled public hearing. The hearings are being held at public facilities believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facilities should contact Ms. Jackson at the address below or by telephone at (804) 527-5163 or (804) 527-4261/TDD. Persons needing interpreter services for the deaf must notify Ms. Jackson no later than Monday, January 25, 1993. The board seeks comments on the proposal and the costs and benefits of the proposal. In addition, the agency has performed certain analyses on the proposed amendments related to the purpose, need, impacts and alternatives which are available to the public upon request.

Written comments may be submitted through March 15, 1993, to Lori Jackson, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Statutory Authority: § 62.1-256 of the Code of Virginia.

Contact: Terry Wagner, State Water Control Board, P.O. Box 11143, Richmond, VA 23230, telephone (804) 527-5203.

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February 23, 1993 - 7 p.m. – Public Hearing
McCourt Building, 4850 Davis Ford Road, 1 County Complex, Prince William County Board Room, Prince William, Virginia.

March 15, 1993 – Written comments may be submitted through 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 680-14-12. Facility and Aboveground Storage Tank Registration Requirements.** The purpose of the proposed regulation is to compile an inventory of facilities and aboveground storage tanks within the Commonwealth.

An informal question and answer period has been scheduled before each hearing. At that time staff will answer questions from the public on the proposal. The question and answer period will begin 1/2 hour before the scheduled public hearing. The hearings are being held at public facilities believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facilities should contact Ms. Dalton at the address below or by telephone at (804) 527-5162 or (804) 527-4261/TDD. Persons needing interpreter services for the deaf must notify Ms. Dalton no later than Monday, January 25, 1993. The board seeks comments on the proposal, the issues and the costs and benefits of the proposal. In addition, the agency has performed certain analyses on the proposed amendments related to the purpose, need, impacts and alternatives which are available to the public upon request.

Written comments may be submitted through March 15, 1993, to Doneva Dalton, State Water Control Board, P.O. Box 11143, Richmond, Virginia.

Statutory Authority: §§ 62.1-44.34:19 and 62.1-44.15 (10) of the Code of Virginia.

Contact: David Ormes, State Water Control Board, P.O. Box 11143, Richmond, VA 23230, telephone (804) 527-5197.

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February 23, 1993 - 7 p.m. – Public Hearing
McCourt Building, 4850 Davis Ford Road, 1 County Complex, Prince William County Board Room, Prince William, Virginia.

March 15, 1993 – Written comments may be submitted through 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 680-14-13. Aboveground Storage Tanks Pollution Prevention Requirements.** The purpose of the proposed regulation is to establish standards and procedures to be followed by facility operators to prevent the discharge of oil to state waters, lands and storm drain systems from new and existing aboveground storage tanks.

An informal question and answer period has been scheduled before each hearing. At that time staff will answer questions from the public on the proposal. The question and answer period will begin 1/2 hour before the scheduled public hearing. The hearings are being held at public facilities believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facilities should contact Ms. Dalton at the address below or by telephone at (804) 527-5162 or (804) 527-4261/TDD. Persons needing interpreter services for the deaf must notify Ms. Dalton no later than Monday, January 25, 1993. The board seeks comments on the proposal, the issues and the costs and benefits of the proposal. In addition, the agency has performed certain analyses on the proposed amendments related to the purpose, need, impacts and alternatives which are available to the public upon request.

Written comments may be submitted through March 15, 1993, to Doneva Dalton, State Water Control Board, P.O. Box 11143, Richmond, Virginia.

Statutory Authority: §§ 62.1-44.34:15.1 and 62.1-44.15 (10) of the Code of Virginia.

Contact: David Ormes, State Water Control Board, P.O. Box 11143, Richmond, VA 23230, telephone (804) 527-5197.

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February 23, 1993 - 7 p.m. – Public Hearing
McCourt Building, 4850 Davis Ford Road, 1 County Complex, Prince William County Board Room, Prince William, Virginia.

March 15, 1993 – Written comments may be submitted through 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 680-14-14. Facility Financial Responsibility Requirements.** The purpose of the proposed regulation is to establish requirements for financial responsibility on the part of operators of facilities having a maximum aboveground storage capacity of 25,000 gallons of oil or having an average daily throughput of 25,000 gallons or more of oil.

An informal question and answer period has been scheduled before each hearing. At that time staff will answer questions from the public on the proposal. The question and answer period will begin 1/2 hour before the scheduled public hearing. The hearings are being

held at public facilities believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facilities should contact Ms. Dalton at the address below or by telephone at (804) 527-5162 or (804) 527-4261/TDD. Persons needing interpreter services for the deaf must notify Ms. Dalton no later than Monday, January 25, 1993. The board seeks comments on the proposal, the issues and the costs and benefits of the proposal. In addition, the agency has performed certain analyses on the proposed amendments related to the purpose, need, impacts and alternatives which are available to the public upon request.

Written comments may be submitted through March 15, 1993, to Doneva Dalton, State Water Control Board, P.O. Box 11143, Richmond, Virginia.

Statutory Authority: §§ 62.1-44.34:16 and 62.1-44:21 and 62.1-44.15 (10) of the Code of Virginia.

Contact: David Ormes, State Water Control Board, P.O. Box 11143, Richmond, VA 23230, telephone (804) 527-5197.

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March 12, 1993 – Written comments may be submitted through 4 p.m. on 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 680-16-03. Upper James River Basin Water Quality Management Plan.** The purpose of the proposed amendment is to increase the waste load allocation for the Town of Crewe's sewage treatment plant discharge to an unnamed tributary of Deep Creek.

An informal question and answer period has been scheduled before the hearing. At that time staff will answer questions from the public on the proposal. The question and answer period will begin 1/2 hour before the scheduled public hearing. The hearing is being held at a public facility believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facility should contact Ms. Dalton at the address below or by telephone at (804) 527-5162 or (804) 527-4261/TDD. Persons needing interpreter services for the deaf must notify Ms. Dalton no later than Monday, January 25, 1993. The board seeks comments on the proposal, the issues and the costs and benefits of the proposal. In addition, the agency has performed certain analyses on the proposed amendments related to the purpose, need, impacts and alternatives which are available to the public upon request.

Statutory Authority: § 62.1-44.15 (10) of the Code of Virginia.

Written comments may be submitted until 4 p.m. on March 12, 1993, to Doneva Dalton, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Curt Linderman, Piedmont Regional Office, State Water Control Board, P.O. Box 11143, Richmond, VA 23230, telephone (804) 527-5038.

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March 15, 1993 – Written comments may be submitted until 4 p.m. on 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 proposed amendment is to update, clarify and correct sections VR 680-21-07.2 (Special Designations in Surface Waters, (VR 680-21-07.3 (Nutrient Enriched Waters) and VR 680-21-08 (River Basin Sections Tables).

Statutory Authority: § 62.1-44.15 (3a) of the Code of Virginia.

Written comments may be submitted until 4 p.m. on March 15, 1993, to Lori Jackson, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Elleanore Daub, State Water Control Board, P.O. Box 11143, Richmond, VA 23230, telephone (804) 527-5091.

February 25, 1993 - 6:30 p.m. – Public Hearing
Culpeper County Middle School, 500 Achievement Drive, Culpeper, Virginia. ♿ (Interpreter for the deaf provided upon request)

The State Water Control Board will hold a public hearing to receive comments on the proposed Virginia Pollutant Discharge Elimination System (VPDES) Permit No. VA0087718 for the Department of Correction's Medium Security Dormitory IV. The purpose of the hearing is to receive comments on the proposed permit, the issuance or denial of the permit and the effect of the discharge on water quality or beneficial uses of state waters.

Contact: Lori F. Jackson, Hearings Reporter, Office of Policy Analysis, State Water Control Board, 4900 Cox Rd., Glen Allen, VA 23060, telephone (804) 527-5163.

† **March 18, 1993 - 6:30 p.m.** – Public Hearing
Nelson County Board of Supervisors Room, Court Street, Lovingston, Virginia. ♿ (Interpreter for the deaf provided upon request)

A public hearing to receive comments on the proposed Virginia Pollutant Discharge Elimination System (VPDES) Permit No. VA0087505 for Henderson's Store Sewage Treatment Plan, P.O. Box 336, Lovingston, Virginia 22949. The purpose of this hearing is to

receive comments on the proposed issuance or denial of the permit and the effect of the proposed discharge on water quality or beneficial uses of state waters.

Contact: Lori F. Jackson, Hearings Reporter, Office of Policy Analysis, State Water Control Board, 4900 Cox Rd., Glen Allen, VA 23060, telephone (804) 527-5163.

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

DEPARTMENT OF YOUTH AND FAMILY SERVICES (BOARD OF)

March 11, 1993 - 8:30 a.m. – Open Meeting
April 8, 1993 - 8:30 a.m. – Open Meeting
700 Centre Building, 7th and Franklin Streets, 4th Floor, Richmond, Virginia. ♿

Committee meetings begin at 8:30 to be followed by a general meeting at 10 a.m. to (i) review programs recommended for certification or probation; (ii) consider adoption of draft policies; and (iii) take up other matters that may come before the board.

Contact: Donald R. Carignan, Policy Coordinator, P.O. Box 1110, Richmond, VA 23208-1110, telephone (804) 371-0692.

State Management Team of the Comprehensive Services Act for At-Risk Youth and Families

February 25, 1993 - 9 a.m. – Open Meeting
March 25, 1993 - 9 a.m. – Open Meeting
Koger Center, 8007 Discovery Drive, Blair Building, Conference Room C, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)
March 11, 1993 - 9 a.m. – Open Meeting
Koger Center, 8007 Discovery Drive, Blair Building, Conference Room A, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A general business meeting to effect the Comprehensive Services Act for At-Risk Youth and Families. Please confirm meeting details before planning to attend.

Contact: Dian McConnel, Coordinator, Council on Community Services for Youth and Families, Department of Youth and Family Services, 700 Centre, 700 E. Franklin St., Richmond, VA 23219, telephone (804) 786-5394 or (804) 371-0772/TDD ☎

LEGISLATIVE

COMMISSION ON POPULATION GROWTH AND DEVELOPMENT

† **March 17, 1993 - 10 a.m.** – Open Meeting
Roslyn Conference Center, 8727 River Road, Richmond, Virginia.

A meeting to discuss Draft #4 of the Virginia Growth Strategies Act.

Contact: Katherine L. Imhoff, Executive Director, General Assembly Bldg., 910 Capitol Street, Room 519B, Richmond, VA 23219, telephone (804) 371-4949.

CHRONOLOGICAL LIST

OPEN MEETINGS

February 22
Cosmetology, Board for
Lottery Department, State
Nursing, Board of
- Special Conference Committee

February 23
Accountancy, Board for
Architects, Professional Engineers, Land Surveyors and Landscape Architects, Board for
- Board for Professional Engineers
Health Services Cost Review Council, Virginia
† Marine Resources Commission

February 24
† Chesapeake Bay Local Assistance Board
- Central Area Review Committee
- Southern Area Review Committee
Medicine, Board of
- Informal Conference Committee
Mental Health, Mental Retardation and Substance Abuse Services Board, State

February 25
Chesapeake Bay Local Assistance Board
Education, Board of
† Mines, Minerals and Energy, Department of
Youth and Family Services, Department of
-State Management Team of the Comprehensive Services Act for At-Risk Youth and Families

February 26
Child Day-Care Council
† Dentistry, Board of
Medicine, Board of
- Informal Conference Committee

February 27
Mary Washington College
- Board of Visitors

March 1
Agriculture and Consumer Services, Department of
- Virginia Small Grains Board
Labor and Industry, Department of
- Apprenticeship Council
Local Government, Commission on

March 2
† Child Day Care and Early Childhood Programs, Council on
Hopewell Industrial Safety Council
Labor and Industry, Department of
- Apprenticeship Council
Local Government, Commission on
† Medicine, Board of

March 3
Compensation Board
Labor and Industry, Department of
- Apprenticeship Council
† - Migrant and Seasonal Farmworkers Board

March 4
Agriculture and Consumer Services, Department of
- Virginia Soybean Board
† Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
Labor and Industry, Department of
- Apprenticeship Council
Local Emergency Planning Committee - Chesterfield County
† Mapping, Surveying and Land Information Systems, Advisory Committee on
Middle Virginia Board of Directors and the Middle Virginia Community Corrections Resources Board
Nursing, Board of
- Special Conference Committee

March 5
Agriculture and Consumer Services, Department of
† - Virginia Bright Flue-cured Tobacco Board
- Virginia Soybean Board
† Medicine, Board of
Nursing, Board of
- Special Conference Committee

March 8
† ASAP Policy Board - Valley
† Defense Conversion and Economic Adjustment Statewide Conference, Governor's Commission on

March 9
† Auctioneers Board, Virginia
† Defense Conversion and Economic Adjustment Statewide Conference, Governor's Commission on
† Higher Education for Virginia, State Council of
Local Emergency Planning Commission - County of Montgomery/Town of Blacksburg
Virginia Resources Authority

March 10
† Agriculture and Consumer Services, Department of
-Virginia Sweet Potato Board
† Historic Preservation Foundation, Virginia
Local Emergency Planning Committee - Portsmouth
† Real Estate Appraiser Board
-Complaints Committee
† Sewage Handling and Disposal Appeals Review Board

March 11
† Real Estate Board
Youth and Family Services, Board of
Youth and Family Services, Department of
- State Management Team of the Comprehensive Services Act for At-Risk Youth and Families

March 12
Aging, Department for the
- Long-Term Care Council
† Fire Services Board, Virginia
Medicine, Board of
- Advisory Board on Physical Therapy

March 13
† Fire Services Board, Virginia

March 14
† Fire Services Board, Virginia

March 15
† Accountancy, Board for
Library Board
† Waste Management Board, Virginia

March 16
Real Estate Appraiser Board
† Waste Management Board, Virginia

March 17
† Contractors, Board for
- Complaints Committee
Local Debt, State Council on
† Population Growth and Development, Commission on
† Transportation Board, Commonwealth
Treasury Board

March 18
† Contractors, Board for
- Recovery Fund Committee
† Transportation Board, Commonwealth

March 19
Interdepartmental Regulation of Residential Facilities for Children
- Coordinating Committee

March 23

† Health Services Cost Review Council, Virginia
Polygraph Examiners Advisory Board
† Psychology, Board of

March 24
Medicine, Board of
-Advisory Board of Occupational Therapists
† Mental Health, Mental Retardation and Substance Abuse Services Board, State
† Mental Health, Mental Retardation and Substance Abuse Services, Department of
- State Human Rights Committee

March 25
Aging, Department for the
- Long-Term Care Ombudsman Program Advisory Council
Education, Board of
† Labor and Industry, Department of
- Apprenticeship Council
Youth and Family Services, Department of
- State Management Team of the Comprehensive Services Act for At-Risk Youth and Families

March 26
Medicine, Board of
- Advisory Board on Respiratory Therapy

March 29
Cosmetology, Board for

March 31
Compensation Board

April 1
Local Emergency Planning Committee - Chesterfield County

April 6
Hopewell Industrial Safety Council

April 8
Youth and Family Services, Board of

April 9
Medicine, Board of
- Advisory Committee on Certification for Optometrists

April 13
† Higher Education for Virginia, State Council of

April 14
† Mount Rogers Alcohol Safety Action Program

April 17
† Mary Washington College
- Board of Visitors

April 21
† Local Debt, State Council on
† Treasury Board

April 22
† Voluntary Formulary Board, Virginia

PUBLIC HEARINGS

February 22
Water Control Board, State

February 23
Water Control Board, State

February 24
Water Control Board, State

February 25
Water Control Board, State

March 1
Health, State Board of
Local Government, Commission on
† Taxation, Department of

March 10
Waste Management, Department of

March 12
Voluntary Formulary Board, Virginia

March 17
† Health, Department of

March 18
Higher Education for Virginia, State Council of
† Water Control Board, State

March 19
Medicine, Board of
- Advisory Committee for Optometry

March 22
Lottery Department, State

March 24
† Deaf and Hard of Hearing, Department for the
† Waste Management, Department of

March 26
† Waste Management, Department of

May 19
Agriculture and Consumer Services, Department of