

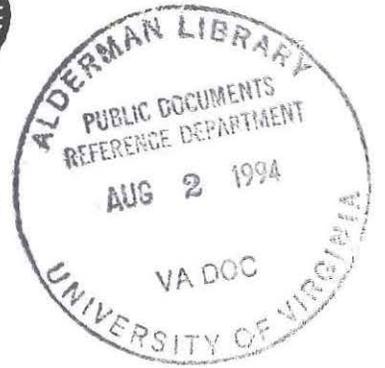
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THE VIRGINIA REGISTER

OF REGULATIONS

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July 25, 1994

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Pages 5495 Through 5642

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 Register* 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

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NOTICES OF INTENDED REGULATORY ACTION

Symbol Key †

† Indicates entries since last publication of the Virginia Register

DEPARTMENTS OF EDUCATION; MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES; SOCIAL SERVICES; AND YOUTH AND FAMILY SERVICES (BOARDS OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with these agencies' public participation guidelines that the Boards of Education; Mental Health, Mental Retardation and Substance Abuse Services; Social Services; and Youth and Family Services intend to consider amending regulations entitled: **VR 270-01-003, VR 470-02-01, VR 615-29-02, VR 690-40-004. Standards for Interdepartmental Regulation of Residential Facilities for Children.** The purpose of the proposed action is to establish standards to provide children in residential facilities with at least a minimum level of care. The current effort is intended to promulgate requirements for background investigations as permitted by § 63.1-248.7:2 of the Code of Virginia. Requirements for conducting background investigations will be the only topic considered. No public hearing will be held on this regulatory action after publication.

Statutory Authority: §§ 16.1-311, 22.1-321, 37.1-10, 37.1-182, 37.1-189.1, 63.1-25, 63.1-196.4, 66-10, and 66-24 of the Code of Virginia.

Written comments may be submitted until July 27, 1994.

Contact: Rhonda M. Harrell, Assistant Coordinator, Office of the Coordinator, Interdepartmental Regulation of Children's Residential Facilities, 730 E. Broad St., 9th Floor, Richmond, VA 23219-1849, telephone (804) 692-1964.

VA.R. Doc. No. R94-1028; Filed May 31, 1994, 2:16 p.m.



DEPARTMENT OF HEALTH (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 Health intends to consider amending regulations entitled: **VR 355-28-300. Regulations for the Immunization of School Children.** The purpose of the proposed action is to

add the Hepatitis B vaccine to the list of vaccines required for children to be admitted to day care centers. The agency does not intend to hold a public hearing on this regulatory action after publication.

Statutory Authority: §§ 22.1-271.2, 32.1-12, and 32.1-46 of the Code of Virginia.

Written comments may be submitted until July 29, 1994.

Contact: A. Martin Cader, M.D., Director, Division of Communicable Disease Control, Department of Health, P.O. Box 2448, Richmond, VA 23218, telephone (804) 786-6261 or FAX (804) 786-1076

VA.R. Doc. No. R94-1058; Filed June 8, 1994, 12:19 p.m.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

Notice of Intended Regulatory Action

Notice is hereby given in accordance with agency's public participation guidelines that the State Council of Higher Education for Virginia intends to consider amending regulations entitled: **VR 380-01-00. Guidelines for Public Participation in the Development and Promulgation of Regulations.** The purpose of the proposed action is to amend the current language to change some unclear language and add language so that they follow the Administrative Process Act guidelines. The emergency regulations currently in place will expire June 29, 1994. The amendments to the former regulations will bring them into needed compliance with the Administrative Process Act. The agency does not intend to hold a public hearing on this regulatory action after publication.

Statutory Authority: §§ 9-6.14:7.1 and 23-9.6:1 of the Code of Virginia.

Written comments may be submitted until July 27, 1994.

Contact: Fran Bradford, Legislative Specialist, State Council of Higher Education for Virginia, 101 N. 14th St., 9th Floor, Richmond, VA 23219, telephone (804) 225-2613.

VA.R. Doc. No. R94-1048; Filed June 8, 1994, 8:32 a.m.

PROPOSED REGULATIONS

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.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

Title of Regulation: VR 380-04-01. Virginia Postsecondary Review Entity Regulations.

Statutory Authority: §§ 23-9.6:1 and 23-261 of the Code of Virginia.

Public Hearing Dates:

July 25, 1994 - 11 a.m. (Annandale, VA)

July 26, 1994 - 11 a.m. (Norfolk, VA)

July 27, 1994 - 11 a.m. (Richmond, VA)

July 28, 1994 - 11 a.m. (Blacksburg, VA)

Written comments may be submitted until September 25, 1994.

(See Calendar of Events section for additional information)

Basis: The Virginia State Postsecondary Review Program resulted from the federal government's desire to decrease default rates on educational loans and to decrease fraud and abuse found at an increasing number of postsecondary institutions in the country. The 1992 amendments to the Higher Education Act of 1965 and subsequent federal regulations (34 CFR Part 667) authorized the Governor to designate the State Postsecondary Review Entity (SPRE) for Virginia. In August 1993, the Governor designated the State Council for Higher Education as Virginia's SPRE and charged the agency with the responsibility of implementing the federal program. Section 23-261 of the Code of Virginia gives the council statutory authority to administer federal programs as assigned by federal statutes and regulations and to "undertake such duties as may be additionally assigned to it by the Governor in response to agency designations requested by the federal government."

Purpose: Each state is required to have a State Postsecondary Review Entity (SPRE) that will work in conjunction with the U.S. Secretary of Education to help review those institutions that are having problems meeting the federal regulations for Title IV, HEA program eligibility. This regulation addresses the methods and criteria the SPRE will use in evaluating institutions.

The primary purpose of the regulation is to reduce fraud and abuse in the Title IV, HEA programs through the development of review standards. This regulation will serve as a mechanism for state oversight and review of those institutions referred to the SPRE by the U.S. Secretary of Education on the basis of one or more review criteria or selected by the SPRE for review due to evidence of fraudulent practices.

Substance: This regulation outlines how an institution becomes eligible and is referred for review by the SPRE, the priority system used by the SPRE to determine which referred institutions are reviewed, what action the SPRE can take if it determines that the institution fails to meet the standards for continued eligibility, the procedures for the receipt and recording of consumer complaints concerning postsecondary educational institutions in the Commonwealth, and the due process provisions afforded to reviewed institutions.

The review standards portion of the regulation (§§ 3.1 - 3.17) examines in part the accuracy and timeliness of an institution's publications, the progress of an institution's students, the completeness of student and financial records, the financial and administrative capacity of the institution, length of programs, graduation rates, placement rates, and other important institutional characteristics.

Issues: The primary issue involves the reduction of the fraud and abuse of Title IV, HEA funds by postsecondary educational institutions in the Commonwealth. New federal statutes and regulations require that the Commonwealth share an increasing portion of the financial burden of Title IV student loan defaults. The program implemented by the proposed regulation aims to ensure that those institutions receiving Title IV, HEA funds maintain the necessary educational, administrative, and financial capacity.

Failure to implement the program would result in the revocation of any Virginia institution's eligibility to receive allotment of funds under the SSIG or NEISP programs and a "freeze" on the granting of Title IV, HEA program eligibility to any Virginia institution not already certified. In addition, the failure to implement the program would also result in the U.S. Secretary of Education's revocation of funds to the council to implement the program and the designation of another entity (either within or external to Virginia) to implement the provisions of the program.

Impact: All postsecondary institutions in the state receiving Title IV, HEA funds will be subject to review by the SPRE if referred by the U.S. Secretary of Education or identified by the SPRE as engaging in fraudulent practices. Referred institutions will be required to provide the data and information described in the regulation.

As a federal program, all agency expenses associated with the planning, implementing, administering, and reporting of the program (including staffing) are reimbursed by the federal government. The council is obligated to administer the program only to the degree it is funded by the federal

government. There will be some direct costs to institutions as they revise their data collection efforts to account for the new requirements imposed by the program.

Summary:

These proposed regulations govern the State Postsecondary Review Entity (SPRE) in Virginia. The impetus for the regulations comes from the 1992 amendments to the Higher Education Act of 1965 and subsequent federal regulations which called for the designation of SPREs in each state to formulate and implement regulations with the explicit purpose of reducing fraud and abuse in postsecondary education, especially in relation to the high loan default rates for Title IV, HEA-related programs. The regulations establish the criteria and procedures used by the SPRE to review referred postsecondary educational institutions participating in Title IV, Higher Education Act (HEA) programs to determine their eligibility for continued Title IV participation. The proposed regulations establish under what conditions an institution will be reviewed by the SPRE; list the standards an institution must meet in order to maintain its Title IV, HEA eligibility; describe the types of action the SPRE may undertake as a result of its review findings; and provide reviewed institutions with an appeals process to object to or comment on the SPRE's findings and recommendations. In an effort to locate patterns of abuse, fraud, or mismanagement, the regulations also establish a process for the recording, referral, and evaluation of complaints filed against a postsecondary educational institution.

VR 380-04-01. Virginia Postsecondary Review Entity Regulations.

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:

"Academic facilities" means the instructional, laboratory, and other physical plant facilities associated with the academic programs.

"Academic year" means a period of time (i) requiring a minimum of 30 weeks of instructional time in which a full-time student is expected to complete 24 semester or 24 trimester or 36 quarter hours at an institution that measures program length in credit hours or 900 clock hours at an institution that measures program length in clock hours; or (ii) otherwise approved by the secretary as meeting Title IV, HEA program eligibility requirements.

"Acid test ratio" means the ratio calculated by adding

cash and cash equivalents to current accounts receivable and dividing the sum by total liabilities. The ratio excludes all unsecured or uncollateralized related party receivables.

"Advisory committee" or "SPRE advisory committee" means the committee established by Part VII of these regulations.

"Award year" means the period of time from July 1 of one year to June 30 of the following year.

"Certificate" means a formal award certifying the satisfactory completion of a postsecondary education program.

"Clock hour" means a 60-minute period which includes a minimum of 50 minutes of instruction.

"Cohort default rate" means, for any fiscal year in which 30 or more current or former students at an institution enter repayment of Stafford of SLS Program loans received for attendance at that institution, the percentage of those students entering repayment during that fiscal year who default before the end of the following fiscal year.

"Council" means the State Council of Higher Education for Virginia.

"Credit hour" means either (i) one semester credit equivalent to 15 clock hours of classroom instruction, 30 hours of laboratory instruction, or 45 hours of internship; or (ii) one quarter credit equivalent to 10 clock hours of classroom instruction, 20 clock hours of laboratory instruction, or 30 hours of internship.

"Defunct institution" means any institution that has permanently closed or ceased to provide educational programs.

"Department of Education" or "USED" means the U.S. Department of Education.

"Educational program" means a combination of courses and related activities organized for the attainment of broad educational objectives as described by the institution which leads to an academic, professional, or other recognized educational credential.

"Enrolled student" means a person who has completed the registration requirements (except for the payment of tuition and fees) at the institution he is attending.

"Federal fiscal year" means the period from and including October 1 of a calendar year through and including September 30 of the following calendar year.

"Fiscal year" means a 12-month period from and including June 1 of a calendar year through and including September 30 of the following calendar year, as defined by the institution.

Proposed Regulations

“Full-time student” means a student enrolled for 12 or more semester credits, 12 or more quarter credits, or 24 or more contact hours per week each term.

“HEA” means the federal Higher Education Act of 1965, as amended (20 USC 1070 et seq.).

“Institution” means any postsecondary entity that participates in a Title IV, HEA program.

“Minimum cash reserve fund” means an amount of money maintained by the institution in the form of a cash deposit in a federally insured bank account or U.S. Treasury securities backed by the full faith and credit of the United States of America and having an original maturity date of three months or less, or both. The fund must be equal to at least 25% of the total dollar amount of refunds paid by the institution in the previous year.

“Normal time to completion” means the period of time specified in the institution’s enrollment contract, catalog, or other materials, for completion of the program by a full-time student, or the period of time between the date of enrollment and the anticipated graduation date appearing on the student’s loan application, if any, whichever is less.

“Part-time student” means a student enrolled for either 11 semester credits or less, 11 quarter credits or less, or less than 24 contact hours per week each term.

“Pro rata refund” means a refund by the institution to a student who is attending the institution for the first time of not less than that portion of tuition, fees, room and board, and any other charges assessed the student by the institution equal to the portion of the period of enrollment for which the student has been charged that remains on the last day of attendance by the student, rounded downward to the nearest 10% of that period, less any unpaid charges owed by the student for the period of enrollment for which the student has been charged, and less a reasonable administrative fee not to exceed the lesser of 5.0% of the tuition, fees, room and board, and other charges assessed the student, or \$100.

“Professional program” means an undergraduate or graduate educational program listed in the Classification of Instructional Programs (CIP) which prepares individuals for an occupation, if that occupation (i) requires at least a bachelor’s degree to qualify for entry; (ii) involves the independent practice or application of a defined or organized body of competencies that is unique to the occupation; and (iii) is formally recognized and regulated under a national or state licensure, accreditation, or permit system.

“Prospective student” means any person (i) who has contacted an institution for the purpose of requesting information concerning admission to the institution, or (ii) who an institution has contacted, either directly or indirectly through general advertising, about enrolling at

the institution.

“Referred institution” means any institution that the U.S. Secretary of Education, in accordance with Section 494C of HEA, refers to the SPRE for review or any institution selected for review by the SPRE, subject to approval by the secretary, in accordance with Section 494C of the HEA and § 2.2 of these regulations.

“Regular student” means a person who is enrolled or accepted for enrollment at an institution for the purpose of obtaining a degree, certificate, or other recognized educational credential offered by that institution.

“Required fees” means the fixed sum charged to students for items not covered by tuition and required of such a large proportion of all students that the student who does not pay is an exception.

“Review standards” or “standards” means the definitions, criteria, and requirements stated in Part III of these regulations.

“Secretary” or “Secretary of Education” means the U.S. Secretary of Education.

“State Postsecondary Review Entity” or “SPRE” means the State Council of Higher Education for Virginia, acting as the designated Virginia state agency for assuming the responsibilities prescribed by Section 494 of the federal Higher Education Act of 1965, as amended (20 USC 1099a) and associated federal regulations (34 CFR Part 667).

“Substantial control” means (i) direct or indirect control over a substantial ownership interest; (ii) representation (under voting trust, power of attorney, or proxy) of a person who individually or with a group has a substantial ownership interest; or (iii) status as chief executive officer or other executive officer or member of a board of directors of an entity holding a substantial ownership interest.

“Tangible net worth” means an institution’s liabilities subtracted from its tangible assets. The calculation of tangible net worth excludes all assets classified as intangible in accordance with generally accepted accounting principles.

“Tuition” means the amount of money charged to students for instructional services. Tuition may be charged per term, per course, or per credit.

“Unrestricted current funds” means all funds, including institutional funds, received for which no stipulation was made by the donor or other external agency as to the purpose for which the funds should be expended.

“Vocational program” means an educational program, below the bachelor’s level, that is designed to prepare individuals with the skills and training required for employment in a specific trade, occupation, or profession

related to the educational program.

PART II. REVIEW OF REFERRED INSTITUTIONS.

Article 1. Institutions Subject to Review.

§ 2.1. Institutions that meet USED criteria.

The U.S. Secretary of Education refers an institution to the SPRE for review if the institution meets one or more of the criteria used by the secretary to identify institutions for SPRE review.

§ 2.2. Institutions proposed by the SPRE.

A. The SPRE may request the secretary to approve its review of an unreferral institution if:

1. Based on more recent data, the SPRE determines that an institution meets one of the referral criteria used by the secretary; or
2. The SPRE has reason to believe that an institution is engaged in fraudulent practices.

B. If, under subdivision A 1 of this section, the SPRE intends to request permission from the secretary to review an institution, the SPRE must first (i) notify the institution of its reasons for requesting permission to review, and (ii) allow a period of 30 days from the date of the SPRE's notification to the institution of its intent to seek approval for review for the institution to challenge the accuracy of the information on which the SPRE selected the institution.

C. To challenge the accuracy of the information used by the SPRE, an institution must deliver its submission and supporting evidence of the inaccuracy of SPRE data by hand or certified mail, return receipt requested, within 30 days after being notified by the SPRE of its intent to seek approval from the secretary to review the institution. The institution's submission must identify specific inaccuracies in the data used by the SPRE and include corrected data.

D. If the secretary fails to approve or disapprove a SPRE request to review additional institutions within 21 days, the SPRE may proceed to review such additional institutions as if approved by the secretary.

Article 2. Notification of Referral.

§ 2.3. Receipt of USED referral by SPRE.

Upon an institution's triggering of one or more of the referral criteria, the secretary notifies the SPRE in writing of the institution's status as a referred institution and its eligibility to be reviewed by the SPRE in accordance with the standards specified in Part III of these regulations.

§ 2.4. SPRE notification to institution.

Within 30 calendar days of its receipt of the USED referral of an institution for review, the SPRE will provide written notice to the designated institution of its referral and eligibility for review by the SPRE.

§ 2.5. SPRE notification to accrediting agencies.

A. The SPRE will notify the nationally recognized accrediting agency when it plans to conduct a review of an institution accredited or preaccredited by that agency.

B. After conducting a review of the institution, the SPRE will notify the accrediting agency of its findings and the actions the SPRE takes, or plans to take, as a result of those findings.

Article 3. Schedule and Cost of Review.

§ 2.6. Establishment of priority of reviews by SPRE.

A. Upon receipt of referrals from the secretary, the SPRE will establish a schedule for review of the referred institutions according to the following order of priority:

1. High priority will be given to an institution:

- a. In the process of being recertified for Title IV, HEA programs; or
- b. Exhibiting a default rate in excess of 20% and a student loan volume in excess of \$250,000 for the most recent completed fiscal year.

2. Priority will be given to an institution:

- a. Triggering two or more of the referral criteria; or
- b. Previously referred to SPRE by the secretary, but not reviewed.

3. Low priority will be given to an institution:

- a. Previously reviewed by the SPRE in the last two years on the basis of the same trigger with a finding of no significant violations;
- b. Referred only for a failure to turn in audit materials in a timely fashion;
- c. Referred only because of changed ownership during the last year; or
- d. Referred only because it has participated for less than five years in Title IV, HEA programs.

B. An institution designated for SPRE review under the provisions of § 2.2 of these regulations will be treated as a

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high priority for review.

§ 2.7. Cost of review borne by referred institution.

The reviewed institution is responsible for the costs associated with supplying the SPRE with the data and other information required by these regulations and for the costs associated with the peer review system defined in § 2.10 of these regulations.

Article 4. Review Process.

§ 2.8. Data provided by referred institution.

A. Unless otherwise notified by the SPRE, a referred institution must provide the SPRE with the data and information, as specified or described in Part III of these regulations, that demonstrates the referred institution's compliance with the standards.

B. If the referred institution was not, prior to referral, otherwise required to keep data or information relating to its compliance with any specific review standard, and did not keep that data or information, the SPRE will allow the referred institution a maximum of six months to obtain that specified data or information. Previously required information must be made available by the institution to the SPRE upon request.

§ 2.9. Site visit review by SPRE.

Upon deciding to review a referred institution, the SPRE shall assign a visiting team to evaluate the institution's compliance with the review standards. The team leader and members are selected by the SPRE staff and will come from outside of the reviewed institution and may include one or more members of the SPRE Advisory Committee. Each member of the team will certify that he has bias for or against the institution or otherwise prejudiced against or for the institution to be reviewed. An institution may nominate individuals to be considered by the SPRE in constructing the review team. A SPRE representative will accompany each team. The institution will be notified of the visit 30 calendar days in advance of the scheduled visit (with the exception of those instances where the SPRE suspects fraudulent practices and has received approval from the secretary to review the institution under such cause). The notification will include a roster of the visiting team, and the institution will be provided the opportunity to object to any team member for just cause.

§ 2.10. Review by accrediting agency or other peer review system.

A. In addition to the site visit review conducted by the SPRE in accordance with § 2.9 of these regulations, the SPRE shall contract for an independent review of the referred institution by an entity that the SPRE determines to be competent in assessing educational programs. The

entity shall be either:

1. An institutional accrediting agency, either regional or national, recognized by the U.S. Department of Education, for review of referred institutions that offer programs in two or more unrelated disciplines;

2. A professional or specialized accrediting agency, recognized by the U.S. Department of Education, for review of referred institutions that offer programs only in the discipline in which the professional or specialized accrediting agency grants accreditation; or

3. A peer review system that has:

a. An established basis for evaluating educational quality;

b. Review procedures that include the selection of peer reviewers who have experience in evaluating the types of programs offered by the referred institution; and

c. Established policies and procedures that guard against bias in conducting reviews of institutions.

B. The contracted review entity shall:

1. Assess the quality and content of each educational program offered by the referred institution in relation to achieving the stated objectives for which the program was offered.

2. Consider the adequacy of the referred institution's provision for each educational program of:

a. Space;

b. Equipment;

c. Instructional materials;

d. Staff;

e. Student support services, including student orientation and counseling; and

f. Any other areas specified in the SPRE's contract with the review entity.

C. The assessment conducted by the contracted reviewing entity shall be based on either:

1. A site visit review of the referred institution that is conducted according to the established policies and procedures of the reviewing entity; or

2. Information about the referred institution collected by the reviewing entity for and during its most recent:

a. Grant of accreditation;

b. Grant of preaccreditation; or

c. Site visit review of the referred institution.

D. The contracted review entity shall prepare a report of its assessment of the referred institution and submit it to the SPRE within the time period specified in the contract.

E. The laws of Virginia shall govern any contract executed between the SPRE and a review entity as defined by subsection A of this section.

§ 2.11. Preparation of preliminary report of reviews: preliminary review standard compliance report; opportunity for comment by reviewed institution.

A. Upon completion of its review of a referred institution's compliance with the review standards, the SPRE review team will produce a preliminary written report of its findings.

B. The preliminary report of the SPRE review team and the report prepared by the contracted review entity in accordance with § 2.10 D of these regulations shall be made available to the reviewed institution for comment.

C. The institution will be given a period of 14 calendar days to submit written comments to the SPRE concerning the initial findings of both reports.

D. Upon expiration of the 14-day comment period, the SPRE staff, in consultation with the site review committee, will evaluate the reports and findings of the SPRE review team and the contracted review entity and will prepare a draft report of findings and proposed action for submission to the SPRE.

PART III. REVIEW STANDARDS.

§ 3.1. The availability to students and prospective students of catalogs, admissions requirements, course outlines, schedules of tuition and fees, policies regarding course cancellations, and the rules and regulations of the institution relating to students.

A. Purpose of the standard. Review standard 1 ensures that enrolled and prospective students have appropriate access to information regarding an institution's policies and procedures in order that they may make informed educational choices.

B. Specifics of institutional compliance.

1. An institution must make available upon request a current and accurate catalog, student handbook, program description, or such other documents used for the same purposes to all enrolled and prospective students.

2. The documents must contain the following information:

a. Admissions procedures and requirements;

b. Rules and regulations governing student conduct;

c. Descriptions of all degree and nondegree programs including:

(1) Program objectives;

(2) Required courses or experiences for degree or completion;

(3) Number of credit or contact hours awarded to each course or experience;

(4) Number of credits or contact hours required for degree or completion;

(5) Relationship of program to any applicable licensure and certificate requirements;

(6) Listing of faculty; and

(7) Description of institutional academic facilities;

d. Schedule of tuition, required fees, and the method used to calculate fees;

e. Course cancellation policy;

f. Financial aid information including:

(1) Types of federal, state, local, private and institutional aid offered to students at the institution;

(2) Description of the financial aid application process and the method for determining student eligibility for aid;

(3) Methods and schedules used to determine and disburse financial aid to students; and

(4) Statement of the rights and responsibilities of financial aid recipients including:

(a) Terms and conditions of any employment included in a financial aid package;

(b) Statement regarding the terms and necessity of loan repayment;

(c) Conditions under which a student may receive a deferral or partial cancellation of his loan debt;

(d) Standards of academic progress required of students for continued participation in federal financial aid programs; and

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(e) Procedures for students to reestablish eligibility for federal financial aid programs; and

3. All catalogs, student handbooks, and program descriptions must indicate a contact person or office from which students can receive additional or current information.

a. The designated person(s) or office must be available, upon reasonable notice, to any enrolled or prospective student seeking assistance during the designated administrative working hours of the institution unless the institution has been granted a waiver from the U.S. Secretary of Education.

b. The granting of a waiver by the Secretary of Education does not exempt the institution from the requirement to designate an employee or office on a part-time basis to provide information to students.

C. Compliance requirements.

1. To determine whether a referred institution adequately makes available the required information to enrolled and prospective students, the SPRE may review the referred institution's procedures for disbursement of catalogs, student handbooks, and program descriptions, the record of complaints from students, a list of the documents made available to students, and the extent to which a person is available at the referred institution to assist students in acquiring institutional information.

2. To ascertain content compliance, the SPRE may review the current catalog, program descriptions, and other relevant publications from a referred institution to evaluate the documents against the criteria delineated in subdivision B 2 of this section.

§ 3.2. The accuracy of catalogs and course outlines in reflecting the courses and programs offered by the institution.

A. Purpose of the standard. Review standard 2 ensures that all statements released to students or the public regarding institutional policies, procedures, and outcomes are accurate and free of misrepresentation.

B. Specifics of compliance. Catalogs, student handbooks, and program descriptions must be current and accurate. If institutional information changes, the institution must:

1. Revise and republish the catalog and other relevant publications;
2. Provide inserts reflecting updated information for existing catalogs and other publications; or
3. Make available timely notices of all changes to all enrolled students and make updated information readily available to prospective students.

C. Compliance requirements. In order to demonstrate the accuracy of the catalog, handbook, or equivalent documents, a referred institution must be prepared to provide supporting documentation such as course syllabi, course schedules, and other documentary evidence that can be compared to the published catalogs and handbooks to determine accuracy.

§ 3.3. The institution has a method to assess a student's ability to successfully complete the course of study for which he has applied.

A. Purpose of the standard. Review standard 3 ensures that the institution uses an established method to determine whether students admitted into a program possess the preparation and abilities necessary to successfully complete the program of study.

B. Specifics of institutional compliance.

1. An institution must demonstrate that it has a defined and consistently applied admissions policy to determine whether applicants have the ability to successfully complete the proposed program of study at the institution.

2. The institution shall have and maintain, and shall provide to all applicants upon request, a policy document describing the criteria used to determine eligibility for admission to the institution and for acceptance at the specific degree level or into specific degree programs offered by the institution.

3. An institution must demonstrate that all students participating in Title IV programs show evidence of or certify to at least one of the following criteria:

a. High school graduate;

b. GED recipient; or

c. Admitted to the institution on the basis of his ability to benefit from the training offered at the institution as evidenced by the student's:

(1) Successful completion of an ability-to-benefit test recognized by the U.S. Department of Education which measures the student's aptitude to successfully complete the program of study;

(2) Enrollment in and successful completion of a remedial instruction program prescribed by the institution which does not exceed one academic year in duration; or

(3) Receipt of a GED before the end of the student's first year of study in the program or the student's completion of the program, whichever occurs first.

4. While an institution may apply different admissions

requirements to different programs, the same requirements must be uniformly applied to all applicants of the same program.

C. Compliance requirements. To demonstrate compliance, the referred institution must supply the SPRE with a description of its admissions criteria and demonstrate through admissions and student records that it has consistently applied the criteria to students.

§ 3.4. Assurance that the institution maintains and enforces standards relating to academic progress.

A. Purpose of the standard. Review standard 4 ensures that an institution maintains and reasonably applies standards of academic progress to all students.

B. Specifics of institutional compliance.

1. An institution must establish, make available to students, and reasonably apply standards relating to academic progress. The standards must be consistently applied to all students, whether they receive Title IV aid or not.

2. An institution's academic progress standards must meet the following minimum standards by:

a. Complying with the minimum requirements for satisfactory progress standards promulgated by the institution's accreditation body;

b. Taking into account academic factors such as grades, projects, and experiences which are evaluated against a minimum benchmark of satisfactory achievement;

c. Establishing a maximum time frame in which the student must complete an educational program or objective.

(1) The time frame must be based on the student's enrollment status;

(2) The time frame shall be divided into increments of no longer than one academic year; and

(3) The established maximum time frame for an undergraduate program must be no longer than 150% of the normal time to completion for a full-time student. For part-time students continuously enrolled in an educational program, the maximum time frame must be no longer than 110% of the full-time equivalency length of the program;

d. Designating the minimum amount of academic work to be completed in a given increment to indicate satisfactory progress;

e. Establishing increments of no longer than one academic year at which student progress is

evaluated by the institution;

f. Consistently applying its standards of satisfactory progress to all students within the same category (i.e., full-time, part-time, graduate);

g. Describing the extent to which course withdrawals, repetitions, and pass/fails affect the satisfactory progress determination; and

h. Establishing procedures for student appeals of an unsatisfactory determination and for reinstating financial aid eligibility after an unsatisfactory academic progress determination.

C. Compliance requirements.

1. The SPRE shall review the referred institution's documented and published policies regarding academic progress.

2. The referred institution must maintain accurate and current information on the number of students not meeting the published satisfactory academic progress standards.

§ 3.5. Institution maintains adequate student and other records.

A. Purpose of the standard. Review standard 5 ensures that an institution adequately adheres to its stated and published policies.

B. Specifics of compliance. The institution shall maintain records on all students while enrolled and for five years after graduation or withdrawal. Student records shall include:

1. Each student's application for admission and admissions records containing information regarding the educational qualifications of each regular student admitted which are relevant to the institution's admissions standards. Each student record must reflect the requirements and justification for admission of the student to the institution.

2. Transcript of the student's academic work, which shall be retained permanently in either hard copy forms or in a database with back up. For newly enrolled students, the institution must have an official student transcript on file by the end of the first academic term.

3. A record of student academic progress at the institution including program of study, dates of enrollment, courses taken and completed, grades, an indication of the student's current status (graduated, discontinued, probation, etc.), and the student's placement if known.

4. A record of all federal, state, and institutional

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financial aid offered to the student.

C. Compliance requirements.

1. The institution must provide SPRE access to student records which indicate that progress evaluations were conducted, the procedures for notifying students of unsatisfactory progress, and that the appropriate sanctions were implemented for those students not meeting the progress requirements.

2. An institution must maintain adequate student records to demonstrate its adherence to stated institutional policies and procedures.

§ 3.6. Compliance by the institution with relevant safety and health standards, such as fire, building, and sanitation codes.

A. Purpose of the standard. Review standard 6 ensures that the physical facilities of the institution meet all relevant safety and health regulations.

B. Specifics of institutional compliance. An institution must:

1. Meet all local, state, and federal health and safety codes and regulations;

2. Maintain on file up-to-date inspection certificates attesting to its compliance; and

3. Maintain records of any violations and the steps taken to remedy the deficiency.

C. Compliance requirements. An institution must maintain and make available to the SPRE, copies of the institution's current inspection certificates, and the institution's log or records of violations, and the record of actions taken to correct violations.

§ 3.7. The financial and administrative capacity of the institution as appropriate to its specified scale of operations and the maintenance of adequate financial and other information necessary to determine the financial and administrative capacity of the institution.

A. Purpose of the standard. Review standard 7 ensures that the institution maintains the administrative structure and financial capability necessary to adequately support all of its educational programs.

B. Specifics of institutional compliance.

1. An institution must have an organizational structure and administrative process which reflects and supports the educational objectives and purposes of the institution.

2. The institution shall provide the SPRE with a written document stating the powers, duties, and

responsibilities of:

a. The governing board or owners of the institution;

b. The chief operating officer at each site in the Commonwealth;

c. The principal administrators at each site in the Commonwealth;

d. The faculty at each site in the Commonwealth; and

e. The students, if students participate in institutional governance.

3. The administrative structure and process must reflect competent support and supervisory capacity in the areas of educational activities, admissions, student financial aid, financial operations, plant and equipment, and student support services.

4. An institution must:

a. Designate an individual responsible for and maintain an adequate staff to administer and coordinate Title IV, HEA programs:

(1) The SPRE may examine the following factors to determine whether an institution's Title IV staff is adequate:

(a) Number of students receiving aid;

(b) Number and types of aid programs offered;

(c) Number of applications evaluated at the institution;

(d) Amount of aid funds administered; and

(e) Aid delivery system used at the institution;

b. Establish, publish, and enforce standards to determine whether students receiving Title IV aid are making satisfactory academic progress;

c. Maintain a separation of duties between the person or office responsible for authorizing financial aid and the person or office responsible for disbursement;

d. Establish and use written policies and procedures for verifying information contained in a student financial aid application;

e. Provide adequate financial aid counseling to students including, but not limited to, providing information regarding the types and amounts of available aid, the methods used to determine and disburse financial aid, and the rights and

responsibilities of financial aid recipients;

f. Publish the duties and responsibilities of all administrators;

g. Develop and make available an organizational chart indicating the lines of authority for all educational endeavors of the institution;

h. Maintain an institutional academic year withdrawal rate of below 33%;

i. Maintain a cohort default rate for Stafford Loans and SLS programs of below 20%;

j. Maintain a default rate for Perkins Loans of below 20% of the principal of all Perkins Loans at the institution which have reached the repayment period; and

k. Maintain an overall loan default rate of below 30% for the most recent three-year period. For those three-year periods including either 1991 or 1992, the cohort default rate must be below 35% for those two years and below 30% for all subsequent years.

5. Historically black colleges and universities, tribally-controlled community colleges, and Navajo community colleges, as defined in Section 322(2) of the HEA, are exempt from the provisions of subdivisions 4 i through 4 k of this subsection until July 1, 1998.

6. An institution must show through financial reports and documents that it maintains the fiscal resources necessary to support all of the educational programs and services described in its publications.

7. An institution's audited financial statements must demonstrate or contain the following:

a. A minimum cash reserve fund equal to at least one quarter of the total dollar amount of refunds paid by the institution in the previous fiscal year;

b. The minimum cash reserve fund balance for the two most recently completed fiscal years;

c. The refund expenditures for the most recently completed fiscal year;

d. Accrued refunds available at the end of each fiscal year for the two most recently completed fiscal years; and

e. An unqualified auditor's opinion.

8. In addition to the provisions of subdivision 7 of this subsection, the audited financial statements of a for-profit institution must demonstrate or contain the

following:

a. Financial ratios and balances.

(1) An acid test ratio of at least 1:1 for the most recently completed fiscal year;

(2) A less than 10% decrease in tangible net worth during the two most recently completed fiscal years; and

(3) A positive tangible net worth for the most recently completed fiscal year; or

b. Certification from the secretary that it has currently issued and outstanding debt obligations that are listed at or above the second highest rating level of credit quality given by a nationally recognized statistical rating organization.

9. In addition to the provisions of subdivision 7 of this subsection, the audited financial statements of a nonprofit institution must demonstrate or contain the following:

a. Financial ratios and balances.

(1) An acid test ratio of at least 1:1 for the most recently completed fiscal year; and

(2) One of the following:

(a) Positive unrestricted current fund balance for the most recently completed fiscal year; or

(b) The absence of operating losses over both of its two most recently completed years which result in a 10% or greater decrease in either unrestricted current fund balance or unrestricted net assets since the beginning of the two-year period; or

b. Certification from the secretary that it has currently issued and outstanding debt obligations that are listed at or above the second highest rating level of credit quality given by a nationally recognized statistical rating organization.

10. In addition to the provisions of subdivision 7 of this subsection, the audited financial statements of a public institution must demonstrate or contain the following:

a. Financial statements, ratios, and balances.

(1) That the institution's liabilities are backed by the full faith and credit of the Commonwealth;

(2) Positive current unrestricted fund balance if reporting under the Single Audit Act;

(3) Positive unrestricted current fund in Educational

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and General funds; and

(4) Record of statement sent to the secretary from the State Auditor General attesting to the institution's meeting of all financial obligations over the most recently completed fiscal year, and the institution's continued fiscal health; or

b. Certification from the secretary that it has currently issued and outstanding debt obligations that are listed at or above the second highest rating level of credit quality given by a nationally recognized statistical rating organization.

11. All audits and financial statements must comply with Generally Accepted Accounting Procedures (GAAP).

12. In determining the financial capacity of an institution under review, the SPRE will evaluate the U.S. Department of Education's determination of the institution's financial responsibility made by the secretary during the initial review of the institution using the referral criteria.

C. Compliance requirements.

1. The SPRE will evaluate the administrative and fiscal capacity of a referred institution in relation to the referred institution's stated educational goals and the nature of the referred institution's programs.

2. In determining administrative capacity, the SPRE may request a referred institution to provide an organizational chart and a description of the duties and responsibilities of all administrators.

3. In determining whether a referred institution maintains the appropriate financial capacity, the SPRE shall evaluate the audited financial statements and documents submitted for review by the referred institution and any additional information available from outside sources, including financial information from the U.S. Department of Education.

§ 3.8. For institutions financially at risk, the adequacy of provisions for the instruction of students and to provide for the retention and accessibility of academic and financial aid records of students in the event the institution closes.

A. Purpose of the standard. Review standard 8 ensures that all students are treated equitably and fairly in the event the institution ceases to operate.

B. Specifics of institutional compliance.

1. An institution is determined to be at risk on the basis of its failure to meet the financial responsibility criteria promulgated in § 3.7 of these regulations.

2. This standard only applies to those institutions identified as financially at risk by the SPRE, and only for the time period for which the at risk institution is so designated.

3. An institution identified as at risk by the SPRE must have an established plan to be implemented in the event the institution closes or terminates teaching activities in a particular program.

4. The plan may either:

a. Provide for a teach-out agreement with a comparable institution which ensures that currently enrolled students will be given the opportunity to resume and complete their programs. The teach-out agreement must conform with the following guidelines:

(1) Teach-out provision must be with an institution offering similar program(s) in the same geographic area, and with which the closing institution has no business connection;

(2) The contracted teach-out institution shall agree not to charge the student for periods of enrollment paid for in advance to the original institution; and

(3) The original school shall notify students in a timely manner of the availability of the teach-out option;

b. Contain provisions for the institution to grant refunds on a pro rata basis;

c. Provide for coverage under a state-administered tuition-recovery fund;

d. Contain a surety bond or letter of credit payable on demand payable on demand to the U.S. Department of Education in the amount of at least 50% of an academic year's tuition and fees for all enrolled students receiving federal financial aid funds and which provides for the refund to lenders; or

e. Provide for coverage under a "pooled risk" program administered by the institution's accrediting body which provides for refunds to lenders.

5. An at-risk institution must select an option in subdivision 4 of this subsection and must document its choice to the SPRE.

6. An institution selecting the option in subdivision 4 a of this subsection must:

a. Biennially reevaluate and renew teach-out agreements;

b. Include a brief description of the teach-out plan

in its catalog or equivalent document or in its enrollment agreement, and provide details of the plan to students upon request;

c. Provide the SPRE, the accreditation agency, and its principal guaranty agency with a copy of its teach-out agreement and copies of its catalog or equivalent document and enrollment agreement; and

d. Make available details of the teach-out plan to enrolled and prospective students upon request.

7. At-risk institutions must establish a plan to ensure that all student, administrative, and financial records will be properly secured and made accessible to students and other appropriate individuals in the event of closure.

8. In the event of closure, an institution must have an established plan to contact all enrolled students and demonstrate a good faith effort to contact all former students to inform them of the location of their records after the closure.

C. Compliance requirements. For those institutions identified as financially at risk, the SPRE requires the referred institution to submit a contingency plan for closure in relation to the above criteria and to demonstrate the extent to which the referred institution has made the provisions of its closure plan known to students.

§ 3.9. For vocational programs, the relationship of the tuition and fees to the remuneration that can be reasonably expected by students who complete the course or program and the relationship of the courses or programs (including the appropriateness of the length of such courses) to providing the student with quality training and useful employment in recognized occupations in the state.

A. Purpose of the standard. With regard to vocational programs of study, review standard 9 ensures that the costs, length, and content of programs are appropriate.

B. Specifics of institutional compliance. An institution must demonstrate that all vocational programs are appropriate in terms of costs, program length, and quality of preparation.

1. Cost of program.

a. The annualized tuition and fees for the program must not exceed 100% of the average statewide annual salary and benefits for the intended occupation.

b. Annualized tuition and fees are calculated by dividing the accumulated tuition charges over the duration of the program by the number of years (or fraction thereof) required to complete the program.

For example, a two-year program charging \$2,500 for tuition and fees in year 1 and \$2,750 in year 2 would have an annualized tuition and fees of \$2,625. As used in this subparagraph, "fees" do not include books or other tools and materials which become the property of the student, but do include any charges required of all students enrolled in the program which are directly related to the delivery of the program.

c. Average annual salary and benefits data must be obtained from the Virginia Employment Commission. Hourly rates shall be multiplied by 2,080 hours to calculate annual salary.

d. Institutions exceeding the 100% threshold must demonstrate the reasonableness of the program's tuition and fees by documenting either of the following:

(1) Future earnings potential of graduates; or

(2) Expensive equipment or materials necessary to deliver educational program.

2. Length of program.

a. Program length must meet the requirements maintained by the institution's accrediting or licensing body, or both.

b. An institution must demonstrate that the number of credit or clock hours required for specific programs is adequate to meet the educational objectives of the program without being excessive.

3. Quality of preparation.

a. The institution must demonstrate that the training provided in its program is necessary for the intended occupation, and that the program's objectives, content, and goals are congruent with those of the occupation.

b. Each program must have documented goals and objectives to be met by graduates.

C. Compliance requirements. A referred institution must document the relationship of its tuition and required fees for vocational programs to the average annualized salary and benefits data provided by the Virginia Employment Commission, provide evidence that the length of each vocational program is defensible by reference to accreditation or licensing standards or other credible evidence that demonstrates the length of the program to be adequate without being excessive, and demonstrate that the training provided in each vocational program is necessary for the preparation for and performance of the intended occupation.

§ 3.10. Availability to students of relevant information by

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institutions of higher education, including information relating to market and job availability for students in occupational, professional, and vocational programs; and information regarding the relationship of courses to specific standards necessary for state licensure in specific occupation.

A. Purpose of the standard. Review standard 10 ensures that students are provided with accurate information regarding the employment prospects and licensing requirements for intended occupations.

B. Specifics of institutional compliance.

1. Any institution offering occupational, vocational, or professional programs must make the following information available to all prospective students prior to enrollment. The information must be directly related to the institution's program and the job for which the program is designed to prepare the student.

- a. Current and accurate employment statistics;
- b. Graduation statistics; and
- c. State licensure or certification requirements.

2. For those programs at the institution which require state licensure or certification to practice the occupation in the Commonwealth, the institution must provide information describing the extent to which the institution's program satisfies the applicable licensure and certification requirements to all enrolled students and make the information readily available to prospective students upon request.

C. Compliance requirements. The SPRE may evaluate the accuracy, availability, and applicability of the employment, licensure, and placement information that a referred institution makes available to both enrolled and prospective students by reviewing the published materials furnished by the referred institution.

§ 3.11. The appropriateness of the number of credit or clock hours required for the completion of programs.

A. Purpose of the standard. Review standard 11 ensures that the number of credit or clock hours required in a program of study is directly related to the stated educational objectives and criteria of the of the course or program.

B. Specifics of institutional compliance.

1. The objectives and goals of all programs must be linked to educational criteria which justify the length of the program.
2. The educational objectives must be published in the institutional catalog, or equivalent publications.

3. An institution must demonstrate that the number of credit or clock hours required for a program is not excessive in relation to the stated objectives of the program. To demonstrate this, an institution may document that the length of its programs;

- a. Conforms with the applicable accreditation or licensure standards for program length; or
- b. Corresponds to the average length of similar programs in the state.

4. The length of all programs must be specified in hours or credits, published, and made available to enrolled and prospective students.

C. Compliance requirements. For each program offered by a referred institution, the SPRE will evaluate whether the program's credit or clock hour length is appropriate in relation to the stated objectives of the course of study.

§ 3.12. The appropriateness of the length of 600-clock-hour educational programs.

A. Purpose of the standard. Review standard 12 ensures that the length of 600-clock-hour programs is directly related to the stated educational objectives and criteria of that program.

B. Specifics of compliance. The institution must demonstrate that the length of any 600-hour program is sufficient to cover the content necessary to meet the educational objectives of the program.

C. Compliance requirements. For each 600-clock-hour program offered by a referred institution, the SPRE will evaluate whether the program's clock-hour length is appropriate in relation to the stated objectives of the course of study.

§ 3.13. Assessing the actions of any owner, shareholder, or person exercising control over the educational institution which may adversely affect eligibility for programs under Title IV, HEA.

A. Purpose of the standard. Review standard 13 ensures that those persons having substantial control of the institution are administratively fit to manage the institution's operations.

B. Specifics of institutional compliance.

1. An institution shall certify that all members of its ownership, its chief executive officer, and all employees administering Title IV, HEA funds have not been convicted of, pled nolo contendere or guilty to, or been judicially determined to have committed a crime involving federal funds.

2. An institution shall certify that it does not contract the services of any individual, agency, or organization

employing persons who have been convicted of, pled nolo contendere or guilty to, or been judicially determined to have committed a crime involving federal funds.

3. An institution shall certify that any person acquiring substantial control over the institution:

a. Has not had the ability to affect substantially the actions of a defunct institution within 90 days of the date that institution became defunct;

b. Does not owe a liability on improperly expended or unspent Title IV, HEA program funds received by a defunct institution or for refunds of institutional charges to students of a defunct institution; and

c. Is not delinquent in making payments in accordance with any previous agreement to repay a Title IV liability associated with a defunct institution.

C. Compliance requirements. A referred institution meets this regulation when the referred institution assures the SPRE of its compliance, and the SPRE has no contrary evidence of impropriety.

§ 3.14. The adequacy of procedures for investigation and resolution of student complaints.

A. Purpose of the standard. Review standard 14 ensures that the institution establishes and maintains a mechanism for appropriately handling student complaints.

B. Specifics of institutional compliance.

1. An institution must publish and make available to all students a list of grievance policies and procedures regarding the receipt, investigation, and resolution of student complaints.

2. These policies must include:

a. An appropriate time frame for investigating and resolving the complaint;

b. Safeguards that those persons charged with resolving the complaint are adequately removed from and be free from any conflict of interest in the issue of the complaint;

c. Protections ensuring that a student will not be subject to unfair actions as a result of his initiation of a complaint proceeding; and

d. The maintenance of complete and accurate records on each complaint for a minimum of seven years.

C. Compliance requirements.

1. The SPRE may review a referred institution's published policies regarding the receipt, investigation, and resolution of student complaints.

2. The SPRE may also review a referred institution's records of student complaints and assess the actions taken by the referred institution to resolve specific complaints.

§ 3.15. The appropriateness of advertising and promotion and student recruitment practices.

A. Purpose of the standard. Review standard 15 ensures that the information provided by the institution to prospective students is accurate and current.

B. Specifics of institutional compliance.

1. An institution using job placement data in its promotions must provide prospective students with current and accurate information regarding job market statistics, graduation rates, and placement rates to support their assertions.

2. Such institutions must also provide prospective students with accurate information regarding licensure and certification requirements for all programs offered by the institution which lead to licensed or certified occupations.

3. All institutions must ensure that their recruitment personnel are providing prospective students with current and accurate information on the institution.

4. All advertisements, announcements, and promotional material of any kind which are distributed in Virginia shall be free from statements that are untrue, deceptive, or misleading with respect to the institution, its personnel, its services, or the content, accreditation status, and transferability of its courses or degree, diploma, or certificate programs.

5. An institution is prohibited from rewarding its recruitment or financial aid personnel with commissions or bonuses based on the number of students they enroll or financial assistance decisions at the institution unless those activities involve the recruitment of foreign students not eligible to receive federal financial assistance.

C. Compliance requirements. The SPRE may review a referred institution's published admissions materials, evaluate a referred institution's recruitment practices, and review the record of student complaints at the referred institution.

§ 3.16. The institution has a fair and equitable refund policy to protect students.

A. Purpose of the standard. Review standard 16 ensures that an institution maintains a fair and equitable refund

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policy.

B. Specifics of the standard.

1. An institution must have an established and published refund policy which fairly treats all students paying tuition to the institution. The institution shall make its refund policy and procedures, including the institutional formulae for granting refunds and repayments, available to students upon request.

2. The refund policy must include:

a. Provisions for both students withdrawing before the start of classes and those students withdrawing during session which include detailed accounts of the pro rated amount of refund relative to how much of the term has elapsed;

b. An established and appropriate time frame for disbursing refunds;

c. Provisions for the refund repayment of institutional refunds to Title IV programs; and

d. A provision which states that the amount of the refund to the student will be the largest amount provided for under the following three calculations:

(1) State formula, when applicable;

(2) Formula of the institution's nationally recognized accrediting agency; and

(3) Pro rata refund formula. The pro rata refund calculation does not apply to the institution's refund policy for any student whose date of withdrawal is after the 60% point in time in the period of enrollment for which the student has been charged.

e. For purposes of determining a refund when the pro rata refund calculation under subdivision B 2 d (3) of this section does not apply, and no standards for refund calculations exist under subdivisions B 2 d (1) and (2) of this section, the refund will be calculated as the larger of:

(1) The institution's refund policy; or

(2) The specific refund standards contained in Appendix A to 34 CFR Part 668.

C. Compliance requirements. The SPRE may review a referred institution's published refund policy against the above criteria.

§ 3.17. The success of the program at the institution, including the rates of the institution's students' program completion and graduation, taking into account the length of the program at the institution and selectivity of the institution's admissions policies; the withdrawal rates of the

institution's students; with respect to vocational and professional programs, the rates of placement of the institution's graduates in occupations related to their course of study; where appropriate, the rate at which the institution's graduates pass licensure examination; and the variety of student completion goals, including transfer to another institution of higher education, full-time employment in the field of study, and military service.

A. Purpose of the standard. Review standard 17 measures the success of an institution's educational programs.

B. Specifics of institutional compliance.

1. Cohort graduation rate.

a. Following the cohort methodology for calculating graduation rates, an institution's graduation rate is defined as the percentage of full-time, undergraduate, degree- or certificate-seeking students entering postsecondary education for the first time who complete the program of study within 150% of the normal time to completion. Students with prior coursework above the secondary level will be excluded from the cohort except for those students who took courses at the same institution during the previous summer and continued in the fall, or who earned advanced placement credit while in high school. Students who withdraw from the institution to serve in the military, on an official church mission, or with a recognized federal foreign aid service will be excluded from the cohort. A student who transfers to a higher level program, at either the same or other eligible institution, will be counted as a "completer" in the initial institution's cohort if that institution can demonstrate that its program provided substantial preparation for study in the higher level program. Students who transfer to a same level program within the same institution or drop to half-time status will remain in the cohort.

b. An institution shall demonstrate compliance with this requirement by documenting one of the following conditions:

(1) Cohort graduation rate equal to or greater than 50%;

(2) Cohort graduation rate placing the institution at or above the 25th percentile of the designated peer group. Peer groups shall be jointly selected by the reviewed institution and the SPRE. A referred institution is responsible for collecting data from the selected peer group; or

(3) Documented justification for a low graduation rate in terms of the institution's unique mission, selectivity of students, program length, or the variety of student completion goals at the institution such as transfer, military service, or employment in

related fields.

c. Because the normal time to completion varies by program, an institution must track the students by program and report graduation rates for different programs, e.g., associate degree, certificate programs, bachelor's degree, etc. The institution also must report a single institutional graduation rate; therefore, each year the data from all the school's programs must be combined to produce an overall institutional graduation rate.

d. All programs requiring less than 600 clock hours must maintain a graduation rate of at least 70%.

2. Withdrawal rates.

a. An institution's withdrawal rate is calculated as follows:

(1) Institutional withdrawal rate is computed by dividing the number of withdrawals for the academic period by the number of regular students enrolled during that same academic period.

(2) Institutions at which the majority of regular students begin and end the academic year on the same date must calculate the withdrawal rate for that academic year; all other institutions must calculate the withdrawal rate for any eight-month period.

(3) Institutions must count all regular students enrolled on the first day of classes for the specified period, except those students who, during that period withdrew from, dropped out of, or were expelled from the institution; and received a refund of 100% (less any permitted administrative fee) of their tuition and fees under the institution's refund policy.

b. Institutions must maintain a withdrawal rate of less than 33%.

3. Job placement rates.

a. Placement rates are required for vocational and professional programs.

b. A "placed student" is defined as a student who, within 180 days of the day he received a degree, certificate, or other recognized educational credential, obtained gainful employment in the recognized occupation for which he was trained.

c. Placement rates are calculated by dividing the total number of students who receive a degree, certificate, or other educational credential in the award year by the total number of placed students as defined in subdivision 3 b of this subsection.

d. An institution may exclude from its calculations

those graduating students unavailable for employment due to continuance of education, military service, or documented illness.

e. The institution must document the means utilized to collect job placement data and the methodology used to compute job placement rates.

f. Excluding those programs defined in subdivision 3 g of this subsection, an institution shall demonstrate compliance with this requirement by documenting one of the following conditions:

(1) Job placement rate equal to or greater than 60%;

(2) Job placement rate placing the institution at or above the 25th percentile of the designated peer group. Peer groups shall be jointly selected by the referred institution and the SPRE. The referred institution is responsible for collecting data from the selected peer group; or

(3) Documented justification for a low job placement rate in terms of the institution's unique mission, selectivity of students, program length, or other relevant factors.

g. All programs requiring less than 600 clock hours must maintain a job placement rate of at least 70%.

4. Licensure examination pass rates.

a. For all programs preparing students for occupations in which a licensing exam is required for an entry-level position, an institution must provide licensure examination pass rates for its graduates.

b. The licensure examination pass rate is defined as the proportion of program graduates who pass a licensure or certification examination to the total number of graduates taking the exams.

c. An institution shall demonstrate compliance with this requirement by documenting one of the following conditions:

(1) Licensure exam pass rate equal to or greater than 60%;

(2) Licensure exam pass rate placing the institution at or above the 25th percentile of the designated peer group. Peer groups shall be jointly selected by the referred institution and the SPRE. The referred institution is responsible for collecting data from the selected peer group; or

(3) Documented justification for a low licensure exam pass rate in terms of the institution's unique mission, selectivity of students, program length, or

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other relevant factors.

C. *Compliance requirements.* The SPRE will evaluate the referred institution's graduation, withdrawal, job placement, and licensure pass rates against the thresholds defined in subsection B of this section.

PART IV. INITIAL ACTIONS BY SPRE.

Article 1. Proposed Action Based on Review.

§ 4.1. SPRE response to review of referred institution.

The SPRE shall issue a written report of its findings and proposed action no later than 45 days after the SPRE formally receives the draft report prepared in accordance with subsection B of § 2.11 of these regulations.

§ 4.2. Recommendation of continued eligibility.

The SPRE will recommend continued eligibility if:

1. The SPRE reviewed the referred institution and found no violations of the review standards; or
2. The SPRE determines, based on compelling evidence offered by the referred institution, that the violation does not warrant further action by the SPRE. In such instances, the SPRE shall report to the secretary an explanation of why no action was prescribed.

§ 4.3. Recommendation of continued eligibility with stipulations for corrective actions.

The SPRE may prescribe a course of action that the referred institution must follow to correct any violations of the review standards. The SPRE maintains sole discretion to determine the period of time for the institution to correct the violation and bring itself into compliance with the standards.

§ 4.4. Recommendation of termination of eligibility.

A. The SPRE may recommend that the referred institution's eligibility for participation in a Title IV, HEA program be terminated for the following reasons:

1. Egregious violation of standards;
 2. Negative review by accrediting agency or peer review system;
 3. Failure to take corrective actions prescribed by the SPRE;
 4. Refusal to allow SPRE personnel at the institution;
- or

5. Failure to provide the SPRE with prompt access to documents and records.

B. Due to the inadequacy and unreliability of current comparable data on job placement, withdrawal, and licensure and certification pass rates, the SPRE will not recommend termination of the institution's eligibility for participation in any Title IV, HEA program solely on the basis of the job placement, withdrawal, or licensure and certification pass rate measures defined in § 3.17 of these regulations.

§ 4.5. Notification to institution of SPRE findings and proposed action.

A. The SPRE shall send to the referred institution by certified mail, return receipt requested, a copy of the written report of its findings and proposed action.

B. If the SPRE finds an institution in violation of a review standard, for each violation the SPRE will cite the review standard violated, the nature of the violation, and any prescribed corrective action to bring the institution into compliance.

Article 2. Initial Action on Review Report.

§ 4.6. Response by institution to SPRE findings and proposed action.

A. If the referred institution elects to respond to the SPRE's findings and proposed action, it will submit a written response to the SPRE which may include:

1. Evidence that demonstrates that one or more of the SPRE's findings were based on incorrect or incomplete information;
2. Evidence that demonstrates that the referred institution has corrected practices or conditions that led the SPRE to find the institution to be in noncompliance with one or more of the review standards in Part III of these regulations; and
3. Evidence that demonstrates that the report of the report from the accrediting agency or peer review system in accordance with § 2.11 of these regulations is factually incorrect.

B. If the referred institution fails to respond in writing to the SPRE's findings and proposed action within 45 calendar days, on the day following the 45-day period:

1. The referred institution cedes all rights to appeal the SPRE's action;
2. The written report becomes the final report, and the proposed action becomes the final action; and
3. The SPRE shall make the appropriate notifications

of the final action in accordance with §§ 6.3, 6.4 and 6.5 of these regulations.

§ 4.7. Initial action by SPRE.

A. Upon receipt of the response by the referred institution, as provided by § 4.6 of these regulations, the SPRE staff, in consultation with the SPRE Advisory Committee, will:

1. Review the written response and modify the findings and proposed action as appropriate; and
2. Prepare a review report and recommended action for submission to the SPRE.

B. Upon consideration of the review report and recommended action, the SPRE may:

1. Return the review report and recommended action to the SPRE Advisory Committee for further consideration;
2. Adopt the recommended action with any modifications that the SPRE deems appropriate; or
3. Adopt the recommended action as submitted by the SPRE staff.

§ 4.8. Notification to referred institution.

A. No later than seven days after the SPRE takes initial action in accordance with § 4.7 of these regulations, the director of the council shall provide written notification to the referred institution of:

1. The SPRE's initial action and reasons for that action, including a copy of the review report; and
2. A statement of the referred institution's rights to appeal the initial action in accordance with Part V of these regulations.

B. The written notification shall be sent to the referred institution by certified mail, return receipt requested.

PART V. INSTITUTIONAL APPEALS OF INITIAL ACTIONS.

Article 1. Notice of Appeal.

§ 5.1. Notice of appeal by referred institution.

A. A referred institution that wishes to appeal the SPRE's initial action shall notify the SPRE of its intent to exercise the appeal rights provided by the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia). The notice of appeal shall be in writing and shall be sent to the SPRE by certified mail, return receipt requested, no later than 15 days after the institution receives notification

of the SPRE's final action in accordance with § 4.8 of these regulations.

B. The institution must state in its written notification of appeal of the SPRE's initial action, as provided by subsection A of this section, whether it wishes to make an informal appeal in accordance with § 9-6.14:11 of the Administrative Process Act (APA) or waive the informal appeal to conduct a formal appeal in accordance with § 9-6.14:12 of the APA.

C. An institution choosing to make an informal appeal does not waive its right to a subsequent formal appeal should consensus between the institution and the SPRE not be reached at the conclusion of the informal appeal process.

Article 2. Informal Appeal.

§ 5.2. Informal appeal by referred institution.

A referred institution that chooses to appeal a SPRE initial action shall comply with the informal appeal procedure governed by § 9-6.14:11 of the Code of Virginia.

§ 5.3. Appeal proceedings.

A. The informal appeal shall be conducted at a time and place mutually acceptable to the SPRE and the appealing institution, no later than 60 days after the SPRE receives notice of appeal from the appealing institution in accordance with § 5.1 of these regulations.

B. The informal appeal shall be heard by a panel composed of members of the SPRE Advisory Committee.

1. The panel shall be composed of at least three members of the Advisory Committee and normally shall include at least two members who are affiliated with postsecondary institutions.

2. The panel shall not include any member of the Advisory Committee who served as a member of the site review team that reviewed the appealing institution in accordance with § 2.9 of these regulations.

§ 5.4. Findings and recommendation of hearing panel.

A. The panel hearing the informal appeal from the referred institution shall prepare a written report no later than 30 days after the informal hearing was conducted.

1. The written report shall include the panel's findings and recommendation to the SPRE.

2. The panel may recommend that any or all of findings in the SPRE's initial action in accordance with §§ 4.2, 4.3 and 4.4 be reaffirmed, modified, or removed.

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3. The panel shall not recommend any new or additional stipulations that were not included in the SPRE's initial action.

B. A copy of the written report of the hearing panel shall be provided to the appealing institution.

§ 5.5. Institutional response to the findings and recommendation of the hearing panel.

A. Upon receipt of the written report of the hearing panel, the institution must respond to the SPRE within 14 calendar days of its decision to:

1. Accept the findings and recommendation of the hearing panel's report by notifying the SPRE in writing of its consensus with the hearing panel; or
2. Dispute the findings and recommendations of the hearing panel's report and notify the SPRE in writing of its intent to pursue a formal appeal in accordance with § 9-6.14:12 of the Administrative Process Act.

B. An institution's acceptance of the hearing panel's findings and recommendation under subdivision A 1 of this section waives institution's right to a formal appeal and makes the findings of the hearing panel final.

Article 3. Formal Appeal.

§ 5.6. Formal appeal by referred institution.

A referred institution that chooses to appeal a SPRE initial action must comply with the formal appeal procedure governed by § 9-6.14:12 of the Code of Virginia.

§ 5.7. Appeal proceedings.

A. The formal appeal shall be conducted at a time and place mutually acceptable to the SPRE and the appealing institution, no later than 60 days after the SPRE receives notice of appeal from the appealing institution in accordance with § 5.1 of these regulations.

B. The formal appeal shall be heard by an impartial hearing officer designated by the Commonwealth in accordance with § 9-6.14:14.1 of the Code of Virginia.

§ 5.8. Findings and recommendation of hearing officer.

A. The hearing officer hearing the formal appeal from the referred institution shall prepare a written report no later than 30 days after the formal hearing was conducted.

1. The written report shall include the hearing officer's findings and recommendation to the SPRE.
2. The hearing officer may recommend that any or all of findings in the SPRE's initial action in accordance with §§ 4.2, 4.3 and 4.4 be reaffirmed, modified, or

removed.

B. A copy of the written report of the hearing officer shall be provided to the appealing institution.

PART VI. FINAL ACTION BY SPRE.

§ 6.1. Final action on initial action that was not appealed.

A. If a referred institution does not exercise its appeal rights, as provided by Part V of these regulations, the initial action by the SPRE in accordance with § 4.7 of these regulations, and the review report on which it was based, shall become final.

B. The review report and initial action become final one day after the time limit specified in § 5.1 of these regulations for the referred institution to exercise its appeal rights.

§ 6.2. Final action on initial action that was appealed.

A. Following a referred institution's appeal of the SPRE's initial action, the SPRE shall prepare a final report that gives due consideration to the findings and recommendations of:

1. The advisory committee panel that heard an informal appeal in accordance with Article 2 of Part V of these regulations; or
2. The hearing officer who heard a formal appeal in accordance with Article 3 of Part V of these regulations.
3. The SPRE will not forward a recommendation concerning an institution's Title IV, HEA eligibility to the secretary until the appeals process has been completed or waived by the referred institution.

B. Based on the referred institution's appeal, the SPRE may:

1. Reaffirm its initial action;
2. Remove any or all of the stipulations from its initial action; or
3. Change its initial action to terminate eligibility to stipulations for corrections.

C. The SPRE shall take final action on the referred institution's appeal no later than 90 days after the completion of the appeals process.

§ 6.3. Notification to referred institution.

A. The SPRE shall notify the referred institution of its final action within 10 days after the action become final in accordance with § 4.6 B, § 6.1 B or § 6.2 C of these

regulations. The written notification shall be sent by certified mail, return receipt requested.

SPRE@pcmail.schev.edu

B. The notification shall include:

1. The final report as defined by § 4.6 B or § 6.1 A, or prepared by SPRE in response to the referred institution's appeal of the SPRE's initial action in accordance with § 6.2 A; and
2. The final action taken by the SPRE.

§ 6.4. Notification to U.S. Secretary of Education.

A. The SPRE shall notify the U.S. Secretary of Education of its final action within 30 days after the action concerning the referred institution become final in accordance with § 4.6 B, § 6.1 B or § 6.2 C of these regulations. The written notification shall be sent by certified mail, return receipt requested.

B. The notification shall include:

1. The final report as defined by § 4.6 B or § 6.1 A, or prepared by SPRE in response to the referred institution's appeal of the SPRE's initial action in accordance with § 6.2 A; and
2. The final action taken by the SPRE.

§ 6.5. Notification to accrediting agencies.

The SPRE shall notify all national accrediting agencies that accredit the referred institution of its final action within 30 days after the action concerning the referred institution become final in accordance with § 4.6 B, § 6.1 B or § 6.2 C of these regulations. The written notification shall be sent by certified mail, return receipt requested.

PART VII. COMPLAINT PROCEDURE.

§ 7.1. Notification to public of SPRE complaint process.

A. An institution participating in any Title IV, HEA program must include the following statement in one of the published documents described in § 3.1 of these regulations:

"Any person who files a complaint at this institution and is not satisfied with the institution's response should contact a SPRE representative at the following address and phone number:

SPRE Coordinator
State Council of Higher Education for Virginia
James Monroe Building
101 North Fourteenth Street
Richmond, Virginia 23219
(800) 225-XXXX"
Internet address:

B. An institution must provide a written copy of the statement listed in subsection A of this section to any person initiating a formal complaint procedure against the institution at the time the initial complaint is received by the institution.

§ 7.2. Receipt of complaints by the SPRE.

A. The SPRE will serve as the central coordinating entity and clearinghouse for receiving complaints by persons of illegal, fraudulent, or deceptive practices at postsecondary educational institutions within the Commonwealth and referring such complaints to the appropriate federal, state, and local departments or agencies charged with enforcement, licensure, or certification.

B. Procedures for receiving complaints are as follows:

1. Individuals will be encouraged to exhaust the institution's complaint or grievance procedures before filing a complaint with the SPRE.
2. Only written complaints submitted by mail, facsimile, or electronic mail to the addresses or facsimile number listed in § 7.1 A will be recorded as formal complaints by the SPRE.
3. Anonymous complaints will be recorded by the SPRE and will be used by the SPRE in its determination of the frequency and nature of complaints at an institution in accordance with § 7.5.
4. Anonymous complaints will be exempted from the provisions of § 7.3.
5. Written complaints may be in either of the following forms:
 - a. Signed letter; or
 - b. Completed complaint form provided by the SPRE upon request from the address and telephone number listed in § 7.1.
6. Agencies that license postsecondary institutions may forward to the SPRE any written complaints received from individuals.

§ 7.3. Response of the SPRE upon receipt of a formal complaint.

A. Within 10 working days of receiving a formal written complaint, the SPRE will issue a letter to the complainant acknowledging receipt of the complaint.

B. Within 10 working days of receiving the complaint, the SPRE will contact the institution identified in the complaint to:

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1. Inform the institution of the nature of the complaint;
2. Collect information on the complaint or grievance procedures employed by the institution to attempt a resolution of the conflict; and
3. Provide the institution opportunity to respond formally to the complaint within 30 calendar days.

C. Within 45 calendar days of receiving the complaint, the SPRE will contact the institution and complainant, if identified, to determine final disposition of the complaint. In the event the final disposition has not been reached, the institution must inform the SPRE of the current status of the complaint and agree to contact the SPRE when final disposition has occurred.

D. The SPRE will refer formal written complaints to the appropriate federal, state, or local agency or entity charged with enforcement. The SPRE will follow-up with the entity to determine and record final disposition of the complaint.

§ 7.4. SPRE records of complaints.

A. The SPRE will maintain records of complaints and their eventual disposition.

B. Written complaints will be entered into a complaints database maintained by the SPRE.

C. Complaints will be entered into the database according to the following characteristics:

1. Name of institution;
2. Date of occurrence;
3. Nature of complaint;
4. Utilization of the institution's complaint or grievance procedures;
5. Complainant type (student, faculty, employee, etc.); and
6. Final disposition of the complaint.

D. Records of complaints will be maintained by the SPRE for a minimum of seven years.

§ 7.5. SPRE determination of the frequency and nature of complaints.

A. The SPRE will evaluate records of complaints annually to determine the frequency and nature of complaints at individual institutions.

B. The evaluation will consider such factors as:

1. Total number of complaints at the institution for that year;
2. Patterns of complaints in certain areas including, but not limited to, admissions, refunds, and misrepresentation of the nature of the academic programs at the institution;
3. Identifiable causes for complaints;
4. Institutional response to complaints; and
5. Final disposition of the complaint.

C. A copy of the SPRE's annual institutional evaluation and complaint data report will be sent to any institution receiving complaints during the previous year.

§ 7.6. SPRE reports to the Department of Education.

The SPRE will notify the secretary of any institution exhibiting a pattern of serious complaints, a habitual ineffectiveness of the institution's grievance procedures to resolve complaints or to treat complainants fairly, or a complaint or complaints that indicates the possibility of fraudulent practices at the institution.

PART VIII POSTSECONDARY REVIEW ADVISORY COMMITTEE.

§ 8.1. Postsecondary Review Advisory Committee established.

A. The SPRE will establish and maintain an advisory committee that includes:

1. Two representatives from:
 - a. Public senior degree-granting institutions, nominated by the Council's General Policies Advisory Committee;
 - b. Public two-year degree-granting institutions, nominated by the Chancellor of the Virginia Community College System;
 - c. Independent non-profit degree-granting institutions, nominated by the Council of Independent Colleges in Virginia;
 - d. Independent for-profit non-degree-granting institutions, nominated by the Virginia Association of Private Career Schools; and
2. One representative from:
 - a. Independent for-profit degree-granting institutions, appointed by the Council;
 - b. Out-of-state institutions operating in Virginia, appointed by the director;

c. Each state agency, excluding the Council of Higher Education, that licenses or regulates postsecondary institutions or programs in Virginia;

d. The State Approving Agency for Veterans Affairs;

e. The Executive Director of the Virginia Student Assistance Authorities;

f. The Virginia Secretary of Education; and

3. Three citizens who represent the interests of the consumers of postsecondary education in Virginia, appointed by the council.

B. The advisory committee will be chaired by the deputy director of the council and shall:

1. Serve as a forum for discussion of issues affecting postsecondary education in Virginia;

2. Provide a continuing means for communication among the SPRE, the various state oversight agencies, and all sectors of postsecondary education in Virginia;

3. Perform those functions specified in these regulations; and

4. Generally assist and advise the SPRE in the performance of its duties.

PART IX. ADDITIONAL REGULATIONS.

§ 9.1. Receipt of correspondence and other materials by SPRE.

A. All correspondence or other materials relating to, or required by, these regulations should be sent to Council of Higher Education, ATTN: SPRE Coordinator, James Monroe Building, 101 North Fourteenth Street, Richmond, Virginia, 23219.

B. The mailing of items specified in subsection A of this section shall not constitute receipt of them by the SPRE unless sent by registered or certified mail, return receipt requested.

V.A.R. Doc. No. R94-1095; Filed July 5, 1994, 11:21 a.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: State Plan for Medical Assistance Relating to OBRA '93 Estate Recoveries.

VR 460-01-53. Liens and Recoveries (§ 4.17 (a) and (b)).

VR 460-01-53.1. Liens and Recoveries (§ 4.17 (c)).

VR 460-01-53.2. Liens and Recoveries (§ 4.17 (d) and (e)).

VR 460-02-4.1730. Estate Recoveries (Attachment 4.17 C).

Statutory Authority: § 32.1-324 of the Code of Virginia.

Public Hearing Date: N/A - Written comments may be submitted through September 23, 1994. (See Calendar of Events section for additional information)

Basis and Authority: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code also provides, in § 9-6.14:9.1 of the Administrative Process Act (APA), for this agency's promulgation of proposed regulations subject to the Governor's review.

Sections 32.1-326.1 and 32.1-327 of the Code of Virginia provide for the recovery, by the Title XIX agency, of expenditures for certain services from the estates of recipients. The Omnibus Budget Reconciliation Act of 1993 § 13612 (OBRA '93) permitted the recovery of Title XIX expended funds from the estates of individuals for all Medicaid covered services. The inclusion of states' estate recovery policies in their state plans for medical assistance was required by the cited OBRA section. Since 1984, DMAS has exercised its authority under state law and recovered expenditures for all Medicaid covered services. The fact that the new federal law makes recovery of institutional payments mandatory, but this degree of recovery an option for states lacking similar state authority, is what causes this regulatory action to be subject to the Article 2 requirements of the APA.

Purpose: The purpose of this action is to amend the Plan for Medical Assistance concerning estate recoveries consistent with the requirements of OBRA 93 § 13612 and §§ 32.1-326.1 and 32.1-327 of the Code of Virginia. The process of recovering funds when they have been expended for persons who had their own resources, but did not use them for their own medical care, returns general fund dollars to the Commonwealth.

Summary and Analysis: The sections of the state plan affected by this action are Liens and Recoveries (§ 4.17 and Attachment 4.17-C).

Prior to July 1984, the Medical Assistance program did not operate an estate recovery program because there was no state law that permitted the Department of Medical Assistance Services (DMAS) to recover payments from deceased eligibles' estates.

During the 1984 session, the General Assembly passed the law (§ 32.1-327 of the Code of Virginia) granting the medical assistance program authority to recover medical assistance payments from deceased eligibles' estates. As a result of this law, DMAS developed procedures in conjunction with the Attorney General's Office and pursued estate recoveries. DMAS pursued recovery of estates for all medical assistance paid for deceased eligibles ages 65 or older.

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During the 1993 session, the General Assembly passed the law mandating that DMAS recover from eligibles' estates assistance paid for nursing facility care. As a result, DMAS initiated a proactive investigation program that identifies nursing home care and other medical assistance paid for deceased eligibles with recoverable assets. The Estate Recovery Unit, which was initiated in 1993, performs all estate recovery activity.

Also, in 1993, OBRA '93 provided the federal mandate that all states' medical assistance programs must pursue, at minimum, recovery of payments for the following services: nursing facility, home and community based care, and related hospital and prescription drugs. States' medical assistance programs were also given the option to pursue recovery of medical assistance paid for any other items or services under the state plan. This OBRA section also required that state plans be amended to incorporate such estate recovery activities as the state elected to pursue. In response to this federal mandate, DMAS is initiating this state plan change to reflect operation of its existing estate recovery program.

The implementation of this new state plan amendment will inform HCFA of the Commonwealth's program for recovering funds spent on long-term care and all other items or services paid under the state plan for deceased eligibles over the age of 55. DMAS, in conjunction with the Office of Attorney General, will continue to coordinate policies and procedures for evaluating the estates of deceased eligibles. As required by federal regulation, DMAS will send deceased eligibles' representatives a "Notice of Claim" specifying the medical assistance amount paid for long-term care and other items, and appeal contact information. In preparation for implementation, a general notice was sent out to the recipient population describing the Medicaid estate law and its provisions.

Adopting this regulation will incorporate the Commonwealth's process for implementing an estate recovery program into its state plan. By adopting this regulation, state funds required for the Medicaid program should be reduced to the extent payments are recovered.

Issues: Because provisions in federal regulations restrict recovery or adjustments against deceased eligible individuals' estates in situations when there is a surviving spouse, a surviving child under 21 or one who is blind or disabled, the impact in cases of extreme hardship is minimized. Family members and other persons whose distribution from a deceased eligible's estate are not exempt may pursue legal action against the Commonwealth to seek their full distribution. Because DMAS has been pursuing these recoveries since 1984, no negative impact is anticipated as this regulatory action represents no actual policy or procedural changes.

Impact: Recovering funds from estates of deceased eligibles in accordance with these mandates and other state and federal laws necessitates periodic communication

between DMAS and nursing facilities and other long-term care facility providers to verify patient accounts and resident information. Recovery from Medicaid eligibles' estates has limited impact on recipients but does impact the distribution of estates if no provision has been made for repayment of medical assistance. It is estimated that DMAS will recover \$400,000 in FY95 (\$200,000 GF and \$200,000 NGF) and \$400,000 in FY96 (\$200,000 GF and \$200,000 NGF). The funds are prior year recoveries which, based on accounting rules, do not affect the Medicaid budget. There are no localities which are uniquely affected by these regulations.

Forms: "Notice of Claim" - DMAS has developed a formal letter to notify the deceased eligibles' estate representatives and implement the agency's claim against estates. Standard letters, developed by DMAS' Estate Recovery Unit to secure and verify pertinent information used to initiate and recover medical assistant estate claims, include: (1) Clerk of Circuit Court, Asset Accounting, (2) Miscellaneous Sources, Asset Accounting, (3) Financial Institution Bank, Account Status, and (4) Deceased Eligible's Legal Representative Inquiry. "Estate Recovery Questionnaire," a form developed by DMAS' estate investigation staff to solicit specific information used to identify deceased eligibles with recoverable assets, is used to request information from the local eligibility offices of the Department of Social Services.

Summary:

This regulatory action amends the Plan for Medical Assistance concerning estate recoveries consistent with the requirements of OBRA 93 § 13612 and §§ 32.1-326.1 and 32.1-327 of the Code of Virginia. The process of recovering funds when they have been expended for persons who had their own resources, but did not use them for their own medical care, returns general fund dollars to the Commonwealth.

VR 460-01-53. Liens and Recoveries (§ 4.17 (a) and (b)).

Citation: 42 CFR 433.36(c); AT-78-90; 47 FR 43644

§ 4.17. Liens and Recoveries.

Liens are can be imposed against an individual's property.

No.

Yes.

(a) Liens are imposed against an individual's property before his death because of Medicaid claims paid or to be paid on behalf of that individual following a court judgment which determined that benefits were incorrectly paid for that individual.

Item (a) is not applicable. No such lien is imposed.

Item (a) applies only to an individual's real property.

Item (a) applies only to an individual's personal property.

Item (a) applies to both an individual's real and personal property.

(b) Liens are placed against the real property of an individual before his death because of Medicaid claims paid or to be paid for that individual in accordance with 42 CFR 433.36(g)(1) and (g)(2).

Item (b) is not applicable. No such lien is imposed.

VR 460-01-53.1. Liens and Recoveries (§ 4.17 (c)).

Citation: 42 CFR 433.36(c); AT-78-90; 47 FR 43644

§ 4.17 (c) Adjustments or recoveries for Medicaid claims correctly paid are ~~imposed only in accordance with § 433.36(h)~~ as follows. See Attachment 4.17 C .

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual.

(2) For any individual who received medical assistance at age 55 or older, recovery of payments are made for nursing facility services, home and community-based services, and related hospital and prescription drug services.

(i) Payments are recovered for other Medicaid services provided to individuals at age 55.

All services covered under the plan.

(ii) Payments are recovered for other Medicaid services provided to individuals at age

Not applicable.

(3) For any individual with long-term care insurance policies, if assets or resources are disregarded, recovery is made for all Medicaid costs for nursing facility and other long-term care services from the estate of persons who have such policies.

VR 460-01-53.2. Liens and Recoveries (§ 4.17 (d) and (e)).

(d) No money payments under another program are reduced as a means of recovering Medicaid claims incorrectly paid.

(e) ATTACHMENT 4.17-A -

(1) Specifies the process for determining that an

institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the process meets the requirements of 42 CFR 433.36(d).

(2) Defines the terms specified in 42 CFR 433.36(e).

(3) Specifies the criteria by which a son or daughter can establish that he or she has been providing care under 42 CFR 433.36(f).

VR 460-02-4.1730. Estate Recoveries.

§ 1. Definitions.

The following words and terms, as used in this regulation, shall have the following meaning unless the context indicates otherwise:

"Applicable medical assistance payments" means the amount of any medical assistance payments made on behalf of an individual under Title XIX of the Social Security Act.

"Estate" means, with respect to a deceased individual, (i) all real and personal property and other assets held by the individual at the time of death, and (ii) any other real and personal property and other assets in which the individual had any legal title or interest (to the extent of such interest) at the time of death.

§ 2. Identification of deceased recipients' estates.

The Medical Assistance Title XIX agency shall take all reasonable measures to determine the existence of deceased eligible individuals with recoverable estates.

§ 3. Initiation of claim and recovery.

A. The Medical Assistance Title XIX agency's estate recovery unit will review and initiate recovery activities for all deceased eligible individual's estates identified which meet agency minimum criteria defined in subsection B of this section. A review of all deceased eligible individuals' applicable medical assistance payments paid correctly must be performed to determine the amount of the Commonwealth's claim against the estate. A "Notice of Claim" shall be sent to the deceased eligible individual's estate administrator or executor upon determination that estate recovery meets the minimum criteria. The "Notice of Claim" shall include, at minimum, (i) the deceased eligible individual's identification information, (ii) the claim amount, (iii) the agency contact, and (iv) the attached summary of applicable medical claims paid.

B. The Medical Assistance Title XIX agency will, at a minimum, initiate recovery when the following conditions are met:

1. Legal estate administrator or executor has been verified.

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2. Dollar amount of applicable medical assistance payments (claim amount) and estate meets agency cost effective threshold. The Title XIX agency will determine a cost effective threshold based on the administrative costs to pursue recovery from an estate. The Title XIX agency will adjust the cost effective threshold if the agency's administrative costs change.

3. Deceased eligible was single or spouse is deceased.

4. Deceased eligible has no surviving children under 21 or children who are blind or disabled.

C. Appeals related to the recovery of funds will be administered by the Medical Assistance Title XIX agency.

D. The Medical Assistance Title XIX agency will pursue recovery only to the extent that payments for applicable medical claims have been correctly made under the State Plan for Medical Assistance.

§ 4. Hardship clause.

The Medical Assistance Title XIX agency may, at its discretion, waive its claim if it determines that enforcement of the claim would result in substantial hardship to the heirs or dependents of the individual against whose estate the claim exists. Determinations of hardship will be based on criteria established by the Secretary of the U.S. Department of Health and Human Services. These criteria shall provide for special consideration of cases in which the estate subject to recovery is (i) the sole income-producing asset of survivors (where such income is limited), such as a family farm or other family business, or (ii) a homestead of modest value, or (iii) other compelling circumstances.

V.A.R. Doc. No. R94-1103; Filed July 6, 1994, 11:41 a.m.

* * * * *

Title of Regulation: State Plan for Medical Assistance Relating to State Agency Fee Schedule – Resource Based Relative Value Scale (RBRVS).

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

VR 460-03-4.1921. Fees for Pediatric and Obstetric CPT Procedures.

VR 460-03-4.1924. State Agency Fee Schedule.

Statutory Authority: § 32.1-324 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted through September 23, 1994.

(See Calendar of Events section for additional information)

Basis and Authority: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code also provides in §

9-6.14:9.1 of the Administrative Process Act for this agency's promulgation of proposed regulations subject to the Governor's review.

The 1994 Appropriations Act § 1-88(313)(W) directs BMAS to develop amendments to the State Plan for Medical Assistance and seek the approval of the Health Care Financing Administration (HCFA) to provide for reimbursement to physicians based on a Resource Based Relative Value Scale (RBRVS).

Purpose: The purpose of this proposal is to implement a new medical and surgical fee schedule for the agency which is based on the federal RBRVS.

Summary and Analysis: The Program reimburses fee-for-service providers the lower of the state agency fee schedule or their actual charge to the general public. The agency fee schedule currently in use was updated in both 1990 and 1991 pursuant to Appropriations Acts of the General Assembly. Since then, the fee schedule has been based on a percentile of provider charges using charge data from an earlier period. At present, obstetric and certain pediatric fees are published annually as required by federal law. Chapter 965 of the Acts of Assembly, item 313.W directs the Board of Medical Assistance Services to develop an RBRVS-based physician fee schedule for approval by the HCFA. RBRVS-based reimbursement links the fee for a service to research-based estimates of the resources necessary to provide that service.

Prior to January 1, 1992, HCFA also used a fee schedule based on provider charges to reimburse physicians for their services rendered to Medicare beneficiaries. However, HCFA concluded that the fees it paid for services did not have a consistent, rational relationship to the actual resources utilized to provide those services. Therefore, HCFA developed a RBRVS-based fee schedule. HCFA assigned a "relative value" to each service expressed in relative value units (RVUs). HCFA computes the fee for a service by multiplying its RVUs times one of three conversion factors (CFs) which it developed for different types of services.

The Department of Medical Assistance Services (DMAS) is adopting HCFA's RVUs for its RBRVS-based fee schedule. DMAS will use HCFA's CFs after they have been adjusted by an additional factor to maintain budget neutrality. DMAS may revise the additional factor whenever HCFA updates its RVUs or CFs so that no change in expenditure will result solely from such update. DMAS will estimate RBRVS-type fees for services that have no HCFA RVUs and use existing fees for services for which it is unable to estimate an RBRVS-type fee. The RBRVS-based fees will be effective July 1, 1995, and will be phased in over a three-year period. There will be one fee schedule for the entire state with no geographic adjusters.

Implementation of the RBRVS-based fee schedule will affect each provider differently depending on the types of services provided since the allowable fee will increase for

some services and decrease for others.

Issues: The agency projects no significant negative issues involved in implementing this proposed change. The primary advantage of this regulation is that reimbursement for primary care services will be enhanced. In addition, the reimbursable fee schedule will be tied to the resources used to provide services rather than a survey of charges for these services. There will be a need to monitor program recipients' access to some kinds of services because while the fees for many services will be increased, those for others will be reduced. This may cause some physicians to reduce the number of Medicaid recipients they treat or to discontinue providing services to Medicaid recipients altogether. DMAS will need to monitor the level of physician participation to assure that recipients are not adversely affected by these changes.

This change to the fee schedule is undertaken only after obtaining input from the physician community. During 1993, DMAS convened an advisory committee composed of physicians selected by professional societies throughout the state. After several months of deliberations, a majority of this group voted to recommend to the department that it proceed to seek authorization to implement a RBRVS-based fee schedule. The details of the present proposal are consistent with the recommendations of the committee.

Impact: All physician providers and some nonphysician providers (such as nurse practitioners) throughout the state will be affected. Each provider will be affected differently based on the types of services he performs since the allowable fee will be raised for some services and lowered for others. Provided there are no changes in the types of services provided as a result of the new fee schedule, there should be no impact on Medicaid recipients and the implementation of the new fee schedule should be budget neutral. DMAS expects to expend \$267 Million (\$133.5 Million GF) in FY '95 and \$284 Million (\$142 Million GF) in FY '96 on physician and physician-related Medicaid services. These expenditures are funded in the current appropriation. This regulatory action is not intended to change these expenditure figures. There are no localities which are uniquely affected by these regulations as they apply statewide.

Forms: No new forms are required to implement this proposed regulation. These services will continue to be billed to Medicaid using the HCFA-1500 form.

Evaluation: DMAS will monitor the level of participation by physician providers to assure that program beneficiaries will continue to have access to needed services following the implementation of the RBRVS-based fee schedule. DMAS will also monitor the services performed by physician providers to ascertain whether these providers have altered the number and/or types of services they perform for program beneficiaries following the implementation of the new fee schedule.

Summary:

The purpose of this proposal is to implement a new medical and surgical fee schedule for the agency which is based on the federal RBRVS.

The program reimburses fee-for-service providers the lower of the state agency fee schedule or their actual charge to the general public. The agency fee schedule currently in use was updated in both 1990 and 1991 pursuant to Appropriations Acts of the General Assembly. Since then, the fee schedule has been based on a percentile of provider charges using charge data from an earlier period. At present, obstetric and certain pediatric fees are published annually as required by federal law. The 1994 Appropriations Act § 1-88(313)(W) directs BMAS to develop a RBRVS-based physician fee schedule for approval by the HCFA. RBRVS-based reimbursement links the fee for a service to research-based estimates of the resources necessary to provide that service.

Prior to January 1, 1992, HCFA also used a fee schedule based on provider charges to reimburse physicians for their services rendered to Medicare beneficiaries. However, HCFA concluded that the fees it paid for services did not have a consistent, rational relationship to the actual resources utilized to provide those services. Therefore, HCFA developed a RBRVS-based fee schedule. HCFA assigned a "relative value" to each service expressed in relative value units (RVUs). HCFA computes the fee for a service by multiplying its RVUs times one of three conversion factors (CFs) which it developed for different types of services.

The Department of Medical Assistance Services (DMAS) is adopting HCFA's RVUs for its RBRVS-based fee schedule. DMAS will use HCFA's CFs after they have been adjusted by an additional factor to maintain budget neutrality. DMAS may revise the additional factor whenever HCFA updates its RVUs or CFs so that no change in expenditure will result solely from such update. DMAS will estimate RBRVS-type fees for services that have no HCFA RVUs and use existing fees for services for which it is unable to estimate a RBRVS-type fee. The RBRVS-based fees will be effective July 1, 1995, and will be phased in over a three-year period. There will be one fee schedule for the entire state with no geographic adjusters.

Implementation of the RBRVS-based fee schedule will affect each provider differently depending on the types of services provided since the allowable fee will increase for some services and decrease for others.

The agency projects no significant negative issues involved in implementing this proposed change. The primary advantage of this regulation is that reimbursement for primary care services will be enhanced. In addition, the reimbursable fee schedule will be tied to the resources used to provide services rather than a survey of charges for these services.

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There will be a need to monitor program recipients' access to some kinds of services because while the fees for many services will be increased, those for others will be reduced. This may cause some physicians to reduce the number of Medicaid recipients they treat or to discontinue providing services to Medicaid recipients altogether. DMAS will need to monitor the level of physician participation to assure that recipients are not adversely affected by these changes.

This change to the fee schedule is undertaken only after obtaining input from the physician community. During 1993, DMAS convened an advisory committee composed of physicians selected by professional societies throughout the state. After several months of deliberations, a majority of this group voted to recommend to the department that it proceed to seek authorization to implement a RBRVS-based fee schedule. The details of the present proposal are consistent with the recommendations of the committee.

All physician providers and some nonphysician providers (such as nurse practitioners) throughout the state will be affected. Each provider will be affected differently based on the types of services he performs since the allowable fee will be raised for some services and lowered for others. Provided there are no changes in the types of services provided as a result of the new fee schedule, there should be no impact on Medicaid recipients and the implementation of the new fee schedule should be budget neutral. Medicaid spent approximately \$205 Million (total funds) for these services in SFY'94, and expects to spend \$244.8 Million (total funds) in SFY '95. This regulatory action is not intended to change these expenditure figures. There are no localities which are uniquely affected by these regulations as they apply statewide.

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:

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.

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.

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.

§ 2. Services which are reimbursed on a cost basis.

A. 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.

B. 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.

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

D. 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.

§ 3. Fee-for-service providers.

A. Payment for the following services shall be the lower of the state agency fee schedule (*Supplement 4 has information about the state agency fee schedule*) or actual charge (charge to the general public):

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

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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.

(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.

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

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

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

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

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

gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

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

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

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

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

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

2. Dentists' services

3. Mental health services including:

Community mental health services

Services of a licensed clinical psychologist

Mental health services provided by a physician

4. Podiatry

5. Nurse-midwife services

6. Durable medical equipment

7. Local health services

8. Laboratory services (Other than inpatient hospital)

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

10. X-Ray services

11. Optometry services

12. Medical supplies and equipment.

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.

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.

C. 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, payment for legend drugs will include the allowed cost of 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. 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.

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).

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.

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

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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

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.

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.

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.

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.

§ 4. Reimbursement for all other nonenrolled institutional and noninstitutional providers.

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.

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.

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.

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.

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.

§ 5. Refund of overpayments.

A. Providers reimbursed on the basis of a fee plus cost of materials.

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.

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.

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.

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. 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

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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.

A. 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.

B. 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).

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

D. 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.

§ 7. Dispute resolution for state-operated providers.

A. Definitions.

"DMAS" means the Department of Medical Assistance Services.

"Division director" means the director of a division of DMAS.

"State-operated provider" means a provider of Medicaid

services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

B. Right to request reconsideration.

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.

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.

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.

D. Division director action.

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

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.

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.

VR 460-03-4.1921. Fees for Pediatric and Obstetric CPT Procedures.

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CPT-4 Code	Description	Payment				
			PEDIATRIC SERVICES			
	1. Evaluation and Management Services - Physician services performed in a physician's office or in an outpatient facility				history, examination, and medical decision making of low to moderate complexity	
				99284	Detailed history, examination, and medical decision making of moderate complexity	57.30 63.50
				99285	Comprehensive history Comprehensive examination Medical decision making of high complexity	81.40 93.85
	NEW PATIENT					
99201	Problem focused history, examination, and straightforward medical decision making	\$ 24.00 24.20		99295	Initial NICU care, per day, for the evaluation and management of a critically ill neonate or infant	213.50 650.00
99202	Expanded problem focused history, examination, and straightforward medical decision making	28.00 31.90		99296	Subsequent NICU care, per day, for the evaluation and management of a critically ill and unstable neonate or infant	160.00 322.00
99203	Detailed history, examination and straightforward medical decision making of moderate complexity	33.00 40.00		99297	Subsequent NICU care, per day, for the evaluation and management of a critically ill and stable neonate or infant	100.00 160.00
99204	Comprehensive history, examination, and medical decision making of moderate complexity	46.75 57.75		99431	History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records	75.00 81.00
99205	Comprehensive history, examination and medical decision making of high complexity	50.00 66.60		99432	Normal newborn care in other than hospital and birthing room setting, including physical examination of baby and conference(s) with parent(s)	33.00 35.60
	ESTABLISHED PATIENT					
99211	Minimal presenting problems	\$ 10.00 10.65		99433	Subsequent hospital care, for the evaluation and management of a normal newborn, per day	26.25 28.30
99212	Problem focused history, or examination, and straightforward medical decision making	19.00 19.75		99440	Newborn resuscitation; care of the high-risk newborn at delivery, including, for example, inhalation therapy, aspiration, administration of medication for initial stabilization	100.00 108.00
99213	Expanded problem focused history or examination, and medical decision making of low complexity	26.50 27.65			3. Immunization Injections*	
99214	Detailed history, or examination, and medical decision making of moderate complexity	35.00 38.85		90700	Immunization, active; diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP)	\$ drug cost
99215	Comprehensive history, or examination and medical decision making of high complexity	45.00 54.30		90701	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)	\$ drug cost
	2. Emergency Department Services for emergency care			90702	Diphtheria and tetanus toxoids (DT)	\$ drug cost
	NEW OR ESTABLISHED PATIENT			90703	Tetanus toxoid	\$ drug cost
99281	Problem focused history, examination and straightforward medical decision making	\$ 26.00 23.75		90704	*** Mumps virus vaccine, live	\$ drug cost
99282	Expanded problem focused history examination and medical decision making of low complexity	40.00 40.35		90705	*** Measles virus vaccine, live, attenuated	\$ drug cost
99283	Expanded problem focused	49.00 49.75		90706	*** Rubella virus vaccine, live	\$ drug cost
				90707	** Measles, mumps and	\$ drug cost

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	rubella virus vaccine, live			(age 1 through 4 years)		
90708	Measles and rubella virus vaccine, live	\$ drug cost		99393 Late childhood (age 5 through 11 years)	36.00	36.95
90709	Rubella and mumps virus vaccine, live	\$ drug cost		99394 Adolescent (age 12 through 17 years)	31.00	31.80
90710	Measles, mumps, rubella, and varicella vaccine	\$ drug cost		OBSTETRICAL SERVICES		
90711	Diphtheria, tetanus, and pertussis (DTP) and injectable poliomyelitis vaccine	\$ drug cost		1. Maternity Care and Delivery		
90712	Poliovirus vaccine, live, oral (any type(s))	\$ drug cost		INCISION		
90713	Poliomyelitis vaccine	\$ drug cost		59000 Amniocentesis, any method	76.00	76.68
90720	Diphtheria, tetanus, and pertussis (DTP) and Hemophilus influenza B (HIB) vaccine	\$ drug cost		59012 Cordocentesis (intrauterine), any method	110.00	197.80
90731	Hepatitis B vaccine	\$ drug cost		59015 Chorionic villus sampling, any method	113.54	108.30
90737	Hemophilus influenza B	\$ drug cost		59020 Fetal oxytocin street test	60.00	64.95
	* (Note: Appropriate office visit may be billed in addition to the above immunization injections. Payment for immunizations shall not exceed the Medicaid fee on file for the drug at time of service.)			59025 Fetal non-stress test	50.00	46.50
	** Vaccine supplied under contract with manufacturer.			59030 Fetal scalp blood sampling	60.00	83.55
	*** Medical justification will be required to demonstrate that use of a single-antigen vaccine is medically appropriate.			59050 Initiation and/or supervision of internal fetal monitoring during labor by consultant	50.00	59.50
	4. Preventive Medicine			59100 Hysterotomy, abdominal (e.g. for hidatidiform mole, abortion)	315.00	343.20
	NEW PATIENT			EXCISION		
99381	Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; infant (age under 1 year)	\$ 35.00	35.90	59120 Surgical treatment of ectopic pregnancy, tubal or ovarian requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	990.00	517.41
99382	Early childhood (age 1 through 4 years)	39.00	40.00	59121 Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy	932.00	422.00
99383	Late childhood (age 5 through 11 years)	39.00	40.00	59130 Abdominal pregnancy	540.00	457.00
99384	Adolescent (age 12 through 17 years)	35.00	35.90	59135 Interstitial, uterine pregnancy requiring total hysterectomy	1,100.00	753.90
	ESTABLISHED PATIENT			59136 Interstitial, uterine pregnancy with partial resection of uterus	1,100.00	514.00
99391	Periodic evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; infant (age under 1 year)	\$ 35.00	35.90	59140 Cervical, with evacuation	402.70	315.00
99392	Early childhood	36.00	36.95	59150 Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	630.00	374.00
				59151 Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy	850.00	518.00
				59160 Curettage, postpartum (separate procedure)	405.00	192.30
				59200 Insertion of cervical dilator (e.g. laminaria, prostaglandin)	60.65	45.40

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REPAIR			
59300	Episiotomy or vaginal repair, by other than attending physician	\$ 250.00	203.25
59320	Cerclage of cervix, during pregnancy; vaginal	315.00	146.60
59325	Cerclage of cervix, during pregnancy; abdominal	525.00	227.60

DELIVERY, ANTEPARTUM AND POSTPARTUM CARE			
59400	Total obstetrical care (all-inclusive, "global" care) includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps or breech delivery) and postpartum care	\$ 1,200.00	1,178.60
59409	Vaginal delivery only (with or without episiotomy and/or forceps)	828.00	774.00
59410	Vaginal delivery only (with or without episiotomy, forceps or breech delivery) including in-hospital postpartum care (separate procedure)	864.00	816.75

OBSTETRICAL SERVICES

59412	External cephalic version, with or without tocolysis	\$ 250.00	166.65
59414	Delivery of placenta	243.00	95.00
59425	Antepartum care only; 4-6 visits	128.58	235.00
59426	7 or more visits	300.00	403.00
59430	Postpartum care only (separate procedure)	36.00	49.65

CESAREAN SECTION

59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	\$ 1,441.00	1,321.65
59514	Caesarean delivery only	1,098.00	897.00
59515	Cesarean delivery only including postpartum care	1,134.00	1,005.25
59525	Subtotal or total hysterectomy after cesarean delivery	383.00	393.85

ABORTION

59812	Treatment of spontaneous abortion, any trimester, completed surgically	\$ 475.00	395.00
59820	Treatment of missed abortion, completed surgically; first trimester	442.00	381.05
59821	Treatment of missed abortion, completed surgically; second trimester	560.00	239.00

59830	Treatment of septic abortion completed surgically	229.15	268.20
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2. Diagnostic Ultrasound

PELVIS

74710	Pelvimetry, with or without placental localization	42.00	48.30
74775	Perineogram (e.g. vaginogram, for sex determination or extent or anomalies)	36.00	74.70
76805	Echography, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation)	\$ 90.00	97.18
76810	Complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester	180.00	193.85
76815	Limited (gestation age,) heart beat, placental location, fetal position, or emergency in the delivery room)	60.00	64.80
76816	Follow-up or repeat	45.00	50.40
76818	Fetal biophysical profile	75.00	78.70
76825	Echocardiography, fetal, real time with image documentation (2D) with or without M-mode recording	90.00	92.20
76826	Follow-up or repeat study	45.00	68.10
76827	Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display; complete	57.24	91.75
76828	Follow-up or repeat study	28.47	28.80

VR 460-02-4.1924. State Agency Fee Schedule.

§ 1. Reimbursement of fee-for-service providers.

Effective for dates of service on or after July 1, 1995, the Department of Medical Assistance Services (DMAS) shall reimburse fee-for-service providers, with the exception of home health services (see Supplement 3), using a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS).

§ 2. Fee schedule.

A. For those services or procedures which are included in the RBRVS published by the Health Care Financing Administration (HCFA) as amended from time to time, DMAS' fee schedule shall employ the Relative Value Units (RVUs) developed by HCFA as periodically updated.

B. DMAS shall calculate the RBRVS-based fees using conversion factors (CFs) published from time to time by

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HCFA. DMAS shall adjust HCFA's CFs by an additional factor so that no change in expenditure will result solely from the implementation of the RBRVS-based fee schedule. DMAS may revise the additional factor when HCFA updates its RVUs or CFs so that no change in expenditure will result solely from such updates. Except for this adjustment, DMAS' CFs shall be the same as those published from time to time by HCFA. The calculation of the additional factor shall be based on the assumption that no change in services provided will occur as a result of these changes to the fee schedule.

C. For those services or procedures for which there are no established RVs, DMAS shall approximate a reasonable relative value payment level by looking to similar existing relative value fees. If DMAS is unable to establish a relative value payment level for any service or procedure, the fee shall not be based on a RBRVS, but shall instead be based on the previous fee-for-service methodology.

D. Fees shall not vary by geographic locality.

E. The RBRVS-based fees shall be phased in over three years. During the first 12 months of implementation, fees shall be based 1/3 on RBRVS-based fees and 2/3 on previously existing fees. During the second 12 months of implementation, fees shall be based 2/3 on RBRVS-based fees and 1/3 on previously existing fees. Thereafter, fees shall be based entirely on RBRVS-based fees.

V.A.R. Doc. No. R94-1104; Filed July 6, 1994, 11:40 a.m.

VIRGINIA SOIL AND WATER CONSERVATION BOARD

Title of Regulations: VR 625-02-00. Erosion and Sediment Control Regulations.

Statutory Authority: §§ 10.1-502 and 10.1-561 of the Code of Virginia.

Public Hearing Dates:

August 3, 1994 - 7 p.m.

August 4, 1994 - 7 p.m.

Written comments may be submitted until September 26, 1994.

(See Calendar of Events section for additional information)

Basis: The proposed amendments to the regulations are based on the provisions of the Virginia Erosion and Sediment Control Law, Article 4 (§ 10.1-560 et seq.) of Chapter 5 of Title 10.1 of the Code of Virginia. Sections 10.1-502 and 10.1-561 of the Code of Virginia authorize the Virginia Soil and Water Conservation Board to promulgate regulations to implement the Erosion and Sediment Control Law.

Purpose: The purpose of the proposed amendments to the regulations is to achieve the effective control of soil erosion, sediment deposition and nonagricultural

precipitation runoff resulting from land-disturbing activities. The objective is to prevent the degradation of property, stream channels, waters and other natural resources in the Commonwealth. Land-disturbing activities include, but are not limited to, clearing, grading, excavation, transporting and filling of land.

Substance: The proposed amendments to the regulations establish minimum statewide standards for the control of erosion and sediment. These standards provide the basis for local erosion and sediment control programs adopted pursuant to the Erosion and Sediment Control Law. The proposed standards also apply to land-disturbing activities conducted by state agencies.

Issues: The proposed amendments contain a number of new provisions:

1. Definitions. The proposal includes new definitions for: "Agreement in lieu of a Plan, Director (Director of the Department of Conservation and Recreation), Energy dissipator, Hydrologic Unit, Plan-approving authority, Program Administrator, Program Authority, Sediment trap, Shore erosion control project, Single family residence-separately built, and Twenty-five year storm." Amendments are proposed to the definitions for "Adequate channel, Development, Dike, Erosion and Sediment Control Plan, Sediment basin, Slope drain, Stabilized, Stormwater detention, Temporary vehicular stream crossing, Ten-year storm, and Two-year storm." Most changes and issues involve the application of the new or amended definitions throughout the regulations.

2. State Agency coordination. Proper coordination between agencies responsible for various programs related to the Erosion and Sediment Control Law is an issue. Coordination with terminology used by the Chesapeake Bay Local Assistance Board and Department has been made throughout these proposed amendments.

3. Legal exemption determinations. Exempt status of certain projects is an issue. The current regulations allow land disturbances for up to one year before the local program authority may challenge the project's exempt status. The proposal eliminates this time delay. In addition, HB 492 of the 1994 Virginia General Assembly provides for coordination by the local E & S Control program authority with the Virginia Department of Forestry to determine whether a certain land disturbing activity qualifies for the silvicultural exemption.

4. Inspection intervals. There is continuing discussion concerning the proper time interval for regular periodic inspections (2 weeks) and for inspections immediately following a runoff producing storm event (48 hours). These time periods were left as current regulation states.

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Impact: The proposed amendments to the regulations affect all soil and water conservation districts, all local governments that adopt erosion and sediment control programs, and all state agencies that engage in land-disturbing activities. Currently 171 local governments have adopted programs leaving one Soil and Water Conservation District administering a program. There are 400 estimated state agency land-disturbing projects commenced annually.

The proposed amendments to the regulations also indirectly affect all land-disturbing activities statewide through the implementation of local erosion and sediment control programs, with the exception of those activities specifically exempted by the Erosion and Sediment Control Law.

Affected Locality: No locality will be particularly impacted more than another by the adoption of this regulation. As stated above 171 local governments have adopted Erosion and Sediment Control Programs. The proposed regulations provide additional flexibility to the localities in the actual administration of the program.

Applicable Federal Requirements: These regulations are based upon Virginia law and are not in response to any federal law.

Summary:

This regulatory action is necessary to amend the existing regulations which became effective September 13, 1990, due to the passage of Chapter 925 of the 1993 Virginia Acts of Assembly and other legislative changes since last amended.

The regulations establish minimum statewide standards for the control of soil erosion, sediment deposition and nonagricultural runoff from land-disturbing activities that must be met in local erosion and sediment control programs, and also by state agencies that conduct land-disturbing activities. Land-disturbing activities include, but are not limited to, clearing, grading, excavating, transporting and filling of land.

VR 625-02-00. Erosion and Sediment Control Regulations.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meaning, unless the context clearly indicates otherwise. In addition, some terms not defined herein are defined in § 10.1-560 of the Erosion and Sediment Control Law.

"Act" means the Erosion and Sediment Control Law, Article 4 (§ 10.1-560 et seq.) of Chapter 5 of Title 10.1 of the Code of Virginia.

"Adequate channel" means a watercourse that will

convey a ~~chosen~~ *the designated* frequency storm event without overtopping its banks or causing erosive damage to the bed, banks and overbank sections of the same.

"Agreement in lieu of a plan" means a contract between the program authority and the owner which specifies conservation measures which must be implemented in the construction of a single-family residence; this contract may be executed by the program authority in lieu of an erosion and sediment control plan.

"Applicant" means any person submitting an erosion and sediment control plan or an agreement in lieu of a plan for approval or requesting the issuance of a permit, when required, authorizing land-disturbing activities to commence.

"Board" means the Virginia Soil and Water Conservation Board.

"Causeway" means a temporary structural span constructed across a flowing watercourse or wetland to allow construction traffic to access the area without causing erosion damage.

"Channel" means a natural stream or manmade waterway.

"Cofferdam" means a watertight temporary structure in a river, lake, etc., for keeping the water from an enclosed area that has been pumped dry so that bridge foundations, dams, etc., may be constructed.

"Dam" means a barrier to confine or raise water for storage or diversion, to create a hydraulic head, to prevent gully erosion, or to retain soil, rock or other debris.

"Denuded" means a term applied to land that has been physically disturbed and no longer supports vegetative cover.

"Department" means the Department of Conservation and Recreation.

"Development" means a tract or parcel of land developed or to be developed as a single unit under single ownership or unified control which is to be used for any business or industrial purpose or is to contain three or more residential dwelling units.

"Dike" means an earthen embankment constructed to confine or control water, especially one built along the banks of a river to prevent overflow of lowlands; levee.

"Director" means the Director of the Department of Conservation and Recreation.

"District" or "soil and water conservation district" means a political subdivision of the Commonwealth organized in accordance with the provisions of Article 3 (§

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10.1-506 et seq.) of Chapter 5 of Title 10.1 of the Code of Virginia.

"Diversion" means a channel with a supporting earthen ridge on the lower side constructed across or at the bottom of a slope for the purpose of intercepting surface runoff.

"Division" means the Division of Soil and Water Conservation.

"Dormant" refers to denuded land that is not actively being brought to a desired grade or condition.

"Energy dissipator" means a nonerodible structure which reduces the velocity of concentrated flow to reduce its erosive effects.

"Erosion and sediment control plan," "conservation plan" or "plan," means a document containing material for the conservation of soil and water resources of a unit or group of units of land. It may include appropriate maps, an appropriate soil and water plan inventory and management information with needed interpretations, and a record of decisions contributing to conservation treatment. The plan shall contain all major conservation decisions and all information deemed necessary by the plan-approving authority to assure that the entire unit or units of land will be so treated to achieve the conservation objectives.

"Flume" means a constructed device lined with erosion-resistant materials intended to convey water on steep grades.

"Hydrologic unit" means a defined land area drained by a river/stream or system of connecting rivers/streams such that all surface water within the area flows through a single outlet.

"Live watercourse" means a definite channel with bed and banks within which concentrated water flows continuously.

"Locality" means a county, city or town.

"Natural stream" means nontidal waterways that are part of the natural topography. They usually maintain a continuous or seasonal flow during the year and are characterized as being irregular in cross-section with a meandering course. Constructed channels such as drainage ditches or swales shall not be considered natural streams.

"Nonerodible" means a material, e.g., riprap, concrete, plastic, etc., that will not experience surface wear due to natural forces.

"Person" means any individual, partnership, firm, association, joint venture, public or private corporation, trust, estate, commission, board, public or private institution, utility, cooperative, county, city, town or other

political subdivision of the Commonwealth, any interstate body, or any other legal entity.

"Plan-approving authority" means the board, ~~the district or a county, city, or town, or the program authority,~~ a department of a county, city, or town, program authority, or an agent of the program authority responsible for determining the adequacy of a conservation plan submitted for land-disturbing activities on a unit or units of land and for approving plans.

"Post-development" refers to conditions that may be reasonably expected or anticipated to exist after completion of the land development activity on a specific site or tract of land.

"Program administrator" means the person or persons responsible for administering and enforcing the erosion and sediment control program of a program authority.

"Program authority" means a district, county, city, or town which has adopted a soil erosion and sediment control program which has been approved by the board.

"Pre-development" refers to conditions at the time the erosion and sediment control plan is submitted to the plan-approving authority. Where phased development or plan approval occurs (preliminary grading, roads and utilities, etc.), the existing conditions at the time the erosion and sediment control plan for the initial phase is submitted for approval shall establish pre-development conditions.

"Sediment basin" means a depression formed from the construction of a barrier or dam built to retain sediment and debris, temporary impoundment built to retain sediment and debris with a controlled stormwater release structure.

"Sediment trap" means a temporary impoundment built to retain sediment and debris which is formed by constructing an earthen embankment with a stone outlet.

"Sheet flow" (also called overland flow) means shallow, unconsolidated and irregular flow down a slope. The length of strip for overland flow usually does not exceed 200 feet under natural conditions.

"Shore erosion control project" means an erosion control project approved by local wetlands boards, the Virginia Marine Resources Commission, the Virginia Department of Environmental Quality or the United States Army Corps of Engineers and located on tidal waters and within nonvegetated or vegetated wetlands as defined in § 28.2 of the Code of Virginia.

"Single family residence separately built" means a nonecommercial dwelling that is occupied exclusively by one family and not part of a residential subdivision development.

"Slope drain" means tubing or conduit made of nonerosive material extending from the top to the bottom of a cut or fill slope with an energy dissipator at the outlet end.

"Stabilized" means an area land that can be expected has been treated to withstand normal exposure to atmospheric conditions natural forces without incurring erosion damage.

"Storm sewer inlet" means a structure through which stormwater is introduced into an underground conveyance system.

"Stormwater detention" means the process of temporarily impounding runoff to reduce flood peaks and discharging it through a hydraulic outlet structure to a downstream conveyance system.

"Stormwater retention" means the process by which an impoundment structure stores the total runoff of a given storm and then releases the flow at a controlled rate over an extended period.

"Subdivision" unless otherwise defined in a local ordinance adopted pursuant to § 15.1-465 of the Code of Virginia, means the division of a parcel of land into three or more lots or parcels of less than five acres each for the purpose of transfer of ownership or building development, or, if a new street is involved in such division, any division of a parcel of land. The term includes resubdivision and, when appropriate to the context, shall relate to the process of subdividing or to the land subdivided.

"Temporary stream crossing" "Temporary vehicular stream crossing" means a temporary nonerodible structural span installed across a flowing watercourse for use by construction traffic. Structures may include bridges, round pipes or pipe arches constructed on or through nonerodible material.

"Ten-year frequency storm" means a storm that is capable of producing rainfall expected to be equaled or exceeded on the average of once in 10 years. It may also be expressed as an exceedence probability with a 10% chance of being equaled or exceeded in any given year.

"Two-year frequency storm" means a storm that is capable of producing rainfall expected to be equaled or exceeded on the average of once in two years. It may also be expressed as an exceedence probability with a 50% chance of being equaled or exceeded in any given year.

"Twenty-five year storm" means a storm that is capable of producing rainfall expected to be equaled or exceeded on the average of once in 25 years. It may also be expressed as exceedence probability with a 4.0% chance of being equaled or exceeded in any given year.

§ 1.2. Authority.

The authority for these regulations is contained in Article 4 (§ 10.1-560 et seq.) of Chapter 5 of Title 10.1 of the Code of Virginia, particularly § 10.1-561.

§ 1.3. Purpose.

The purpose of these regulations is to form the basis for the administration, implementation and enforcement of the Act. The intent of these regulations is to establish the framework for compliance with the Act while at the same time providing flexibility for innovative solutions to erosion and sediment control concerns.

§ 1.4. Scope and applicability.

A. These regulations set forth minimum standards for the effective control of soil erosion, sediment deposition and nonagricultural runoff that are required to *must* be met in erosion and sediment control programs adopted by districts and localities under the Act.

B. The standards contained in these regulations also apply to:

1. In erosion and sediment control programs adopted by districts and localities under § 10.1-562 of the Act.

2. Erosion In erosion and sediment control plans that may be submitted directly to the board pursuant to § 10.1-563 A of the Act;

3. Annual In annual general erosion and sediment control specifications that electric and telephone utility companies and railroad companies are required to file with the board pursuant to § 10.1-563 D of the Act;

4. Conservation In conservation plans and annual specifications that state agencies are required to file with the department pursuant to § 10.1-564 of the Act; and

5. Federal By federal agencies that enter into agreements with the board.

C. B. The submission of annual specifications to the board or the department by any agency or company does not eliminate the need for a project specific erosion and sediment control plan.

C. These regulations must be incorporated into the local erosion and sediment control program within one year of their effective date.

§ 1.5. Minimum standards.

An erosion and sediment control program adopted by a district or locality shall contain regulations that are *must* be consistent with the following criteria, techniques and methods:

1. Permanent or temporary soil stabilization shall be

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applied to denuded areas within seven days after final grade is reached on any portion of the site. Temporary soil stabilization shall be applied within seven days to denuded areas that may not be at final grade but will remain dormant (~~undisturbed~~) for longer than 30 days. Permanent stabilization shall be applied to areas that are to be left dormant for more than one year.

2. During construction of the project, soil stock piles *and borrow areas* shall be stabilized or protected with sediment trapping measures. The applicant is responsible for the temporary protection and permanent stabilization of all soil stockpiles on site as well as *borrow areas and* soil intentionally transported from the project site.

3. A permanent vegetative cover shall be established on denuded areas not otherwise permanently stabilized. Permanent vegetation shall not be considered established until a ground cover is achieved that ; ~~in the opinion of the local program administrator or his designated agent,~~ is uniform, mature enough to survive and will inhibit erosion.

4. Sediment basins and traps, perimeter dikes, sediment barriers and other measures intended to trap sediment shall be constructed as a first step in any land-disturbing activity and shall be made functional before upslope land disturbance takes place.

5. Stabilization measures shall be applied to earthen structures such as dams, dikes and diversions immediately after installation.

6. *Sediment traps and sediment basins shall be designed and constructed based upon the total drainage area to be served by the trap or basin.*

a. The minimum storage capacity of a sediment trap shall be 134 cubic yards per acre of drainage area and the trap shall only control drainage areas less than three acres.

b. Surface runoff from disturbed areas that is comprised of flow from drainage areas greater than or equal to three acres shall be controlled by a sediment basin. The sediment basin shall be designed and constructed to accommodate the anticipated sediment loading from the land-disturbing activity. The outfall device or system design shall take into account the total drainage area flowing through the disturbed area to be served by the basin. The minimum storage capacity of a sediment basin shall be 134 cubic yards per acre of drainage area. The outfall system shall, at a minimum, maintain the structural integrity of the basin during a 25 year storm of 24-hour duration. Runoff coefficients used in runoff calculations shall correspond to a bare earth condition or those conditions expected to exist while the sediment

basin is utilized.

7. Cut and fill slopes shall be designed and constructed in a manner that will minimize erosion. Slopes that are found to be eroding excessively within one year of permanent stabilization shall be provided with additional slope stabilizing measures until the problem is corrected.

8. Concentrated runoff shall not flow down cut or fill slopes unless contained within an adequate temporary or permanent channel, flume or slope drain structure.

9. Whenever water seeps from a slope face, adequate drainage or other protection shall be provided.

10. All storm sewer inlets that are made operable during construction shall be protected so that sediment-laden water cannot enter the conveyance system without first being filtered or otherwise treated to remove sediment.

11. Before newly constructed stormwater conveyance channels *or pipes* are made operational, adequate outlet protection and any required temporary or permanent channel lining shall be installed in both the conveyance channel and receiving channel.

12. When work in a live watercourse is performed, precautions shall be taken to minimize encroachment, control sediment transport and stabilize the work area to the greatest extent possible during construction. Nonerrodible material shall be used for the construction of causeways and cofferdams. Earthen fill may be used for these structures if armored by nonerrodible cover materials.

13. When a live watercourse must be crossed by construction vehicles more than twice in any six-month period, a temporary *vehicular* stream crossing constructed of nonerrodible material shall be provided.

14. All applicable federal, state and local regulations pertaining to working in or crossing live watercourses shall be met.

15. The bed and banks of a watercourse shall be stabilized immediately after work in the watercourse is completed.

16. Underground utility lines shall be installed in accordance with the following standards in addition to other applicable criteria:

a. No more than 500 linear feet of trench may be opened at one time.

b. Excavated material shall be placed on the uphill side of trenches.

c. Effluent from dewatering operations shall be

filtered or passed through an approved sediment trapping device, or both, and discharged in a manner that does not adversely affect flowing streams or off-site property.

d. Material used for backfilling trenches shall be properly compacted in order to minimize erosion and promote stabilization.

d. e. Restabilization shall be accomplished in accordance with these regulations.

e. f. Applicable safety regulations shall be complied with.

17. Where construction vehicle access routes intersect paved or public roads, provisions shall be made to minimize the transport of sediment by vehicular tracking onto the paved surface. Where sediment is transported onto a paved or public road surface, the road surface shall be cleaned thoroughly at the end of each day. Sediment shall be removed from the roads by shoveling or sweeping and transported to a sediment control disposal area. Street washing shall be allowed only after sediment is removed in this manner. This provision shall apply to individual subdivision development lots as well as to larger land-disturbing activities.

18. All temporary erosion and sediment control measures shall be removed within 30 days after final site stabilization or after the temporary measures are no longer needed, unless otherwise authorized by the local program administrator authority. Trapped sediment and the disturbed soil areas resulting from the disposition of temporary measures shall be permanently stabilized to prevent further erosion and sedimentation.

19. Properties and waterways downstream from development sites shall be protected from sediment deposition, erosion and damage due to increases in volume, velocity and peak flow rate of stormwater runoff for the stated frequency storm of 24-hour duration in accordance with the following standards and criteria:

a. Concentrated stormwater runoff leaving a development site shall be discharged directly into an adequate natural or man-made receiving channel, pipe or storm sewer system. For those sites where runoff is discharged into a pipe or pipe system, downstream stability analyses at the outfall of the pipe or pipe system shall be performed.

b. Adequacy of all channels and pipes shall be verified in the following manner:

(1) The applicant shall demonstrate that the total drainage area to the point of analysis within the channel is one hundred times greater than the

contributing drainage area of the project in question ; ; or

(2) (a) Natural channels shall be analyzed by the use of a two-year frequency storm to verify that stormwater will not overtop channel banks nor cause erosion of channel bed or banks ; ;

(3) (b) All previously constructed man-made channels shall be analyzed by the use of a ten-year frequency storm to verify that stormwater will not overtop its banks and by the use of a two-year storm to demonstrate that stormwater will not cause erosion of channel bed or banks ; ; and

(4) (c) Pipes and storm sewer systems shall be analyzed by the use of a ten-year frequency storm to verify that stormwater will be contained within the pipe or system.

c. If existing natural receiving channels or previously constructed man-made channels or pipes are not adequate, the applicant shall:

(1) Improve the channels to a condition where a ten-year frequency storm will not overtop the banks and a two-year frequency storm will not cause erosion to channel the bed or banks;

(2) Improve the pipe or pipe system to a condition where the ten-year frequency storm is contained within the appurtenances; or

(3) Develop a site design that will not cause the pre-development peak runoff rate from a two-year storm to increase when runoff outfalls into a natural channel or will not cause the pre-development peak runoff rate from a ten-year storm to increase when runoff outfalls into a man-made channel ; ; or

(4) Provide a combination of channel improvement, stormwater detention ~~retention~~ or other measures which is satisfactory to the plan-approving authority to prevent downstream erosion.

d. The applicant shall provide evidence of permission to make the improvements.

e. All hydrologic analyses shall be based on the existing watershed characteristics and the ultimate development condition of the subject project.

f. If the applicant chooses an option that includes stormwater detention ~~retention~~, he shall obtain approval from the locality of a plan for maintenance of the detention facilities. The plan shall set forth the maintenance requirements of the facility and the person responsible for performing the maintenance.

g. Outfall from a detention facility shall be

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discharged to a receiving channel, and energy dissipators shall be placed at the outfall of all detention facilities as necessary to provide a stabilized transition from the facility to the receiving channel.

h. All on-site channels must be verified to be adequate.

~~g.~~ *i. Increased volumes of sheet flows that may cause erosion or sedimentation on adjacent property shall be diverted to a stable outlet, adequate channel, pipe or pipe system, or to a detention facility.*

~~h.~~ *j. In applying these stormwater management criteria, individual lots or parcels in a residential subdivision, commercial or industrial development shall not be considered to be separate development projects. Instead, the residential subdivision development, as a whole, shall be considered to be a single development project. Hydrologic parameters that reflect the ultimate subdivision development condition shall be used in all engineering calculations.*

~~i.~~ *Proposed commercial or industrial subdivisions shall apply these stormwater management criteria to the development as a whole. Hydrologic parameters that reflect the ultimate subdivision development shall be used in all engineering calculations.*

k. All measures used to protect properties and waterways shall be employed in a manner which minimizes impacts on the physical, chemical and biological integrity of rivers, streams and other waters of the state.

§ 1.6. Variances.

The plan-approving authority may waive or modify any of the regulations that are deemed inappropriate or too restrictive for site conditions, by granting a variance. A variance may be granted under these conditions:

1. At the time of plan submission, an applicant may request a variance to become part of the approved erosion and sediment control plan. The applicant shall explain the reasons for requesting variances in writing. Specific variances which are allowed by the plan-approving authority shall be documented in the plan.

2. During construction, the person responsible for implementing the approved plan may request a variance in writing from the plan-approving authority. The plan-approving authority shall respond in writing either approving or disapproving such a request. If the plan-approving authority does not approve a variance within 10 days of receipt of the request, the request shall be considered to be disapproved. Following

disapproval, the applicant may resubmit a variance request with additional documentation.

3. The plan-approving authority shall consider variance requests judiciously, keeping in mind both the need of the applicant to maximize cost effectiveness and the need to protect off-site properties and resources from damage.

§ 1.7. Maintenance and inspections.

A. All erosion and sediment control structures and systems shall be maintained, inspected and repaired as needed to insure continued performance of their intended function. A statement describing the maintenance responsibilities of the permittee shall be included in the approved erosion and sediment control plan.

B. Periodic inspections are required on all projects by the enforcement program authority. ~~Am~~ *The program authority shall provide for an inspection shall be made during or immediately following initial installation of erosion and sediment controls, at least once in every two-week period, within 48 hours following any runoff producing storm event, and at the completion of the project prior to the release of any performance bonds.*

§ 1.8. Residential subdivision development *Developments* .

A. An erosion and sediment control plan shall be filed for a residential development and the buildings constructed within, regardless of the phasing of construction.

B. If individual lots or sections in a residential development are being developed by different property owners, all land-disturbing activities related to the building construction shall be covered by an erosion and sediment control plan or an "Agreement in Lieu of a Plan" signed by the property owner.

C. Land-disturbing activity of less than 10,000 square feet on individual lots in a residential development shall not be considered exempt from the provisions of the Act and these regulations *if the total land-disturbing activity in the development is equal to or greater than 10,000 square feet*

~~D.~~ *The construction of permanent roads or driveways that disturb in excess of 10,000 square feet and that serve more than one single-family residence separately built is not exempt from the requirements of the Act and these regulations.*

§ 1.9. Criteria for determining status of land-disturbing activity.

A. A property owner who disturbs 10,000 square feet, or more, of land and claims that the activity is exempted from the requirements of the Act as shown in § 10.1-560 of the Code of Virginia shall have one year from the date of commencement of the activity to demonstrate to the

erosion and sediment control enforcement authority that the activity is exempt. As soon as a nonexempt status is determined, the requirements of the Act shall be immediately enforced. The program administrator shall determine the validity of a claim of exempt status by a property owner who disturbs 10,000 square feet or more. As soon as a nonexempt status is determined, the requirements of the Act shall be immediately enforced.

B. Should a land-disturbing activity not begin during the 180-day period following plan approval or cease for more than 180 days, the plan-approval authority or the permit-issuing authority shall may evaluate the existing approved erosion and sediment control plan to determine whether the plan still satisfies local and state erosion and sediment control criteria and to verify that all design factors are still valid. If the authority finds the previously filed plan to be inadequate, a modified plan shall be submitted and approved prior to the resumption of land-disturbing activity.

C. Shore erosion control projects are not subject to these regulations. However, land-disturbing activity immediately outside the limits of the shore erosion project is subject to the Act and these regulations.

D. Whenever land-disturbing activity involves activity at a separate location (including but not limited to borrow and disposal areas), the program authority may either:

1. Consider the off-site activity as being part of the proposed land-disturbing activity; or

2. If the off-site activity is already covered by an approved erosion and sediment control plan, the program authority may require the applicant to provide proof of the approval and to certify that the plan will be implemented in accordance with the Act and these regulations.

§ 1.10. Review and evaluation of local programs: minimum program standards.

A. This section sets forth the criteria that will be used by the department to determine whether a local program operating under authority of the Act, satisfies minimum standards of effectiveness, as follows.

Each local program must contain an ordinance or other appropriate document(s) adopted by the governing body. Such document(s) must be consistent with the Act and regulations (VR 625-02-00 and VR 625-02-01), including the following criteria:

1. The document(s) shall include or reference the definition of land-disturbing activity including exemptions, as well as any other significant terms, as necessary to produce an effective local program.

2. The document(s) shall identify the plan-approving authority and other positions of authority within the

program, and must include the regulations and design standards to be used in the program.

3. The document(s) shall include procedures for submission and approval of plans, issuance of permits, monitoring and inspections of land-disturbing activities. The position, agency, department, or other party responsible for conducting inspections shall be identified. The local program authority shall maintain, either on-site or in local program files, a copy of the approved plan and a record of inspections for each active land-disturbing activity.

4. The local program authority must take appropriate enforcement actions to achieve compliance with the program and maintain a record of enforcement actions for all active land-disturbing activities.

B. The department staff, under authority of the board, shall periodically conduct a comprehensive review and evaluation of local programs. The review of a local program shall consist of the following: (i) personal interview between the department staff and the local program administrator or designee(s); (ii) review of the local ordinance and other applicable documents; (iii) review of plans approved by the program; (iv) inspection of regulated activities; and (v) review of enforcement actions.

C. Local programs shall be reviewed and evaluated for effectiveness in carrying out the Act using the criteria in this section. However, the director is not limited to the consideration of only these items when assessing the overall effectiveness of a local program.

D. If the director determines that the deficiencies noted in the review will cause the local erosion and sediment control program to be inconsistent with the state program and regulations, the director shall notify the local program authority concerning the deficiencies and provide a reasonable period of time for corrective action to be taken. If the program authority fails to take the corrective action within the specified time, the director may formally request board action pursuant to § 10.1-562 of the Code of Virginia.

E. Review and evaluation of local programs shall be conducted according to a schedule adopted by the board.

§ ~~1.10~~. 1.11. State agency projects.

A. All state agency land-disturbing activities that are not exempt and that have commenced without an approved erosion and sediment control plan shall immediately cease until an erosion and sediment control plan has been submitted to and approved by the department. A formal "Notice of Permit Plan Requirement" will be sent to the state agency under whose purview the project lies since that agency is responsible for compliance with the Act.

B. Where inspections by ~~division~~ department personnel

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reveal deficiencies in carrying out an approved plan, the person responsible for carrying out the plan, as well as the state agency responsible, will be issued a notice to comply with specific actions and the deadlines that shall be met. Failure to meet the prescribed deadlines can result in the issuance of a stop work order for all land-disturbing activities on the project at the discretion of the Chief Administrative Officer of the Board, who is authorized to sign such an order. The stop work order will be lifted once the required erosion and sediment control measures are in place and inspected by ~~division~~ department staff.

C. Whenever the Commonwealth or any of its agencies fails to comply within the time provided in an appropriate final order, the director of the department may petition for compliance as follows: For violations in the Natural Resources Secretariat, to the secretary of Natural Resources; for violations in other secretariats, to the appropriate Secretary; for violations in other state agencies, to the head of such agency. Where the petition does not achieve timely compliance, the director shall bring the matter to the Governor for resolution.

D. Where compliance will require the appropriation of funds, the director shall cooperate with the appropriate agency head in seeking such an appropriation; where the director determines that an emergency exists, he shall petition the Governor for funds from the Civil Contingency Fund or other appropriate source.

§ 1.12. Board adopted local erosion and sediment control programs.

A. To carry out its duties under § 10.1-562 of the Code of Virginia, the board shall develop, adopt, and administer an appropriate local erosion and sediment control program for the locality under consideration. In fulfilling these duties, the board shall assume the full powers of the local erosion and sediment control program granted by law.

B. The board shall develop, adopt and administer a local erosion and sediment control program based on the minimum program standards established by these regulations and, as deemed appropriate by the board, may include any or all of the provisions provided by law and regulations including administrative fees and performance securities.

C. Upon adoption of a local erosion and sediment control program by the board, payment of moneys, including fees, securities, and penalties, shall be made to the state treasury.

D. When administering a local erosion and sediment control program the board may delegate to the director such operational activities as necessary. Further, the board may enter into agreements with other public or private entities to accomplish certain program responsibilities as it deems necessary to administer the

local program.

VA.R. Doc. No. R94-1102; Filed July 5, 1994, 3:59 p.m.

APPENDIX A.1 is published as supplemental guidance to the proposed regulation; however, is not part of the proposed regulation.

[APPENDIX A.1

REVIEW AND EVALUATION OF A LOCAL EROSION AND SEDIMENT CONTROL PROGRAM

PART I: ADMINISTRATION

The following checklist will be used as a guide in reviewing the administration component of a local erosion and sediment control program, minimum standards of effectiveness in accordance with §10.1-561 of the Code of Virginia and regulations VR 625-02-00 and VR 625-02-01.

- Locality has a certified Program Administrator or a person who meets the provisions in the definition of certified program administrator.

Ordinance:

** Denotes items that are required by state law or are considered to be essential in order for the ordinance to meet minimum standards of program effectiveness.

- Authority section referencing state code

Definitions (Reference to §10.1-560)

- → Applicant, owner, permittee, person, or other (as appropriate)
- Plan
- Program Authority
- Plan-approving Authority
- Certified Inspector
- Certified Program Administrator
- Certified Plan Reviewer

** Land-disturbing Activity:

** Exemptions

- ** Minor land-disturbing activities (landscaping, home gardening, etc.)

CONTINUATION OF APPENDIX A.1

- ** Individual service connections
- ** Underground utilities on hard surface roads
- ** Septic systems
- ** Mining
- ** Exploration for gas and oil
- ** Tilling, planting, harvesting, etc. for agriculture, silviculture, etc.
- ** Railroad repair, rebuilding, other facilities
- ** Agricultural engineering operations
- ** Less than 10,000 square feet (may be reduced)
- ** Fence, post, poles, signs
- ** Shore erosion control projects (not required for localities outside of the tidal zone)
- ** Emergency Work

Local Program

- ** Designate Plan-approving Authority
- ** Adopt Virginia Erosion and Sediment Control Regulations or more stringent standards as an integral part of the program.
- ** Designate design standards to be used in plan review and inspection (e.g., VESCH, local manual, etc.)

Regulated Land-disturbing Activities: Submission and Approval of Plans,

- ** No land-disturbing activity allowed without an approved plan or agreement in lieu of a plan
- ** Board option for plan approval of multi-jurisdictional projects

CONTINUATION OF APPENDIX A.1

- ** 45-day (maximum) plan review
- ** Written response within 45 days
- Plan can be changed if:
 - Inspection reveals inadequacy (agreement not required)
 - Controls are unnecessary due to changed circumstances, request for variance, etc. (plan-approving authority must approve)
- ** Owner is responsible for plan

Approved plan required for issuance of permit, securities

- ** No permits which authorize land-disturbing activity issued without approved erosion and sediment control plan
- ** Certification to carry out plan
- Provision to require security
- Refund of security within 60 days of adequate stabilization

Monitoring, Inspections

- Locality must provide for periodic inspections
- ** Notice of inspection given to responsible party
- ** Procedures for issuing Notice to Comply
- ** Designate inspector/inspection department
- Provisions for issuing stop work order and revoking permit

Appeals

- ** Appeals must be filed within 30 days (minimum)
- Appeal district decision (if applicable)

CONTINUATION OF APPENDIX A.1

Judicial appeal

Penalties and Other Legal Actions

- ** Class I Misdemeanor (not required if the locality has adopted a schedule of civil penalties)
- Civil penalty
- Civil fines

Administration Evaluation Guidelines

The following guidelines will be used in evaluating the administration component of a local erosion and sediment control program.

- Inconsistent
One or more of the required items are not included.
- Provisionally Consistent
The program does not meet all the requirements; however, the locality has agreed to correct the deficiency(s) within a specified time period.
- Consistent
This rating applies to programs that contain all the required items in the checklist. This rating also applies to programs that contain, reference, or operate in concert with other provisions which adequately satisfy the requirements.

CONTINUATION OF APPENDIX A.1

PART II: PLAN REVIEW

The following checklist will be used as a guide in reviewing the plan review component of a local erosion and sediment control program, minimum standards of effectiveness in accordance with §10.1-561 of the Code of Virginia and regulations VR 625-02-00 and VR 625-02-01.

Required items for Local Plan Review:

- Plans are reviewed by certified plan reviewer or by a person who meets the provisions in the definition of a certified plan reviewer.
- Plans are reviewed within 45 days of receipt. Plans which are not deemed adequate are required to be revised prior to approval.
- Plan reviewer states in writing the reason(s) for disapproval and specifies the modifications, terms, and conditions that will permit approval of the plan.
- Approved plans comply with state Minimum Standards for controlling erosion and the locally-adopted design criteria or an appropriate variance is granted.
- Locality maintains a copy of approved plan or agreement in lieu of plan until final stabilization is achieved.

CONTINUATION OF APPENDIX A.1

Plan Review Evaluation Guidelines

The following guidelines will be used in evaluating the plan review component of the local erosion and sediment control program.

- Inconsistent
One or more of the required items are not included. This rating also applies to programs in which plans are not required pursuant to §10.1-565.
- Provisionally Consistent
The program does not meet all the requirements; however, the locality has agreed to correct the deficiency(s) within a specified time period.
- Consistent
This rating applies to programs that contain all the required items in the checklist. This rating also applies to programs that contain, reference, or operate in concert with other provisions which adequately satisfy the requirements.

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CONTINUATION OF APPENDIX A.1

PART III: INSPECTION

The following checklist will be used as a guide in reviewing the inspection component of a local erosion and sediment control program, minimum standards of effectiveness in accordance with §10.1-561 of the Code of Virginia and regulations VR 625-02-00 and VR 625-02-01.

Required Items of Local Inspection Program:

- Inspections are performed by certified inspector or by a person who meets the provisions in the definition of a certified inspector.
- Inspections are conducted during or immediately following initial installation of erosion and sediment controls.
- Inspections frequency satisfies the requirement in Section 1.7 of the Regulations.
 - Inspections are conducted at least once in every two week period
 - Inspections are conducted within 48 hours of runoff-producing storm events.
 - If no, describe the local inspection procedures and evaluate the effectiveness:
- Inspections are documented on report/violation forms, inspection diary, etc. Documentation includes project name, date, violations, and other essential information.
- Record of inspections assures quality of inspections is adequate by noting all violations, deadlines for correcting violations, and changes or maintenance that are required. Department staff verify periodically or during program review process that inspections ensure compliance with program standards.

Inspection Evaluation Guidelines

The following guidelines shall be used in evaluating the inspection component of a local erosion and sediment control program.

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CONTINUATION OF APPENDIX A.1

- Inconsistent
One or more of the required items are not included.
- Provisionally Consistent
The program does not meet all the requirements; however, the locality has agreed to correct the deficiency(ies) within a specified time period.
- Consistent
This rating applies to programs that contain all the required items in the checklist. This rating also applies to programs that contain, reference, or operate in concert with other provisions which adequately satisfy the requirements.

Appendix A.1 - 8

CONTINUATION OF APPENDIX A.1

PART IV: ENFORCEMENT

The following checklist will be used as a guide in reviewing the enforcement component of a local erosion and sediment control program, minimum standards of effectiveness in accordance with §10.1-561 of the Code of Virginia and regulations VR 625-02-00 and VR 625-02-01.

Required items for the Local Enforcement Program:

- Locality maintains record of written notification of violations. Notification must be in accordance with Virginia Erosion and Sediment Control law.
- Notice to Comply orders contain specific measures or corrections which need to be made and specify deadlines for completion.
- Stop Work Orders, court action, bond revocation, or other appropriate actions are initiated after notice to comply deadline has passed without compliance with the order.

CONTINUATION OF APPENDIX A.1

Enforcement Evaluation Guidelines

The following guidelines will be used in evaluating the enforcement component of a local erosion and sediment control program.

- Inconsistent
One or more of the required items are not included. This rating also applies to programs that do not consistently initiate enforcement action when needed and/or Board has had to take enforcement action due to lack of local enforcement.
- Provisionally Consistent
The program does not meet all the requirements; however, the locality has agreed to correct the deficiency(s) within a specified time period.
- Consistent
This rating applies to programs that contain all the required items in the checklist, and program requirements are consistently enforced by a written notice, notice to comply, stop work order, or other appropriate action. (This rating also applies to programs that contain, reference, or operate in concert with other provisions which adequately satisfy the requirements.)

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Title of Regulation: VR 625-02-01. Erosion and Sediment Control Certification Regulations.

Statutory Authority: §§ 10.1-502 and 10.1-561 of the Code of Virginia.

Public Hearing Dates:

August 3, 1994 - 7 p.m.

August 4, 1994 - 7 p.m.

Written comments may be submitted until September 26, 1994.

(See Calendar of Events section for additional information)

Basis: The proposed regulations are based on the provisions of the Virginia Erosion and Sediment Control Law, Article 4 (§ 10.1-560 et seq.) of Chapter 5 of Title 10.1 of the Code of Virginia. Sections 10.1-502 and 10.1-561 of the Code of Virginia authorize the Virginia Soil and Water Conservation Board to promulgate regulations to implement the Erosion and Sediment Control Law.

Purpose: The purpose of the proposed regulations is to establish requirements and guidelines for the issuance of certificates of competence by the Virginia Soil and Water Conservation Board concerning the content, application and intent of the Erosion and Sediment Control Act and accompanying regulations including program administration, plan review and project inspection. The objective is to provide an educated and informed group of individuals to effectively and efficiently implement the state Erosion and Sediment Control Act and regulations through state and local programs and the private sector.

Substance: The proposed regulations establish minimum statewide standards for the certification of erosion and sediment control plan reviewers, inspectors, and program administrators. The regulations provide four classifications of certification: Program Administrator, Plan Reviewer, Inspector, and Combined Administrator. In addition, the regulations provide for eligibility requirements, fees, examinations, applications, and discipline of certified personnel.

Issues: The proposed regulations are entirely new and thus all new provisions:

1. Definitions. The proposal includes new definitions for: "Applicant, Board (Virginia Soil and Water Conservation Board), Certification, Certified inspector, Certified plan reviewer, Certified program administrator, Certified combined administrator, Classification, Department (Department of Conservation and Recreation), Erosion and Sediment Control Plan, Inspector, Plan reviewer, Program administrator, Program authority, and state erosion and sediment control program." Most issues involve the application of the new definitions throughout the regulations.

2. Certification of State Agency Personnel. The law clearly mandates certification requirements for local program personnel. This requirement is not so clear for individuals conducting work for state agencies. It is clear that individuals who demonstrate the proper knowledge, skills and abilities may be issued certificates of competence and these regulations will cover those individuals including state agency personnel and private sector individuals.

3. Grandfathering Existing Certificates of Competence. Prior to the adoption of mandatory certification requirements for local government personnel, the board offered certification under a voluntary program. The revised Act provides for grandfathering of individuals holding current certificates of competence from the board. There may be some confusion since the board previously offered two levels of certification for plan review and inspection. Level I was considered a prerequisite for level II certification which is interpreted to be a certificate of competence. Since level I is preliminary and does not represent certification for the full range of knowledge, skills and abilities required, level I certificate holders will not be grandfathered under the proposed regulations. Level I certificates will be valid until the previously scheduled expiration date.

Impact: The proposed certification regulations affect all local erosion and sediment control programs. Currently 171 local governments have adopted programs leaving one Soil and Water Conservation District administering a program. The cost to localities for certification is variable depending on such factors as employee experience and proximity to training and testing locations. The single largest cost is the loss of productivity of staff for time spent in training or examination. However, this may well be overcome since more qualified and skilled staff will perform more efficiently.

Affected Locality: No locality will be particularly impacted more than another by the adoption of this regulation. As stated above, 171 local governments have adopted Erosion and Sediment Control Programs.

Applicable Federal Requirements: These regulations are based upon Virginia law and are not in response to any federal law.

Summary:

The proposed regulations establish minimum statewide standards for the certification of erosion and sediment control plan reviewers, inspectors, and program administrators. The regulations provide four classifications of certification: Program Administrator, Plan Reviewer, Inspector, and Combined Administrator. In addition, the regulations provide for eligibility requirements, fees, examinations, applications, and discipline of certified personnel.

Training will be based upon the Erosion and Sediment Control Law and attendant regulations which establish minimum statewide standards for the control of soil erosion, sediment deposition and nonagricultural runoff from land-disturbing activities that must be met in local erosion and sediment control programs, and also by state agencies that conduct land-disturbing activities. Land-disturbing activities include, but are not limited to, clearing, grading, excavating, transporting and filling of land.

Certification will be based upon completion of the training programs, work experience or combination thereof, plus obtaining a passing grade on the certification test. Recertification and decertification are also covered by the regulations.

VR 625-02-01. Erosion and Sediment Control Certification Regulations.

§ 1. Definitions.

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

"Act" means the Erosion and Sediment Control Law, Article 4 (§ 10.1-560 et seq.) of Chapter 5 of Title 10.1 of the Code of Virginia.

"Applicant" means any person submitting a request to be considered for certification.

"Board" means the Virginia Soil and Water Conservation Board.

"Certification" means the process whereby the board, on behalf of the Commonwealth, issues a certificate to persons who have completed training programs or in other ways demonstrated adequate knowledge in the specified subject areas.

"Certified combined administrator" means an employee or agent of a program authority who: (i) holds a certificate of competence from the board in the combined areas of program authority, plan review, and project inspection; or (ii) is enrolled in the board's training program for program administrator, plan reviewer, and project inspection and successfully completes such program within one year after enrollment.

"Certified inspector" means an employee or agent of a program authority who: (i) holds a certificate of competence from the board in the area of project inspection; or (ii) is enrolled in the board's training program for project inspection and successfully completes such program within one year after enrollment.

"Certified plan reviewer" means an employee or agent of a program authority who: (i) holds a certificate of competence from the board in the area of plan review; (ii)

is enrolled in the board's training program for plan review and successfully completes such program within one year after enrollment; or (iii) is licensed as a professional engineer, architect, certified landscape architect or land surveyor pursuant to Article 1 (§ 54.1-400 et seq.) of Chapter 4 of Title 54.1 of the Code of Virginia.

"Certified program administrator" means an employee or agent of a program authority who: (i) holds a certificate of competence from the board in the area of program administration; or (ii) is enrolled in the board's training program for program administrator and successfully completes such program within one year after enrollment.

"Classification" refers to the four specific subject areas that make up activities being performed (program administrator, plan reviewer, inspector, and combined).

"Combined administrator" means anyone who is responsible for performing the combined duties of a program administrator, plan reviewer and project inspector of a program authority.

"Department" means the Department of Conservation and Recreation.

"Erosion and Sediment Control Plan," "conservation plan" or "plan," means a document containing material for the conservation of soil and water resources of a unit or group of units of land. It may include appropriate maps, an appropriate soil and water plan inventory and management information with needed interpretations, and a record of all decisions contributing to conservation treatment. The plan shall contain all major conservation decisions and all information deemed necessary by the plan-approving authority to assure that the entire unit or units of land will be so treated to achieve the conservation objective.

"Inspector" means anyone who, as a representative of a program authority, is responsible for periodically examining the erosion and sediment control activities and premises of a land-disturbing activity for consistency with the Erosion and Sediment Control Law and Regulations.

"Plan reviewer" means anyone who is responsible for determining the accuracy of erosion and sediment control plans and supporting documents for approval by a program authority.

"Program administrator" means the person or persons responsible for administering and enforcing the erosion and sediment control program of a program authority.

"Program authority" means a soil and water conservation district, county, city or town which has adopted an erosion and sediment control program which has been approved by the board.

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“State erosion and sediment control program” or “state program” means the program administered by the board through the Director of the Department of Conservation and Recreation pursuant to the Erosion and Sediment Control Law and VR 625-02-00, Erosion and Sediment Control Regulations.

§ 2. Purpose.

The purpose of these regulations is to guide the issuance of certificates of competence required by § 10.1-561 of the Act.

§ 3. Applicability.

These regulations are applicable to:

1. Every program authority that administers an erosion and sediment control program. Staff of program authority must be certified in accordance with § 10.1-561.1 of the Act.
2. Anyone who is contracted by a program authority to perform any or all of the functions of that authority. This person will be subject to the same certification requirements as the authority.
3. Anyone voluntarily seeking certificates of competence from the board for classifications described in § 4 of these regulations.

§ 4. Certificates of competence.

A. Certificates of competence shall be issued by the board for the following classifications:

1. Program administrator. The person or persons employed as the erosion and sediment control program administrator.
2. Plan reviewer. The person or persons who review conservation plans to be approved by the program authority.
3. Inspector. The person or persons responsible for inspecting erosion and sediment control practices to ensure compliance with the Virginia Erosion and Sediment Control Law and Regulations.
4. Combined administrator. The person or persons responsible for the combined duties of administration, plan review and inspection of regulated activities of a local program authority.

B. Any person employed as a plan reviewer who is licensed as a professional engineer, architect, certified landscape architect or land surveyor pursuant to Article 1 (§ 54.1-400 et seq.) of Chapter 4 of Title 54.1 shall qualify as a certified plan reviewer and will not require a certificate of competence from the board.

C. Any person who holds a level II certificate of competence from the board in areas of plan review, project inspection or as a program administrator which was obtained prior to adoption of the mandatory certification as specified in § 10.1-561.1 B of the Act shall be deemed to satisfy the requirements of that area of certification. Any certification obtained before the adoption of the mandatory program which satisfies the requirements will be valid until its previously scheduled expiration date.

§ 5. Eligibility requirements.

A. Certification may be obtained by satisfactorily completing and submitting an application to the department for review and approval and:

1. By obtaining a total of six months of experience (880 hours) as a plan reviewer, inspector or combined duties and obtaining a passing score on the certification examination administered by the department; or
2. By enrolling in and completing a board-approved training program in the areas of program administrator, plan reviewer, inspector, or combined administrator within 12 months of the time of enrollment (starting with the first training course enrolled) and obtaining a passing score on the certification examination.

a. The training program for inspectors will consist of attending and completing courses/seminars in “Basic Erosion and Sediment Control in Virginia” and “Erosion and Sediment Control for Inspectors.”

b. The training program for plan reviewers will consist of attending and completing courses/seminars in “Basic Erosion and Sediment Control in Virginia” and “Erosion and Sediment Control for Plan Reviewers.”

c. The training program for program administrators will consist of attending the seminar “Basic Erosion and Sediment Control in Virginia.”

d. The training program for combined administrators will consist of attending the courses/seminars in “Basic Erosion and Sediment Control in Virginia,” “Erosion and Sediment Control for Inspectors,” and “Erosion and Sediment Control for Plan Reviewers.”

B. Certification shall be valid for three years and will expire on the last day of the expiration month.

C. Recertification may be obtained for classifications outlined in § 4 of these regulations prior to the expiration of a certification by:

1. Obtaining a passing score on the certification

examination; or

2. Successfully completing a board-approved training program.

§ 6. Fees.

A. Application and recertification fees shall be collected to cover the administrative cost for the certification program.

B. A fee will also be charged to present education and training programs which support the certification program.

C. Fees are nonrefundable and shall not be prorated.

§ 7. Examination.

A. A board-approved examination shall be administered at least twice a year.

B. An individual may take the certification examination for the desired certificate of competence after fulfilling the prerequisite experience requirement or completing a board-approved training program in accordance with § 5 of these regulations.

C. An individual who is unable to take an examination at the time scheduled shall notify the department within 48 hours prior to the date of the examination; such an individual shall be rescheduled for the next examination. Failure to notify the department may require the individual to submit a new application and payment of fees in accordance with these regulations.

D. An applicant who is unsuccessful in passing an examination will be allowed to pay the appropriate fee and retake the appropriate exam within one year without resubmitting an application. After the one-year period has elapsed, an applicant will be required to submit a new application with the appropriate fee in accordance with these regulations in order to take the examination. Application for examination must be received at least 60 days prior to the scheduled examination by the department to be eligible to sit for the examination.

E. An acceptable passing score of 70% will be required on the appropriate certification exam.

F. All applicants will be notified in writing within 60 days of the results of the examination.

§ 8. Application.

A. Any person seeking certification by a combination of experience and examination or by the combination of completion of the training program and examination shall submit a completed application with the appropriate fee(s) attached. The application shall contain the following:

1. The applicant's name, address, daytime phone number, social security number, name and address of business as well as the date the application was filled out.

2. The classification of certification applying for as set forth in § 4 of these regulations, and if applying for initial certification or recertification.

3. If any special arrangements must be provided for because of a handicap.

4. A verification of all work experience signed and dated by applicant's employer.

5. A signed and notarized affidavit confirming that all statements in the application are believed to be true.

Incomplete applications will be returned to the applicant. All applications must be received in the appropriate department office or by mail post marked at least 60 days prior to the scheduled examination date in order to be able to sit for the examination.

B. All applications of candidates will be reviewed by the department to determine eligibility for certification. All applicants will be notified of the results of the review within 30 days of receipt of the application. Any applicant may appeal the review, in writing, to the board within 30 days of the department's determination. No applicant will be approved for certification unless they meet all the requirements of these regulations.

C. Applicants who have been found ineligible to sit for an examination may request further consideration by submitting a letter to the board with the necessary evidence of additional qualifications. No additional fee will be required provided that all requirements for certification are met within one year from the date of the original application.

§ 9. Discipline of certified personnel.

The board may suspend, revoke or refuse to grant or renew the certification of any person if the board, in an informal fact finding under § 9-6.14:11 of the Code of Virginia, finds that:

1. The certification was obtained or renewed through fraud or misrepresentation;

2. The certified person has violated or cooperated with others in violating any provision of these regulations;

3. The certified person has not demonstrated reasonable care, judgment, or application of his knowledge and ability in the performance of his duties; or

4. The certified person has made any material

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misrepresentation in the course of performing his duties.

VA.R. Doc. No. R94-1101; Filed July 5, 1994, 4:01 p.m.

FINAL REGULATIONS

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.

GOVERNOR'S EMPLOYMENT AND TRAINING DEPARTMENT

Title of Regulation: VR 350-01-1. Public Participation Guidelines.

Statutory Authority: §§ 2.1-708(3) and 9-6.14:7.1 of the Code of Virginia.

The Governor's Employment and Training Department has **WITHDRAWN** the final regulation entitled, "VR 350-01-1, Public Participation Guidelines," published in 10:19 V.A.R 5102-5105 June 13, 1994, which was scheduled to become effective July 13, 1994.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: VR 460-01-86. Hospital Credit Balance Reporting.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Date: October 1, 1994.

Summary:

The purpose of this action is to promulgate regulations which ensure that hospitals refund Medicaid overpayments in a timely fashion. Untimely review and refunding of Medicaid overpayments result in Medicaid program funds being unavailable for payment of services.

The section of the State Plan for Medical Assistance which is affected by this action are new pages 86 and 86.1, which create § 6.4, Hospital Credit Balance Reporting.

Title XIX of the Social Security Act § 1902(a)(25) provides that states take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available to recipients of Medicaid. Medicaid is by law the payor of last resort.

In December 1992, the Office of the Inspector General of the U.S. Department of Health and Human Services issued a report entitled "Medicaid Accounts Receivables with Credit Balances at Hospitals Participating in the Medicaid Program Administered by the Virginia Department of Medical Assistance

Services." As a result of a review of a sample number of hospitals participating in the Virginia Medicaid program, hospitals were determined to be receiving and retaining Medicaid overpayments contrary to federal law and regulations.

The requirement that Medicaid be the payor of last resort is important because the majority of Medicaid credit balance accounts reviewed by the Inspector General resulted from payments by Medicaid and a primary third party insurer. Other credit balances resulted from various billing practices by the hospital providers which resulted in duplicate payments or the billing for an anticipated service not actually delivered.

Since the states share responsibility with hospitals for ensuring that Medicaid credit balances caused by overpayments are refunded to the Medicaid program, the Inspector General recommended that the department require hospitals to report Medicaid credit balance accounts on a quarterly basis and to make timely refunds of all identified Medicaid overpayments. A similar requirement is already in effect for all hospitals under the Medicare program.

Failure to enact this regulation will result in Medicaid overpayments not being refunded to this agency either in a timely manner or at all. It would also leave this department out of compliance with recommendations contained in the Inspector General's report.

The agency projects no negative issues involved in implementing this recommended change, primarily because the affected hospitals are already complying with a similar requirement under the Medicare program. The primary advantage to the public of the adoption of this regulation is that public funds appropriated for the coverage of medical care services for the indigent will be more quickly returned to DMAS for appropriate expenditure. There is no known disadvantage to the public in the adoption of this regulation.

The primary disadvantage to the hospital providers, who receive Medicaid funds in payment for services rendered, is that they will be required to monitor their credit balance accounts more diligently and return funds to DMAS more diligently. These providers will no longer have the short term use of these public funds.

The primary advantage to DMAS of the adoption of this regulation is the improved management and

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accountability of public funds. There is no disadvantage to the agency in implementing this regulation.

Prior to this regulation, there was no assurance that hospitals were performing timely reviews of accounts with credit balances and refunding all identified Medicaid overpayments to the department. This regulation is budget neutral since these funds would have eventually been recovered by DMAS during the cost settlement or third party liability processes.

All hospitals, which number approximately 150, will be affected by this proposed regulation. There will be no additional costs to this provider group's operations because reviewing accounts for credit balances is part of routine bookkeeping practice. There will be no additional costs to DMAS to administer this regulation because these funds would have eventually been recovered through the cost settlement or third party liability processes. This regulation will merely speed up the funds recovery process. There are no localities which are uniquely affected by these regulations as they apply statewide.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Copies of the regulation may be obtained from Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8850. There may be a charge for copies.

VR 460-01-86. Hospital Credit Balance Reporting.

Citations: § 1902(a)(25) of the Act; 42 CFR Part 43 B, Subparts D and F

§ 6.4. Hospital credit balance reporting.

Hospitals shall be required to report Medicaid credit balances on a quarterly basis no later than 30 days after the close of each quarter. For a credit balance arising on a Medicaid claim within three years of the date paid by the DMAS, the hospital shall either submit a check for the balance due or an adjustment claim with the Credit Balance Report. For credit balances arising on claims over three years old, the hospital shall submit a check for the balance due. Interest at the maximum rate allowed shall be assessed for those credit balances (overpayments) which are identified on the quarterly report but not reimbursed with the submission of the form. Interest will begin to accrue 30 days after the end of the quarter and will continue to accrue until the overpayment has been refunded or adjusted. A penalty shall be imposed for failure to submit the form timely as follows:

1. Hospitals which have not submitted their Medicaid credit balance data within the required 30 days after the end of a quarter shall be notified in writing. If

the required report is not submitted within the next 30 days, there will be a 20% reduction in the Medicaid per diem payment.

2. If the required report is not submitted within the next 30 days (60 days after the due date), the per diem payments shall be reduced to -0- until the report is received.

3. If the credit balance has not been refunded within 90 days of the end of a quarter, it shall be recovered, with interest, through the use of a negative balance transaction on the weekly remittance.

A periodic audit shall be conducted of hospitals' quarterly submission of Medicaid credit balance data. Hospitals shall maintain an audit trail back to the underlying accounts receivable records supporting each quarterly report.

VA.R. Doc. No. R94-1090; Filed June 24, 1994, 3:26 p.m.

* * * * *

Title of Regulations: State Plan for Medical Assistance Relating to Durable Medical Equipment.

VR 460-03-3.1100. Amount, Duration and Scope of Services (Supplement 1 to Attachment 3.1 A & B).

VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality of Care (Attachment 3.1-C).

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

Effective Date: September 1, 1994.

Summary:

The purpose of this action is to promulgate permanent regulations, to supersede the existing emergency regulations, clarifying the requirements and the process for providing durable medical equipment and supplies.

Durable medical equipment, supplies, and appliances are only available under the home health benefit. Services are available as prescribed by the home health regulations at Title 42, Code of Federal Regulations, Part 440, in the recipient's home on a physician's order as part of a written plan of care that is periodically reviewed.

DMAS previously required that a recipient who received durable medical equipment or supplies also receive skilled nursing visits provided by a home health agency. Previously also, DMAS never specified those services which will not be covered under home health services program. In addition, a single skilled nursing follow-up visit was required after the recipient

received the prescribed equipment or supplies to determine that it met the recipient's needs, that it was suitable for use in the home, and the recipient or caregiver was knowledgeable and comfortable in using the equipment.

Care provided by a home health agency follows a written plan of care established and reviewed by a physician as often as the patient's condition requires, but at least every 60 days. The requested services or items must be necessary to carry out the plan of care and must be related to the patient's condition.

In addition to these changes, the population for which nutritional supplements will be covered is expanded under home health services. Instead of requiring that the enteral or total parenteral nutrition be the sole source of nutrition and administered only by nasogastric or gastrostomy tube, coverage will also include individuals who receive the nutrition orally. All other criteria must still be met (e.g., the supplement must be medically necessary). Coverage of oral administration does not include the provision of routine infant formulae.

This action amends the State Plan for Medical Assistance by removing the currently required prerequisite skilled nursing visit for persons receiving durable medical equipment and supplies through the home health services program. This change has been required by the Health Care Financing Administration (HCFA) to bring the Commonwealth's State Plan into compliance with federal regulations. This regulation also specifies those services which Medicaid does not cover under the home health services program.

For DMAS, the elimination of the home health agency as the conduit for the provision of equipment and supplies removes a level of professional medical review for ensuring that the equipment and supplies are appropriate. As such, utilization review activities will be increased. The physician is required to prescribe all equipment and supplies and will be completing a Certificate of Medical Necessity in lieu of the current home health plan of care for each recipient who requires equipment or supplies.

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.

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EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in 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. Transplant services for kidneys and corneas shall be covered for all eligible persons. Transplant services for liver, heart, and bone marrow transplantation and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization. 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. Reimbursement for covered liver, heart, and bone marrow transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be based upon a rate negotiated with providers on an individual case basis, or a flat rate by procedure, or by procedure and facility. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

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 performance 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 sterilization, hysterectomy or abortion procedures were performed, shall be subject to medical documentation requirements.

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

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

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

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

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

5. The department may, at its option, depending on the utilization review performance determined by an audit based on criteria set forth in the hospital provider manual, remove a hospital from delegated review status and reapply certain or all prepayment utilization review documentation requirements.

§ 2. Outpatient hospital and rural health clinic services.

2a. Outpatient hospital services.

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

1. Are furnished to outpatients;

2. 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

3. Are furnished by an institution that:

- a. Is licensed or formally approved as a hospital by an officially designated authority for state

standard-setting; and

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

B. 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.

C. 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.

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.

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.

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 the 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.

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.

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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.

Psychiatric services can be provided by psychiatrists, clinical psychologists licensed by the State Board of Medicine, psychologists clinical licensed by the Board of Psychology, or by a licensed clinical social worker under the direct supervision of a psychiatrist, licensed clinical psychologist or a licensed psychologist clinical.

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. Transplant services for kidneys and corneas shall be

covered for all eligible persons. Transplant services for liver, heart, and bone marrow and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization. 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. Reimbursement for covered liver, heart, and bone marrow transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be based upon a rate negotiated with providers on an individual case basis, or a flat rate by procedure, or by procedure and facility. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

§ 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. Optometrists' services.

Diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services.

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. *Home health services shall be provided in accordance with guidelines found in the Virginia Medicaid Home Health Manual.*

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. 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. Payment shall not be made for additional service unless authorized by DMAS.

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~~ *Medicaid recipients who meet home health criteria*. 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. *All medical supplies, equipment, and appliances shall be provided in accordance with guidelines found in the Virginia Medicaid DME and Supplies Manual.*

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

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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.).

4. For coverage of blood glucose meters for pregnant women, refer to Supplement 3 to Attachments 3.1 A and B.

5. *Durable medical equipment, supplies, and appliances must be ordered by a physician and be medically necessary to treat a health care condition. The physician shall complete a written certificate of medical necessity for all durable medical equipment, supplies, and appliances based on an assessment of the patient's needs. The medical and supply provider shall keep a copy of the certificate of medical necessity. The certificate of medical necessity shall be signed and dated by the physician.*

6. *The medical equipment and supply vendor must provide the equipment and supplies as prescribed by the physician on the certificate of medical necessity. Orders shall not be changed unless the vendor obtains a new certificate of medical necessity prior to ordering or providing the equipment or supplies to the patient.*

7. *Medicaid shall not provide reimbursement to the medical equipment and supply vendor for services provided prior to the date prescribed by the physician or prior to the date of the delivery or when services are not provided in accordance with published policies and procedures. If reimbursement is denied for one of these reasons, the medical equipment and supply vendor may not bill the Medicaid recipient for the service that was provided.*

8. *Only supplies, equipment, and appliances that are considered medically necessary shall be covered. All of the following must be met to be considered medically necessary. The supplies, equipment, or appliance must be:*

a. *A reasonable and necessary part of the recipient's treatment plan;*

b. *Consistent with the symptoms, diagnosis, or medical condition of the illness or injury under treatment;*

c. *Not furnished for the convenience of the*

recipient, the family, the attending practitioner, or other practitioner or supplier;

d. *Necessary and consistent with generally accepted professional medical standards (i.e., not experimental or investigational);*

e. *Established as safe and effective for the recipient's treatment protocol; and*

f. *Furnished at the most appropriate level which is suitable for use in the recipient's home environment.*

9. *Coverage of enteral nutrition (EN) and total parenteral nutrition (TPN) which do not include a legend drug shall be limited to when the nutritional supplement is the sole source form of nutrition, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of EN and TPN shall not include the provision of routine infant formulae.*

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 without authorization. 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.*

F. *The following services are not covered under the home health services program:*

1. *Medical social services;*

2. *Services or items which would not be paid for if provided to an inpatient of a hospital, such as private-duty nursing services, or items of comfort which have no medical necessity, such as television;*

3. *Community food service delivery arrangements;*

4. *Domestic or housekeeping services which are unrelated to patient care and which materially increase the time spent on a visit;*

5. *Custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care; and*

6. *Services related to cosmetic surgery.*

§ 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,

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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-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, school divisions, or home health agencies shall include authorization for up to 24 visits by each ordered rehabilitative service annually. 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. Documentation for medical justification must include physician orders or a plan of care 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.

A. 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.

B. 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.

C. Legend drugs are covered, with the exception of

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anorexiants prescribed for weight loss and the drugs for classes of drugs identified in Supplement 5.

D. 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.

E. New drugs shall be covered in accordance with the Social Security Act § 1927(d) (OBRA 90 § 4401).

F. The number of refills shall be limited pursuant to § 54.1-3411 of the Drug Control Act.

G. Drug prior authorization.

1. Definitions.

"Board" means the Board for Medical Assistance Services.

"Committee" means the Medicaid Prior Authorization Advisory Committee.

"Department" means the Department of Medical Assistance Services.

"Director" means the Director of Medical Assistance Services.

"Drug" shall have the same meaning, unless the context otherwise dictates or the Board otherwise provides by regulation, as provided in the Drug Control Act (§ 54.1-3400 et seq.).

2. Medicaid Prior Authorization Advisory Committee; membership. The Medicaid Prior Authorization Committee shall consist of 10 members to be appointed by the board. Five members shall be physicians, at least three of whom shall care for a significant number of Medicaid patients; four shall be pharmacists, two of whom shall be community pharmacists; and one shall be a Medicaid recipient.

a. A quorum for action by the committee shall consist of six members.

b. The members shall serve at the pleasure of the board; vacancies shall be filled in the same manner as the original appointment.

c. The board shall consider nominations made by the Medical Society of Virginia, the Old Dominion

Medical Society and the Virginia Pharmaceutical Association when making appointments to the committee.

d. The committee shall elect its own officers, establish its own procedural rules, and meet as needed or as called by the board, the director, or any two members of the committee. The department shall provide appropriate staffing to the committee.

3. Duties of the committee.

a. The committee shall make recommendations to the board regarding drugs or categories of drugs to be subject to prior authorization, prior authorization requirements for prescription drug coverage and any subsequent amendments to or revisions of the prior authorization requirements. The board may accept or reject the recommendations in whole or in part, and may amend or add to the recommendations, except that the board may not add to the recommendation of drugs and categories of drugs to be subject to prior authorization.

b. In formulating its recommendations to the board, the committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§ 9-6.14:1 et seq.). The committee shall, however, conduct public hearings prior to making recommendations to the board. The committee shall give 30 days written notice by mail of the time and place of its hearings and meetings to any manufacturer whose product is being reviewed by the committee and to those manufacturers who request of the committee in writing that they be informed of such hearings and meetings. These persons shall be afforded a reasonable opportunity to be heard and present information. The committee shall give 30 days notice of such public hearings to the public by publishing its intention to conduct hearings and meetings in the Calendar of Events of The Virginia Register of Regulations and a newspaper of general circulation located in Richmond.

c. In acting on the recommendations of the committee, the board shall conduct further proceedings under the Administrative Process Act.

4. Prior authorization of prescription drug products, coverage.

a. The committee shall review prescription drug products to recommend prior authorization under the state plan. This review may be initiated by the director, the committee itself, or by written request of the board. The committee shall complete its recommendations to the board within no more than six months from receipt of any such request.

b. Coverage for any drug requiring prior

authorization shall not be approved unless a prescribing physician obtains prior approval of the use in accordance with regulations promulgated by the board and procedures established by the department.

c. In formulating its recommendations to the board, the committee shall consider the potential impact on patient care and the potential fiscal impact of prior authorization on pharmacy, physician, hospitalization and outpatient costs. Any proposed regulation making a drug or category of drugs subject to prior authorization shall be accompanied by a statement of the estimated impact of this action on pharmacy, physician, hospitalization and outpatient costs.

d. The committee shall not review any drug for which it has recommended or the board has required prior authorization within the previous 12 months, unless new or previously unavailable relevant and objective information is presented.

e. Confidential proprietary information identified as such by a manufacturer or supplier in writing in advance and furnished to the committee or the board according to this subsection shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§ 2.1-340 et seq.). The board shall establish by regulation the means by which such confidential proprietary information shall be protected.

5. Immunity. The members of the committee and the board and the staff of the department shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in performance of their duties pursuant to this subsection while serving as a member of such board, committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.

6. Annual report to joint commission. The committee shall report annually to the Joint Commission on Health Care regarding its recommendations for prior authorization of drug products.

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

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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 780 units, 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 780 units, 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 936 units, 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:

Day health and rehabilitation services (limited to

780 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.

§ 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

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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.

§ 22. Emergency Services for Aliens.

A. 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.

B. 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

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3. Serious dysfunction of any bodily organ or part.

C. 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.

D. Claims for conditions which do not meet emergency criteria 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. General acute care 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, five days 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);

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

(g) Services required for terminal care.

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

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

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

C. Nursing facilities.

1. Long-term care of residents in nursing facilities will be provided in accordance with federal law using practices and procedures that are based on the resident's medical and social needs and requirements. *All nursing facility services, including specialized care, shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.*

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 *periodically* 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 (after initial physician visit, subsequent visits may alternate between physician and physician assistant or nurse practitioner);
- (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 90 minutes each day, 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 two hours per day, 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 or by a licensed clinical social worker under the direct supervision of a licensed clinical psychologist or a licensed psychologist clinical 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. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Institutions for Mental Disease (IMD).

1. With respect to each Medicaid-eligible resident in an ICF/MR 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 ICF/MR 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

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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.

6. *All services provided in an IMD and in an ICF/MR shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.*

E. 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. Be enrolled in the Commonwealth's Medicaid program for the specific purpose of providing

psychiatric services resulting from an EPSDT screening.

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 *who are required to provide medically necessary health care interventions* or the use of special *medical* 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: skilled nursing, home health aide, physical therapy, occupational therapy, and speech-language pathology services provided by home health agencies.~~

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

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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-~~ 7. 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- 8. 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-Language Pathology. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and 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 for persons receiving home health services in addition to durable medical equipment and supplies. 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.

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).

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.

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

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

* * *

PART I.

INTENSIVE PHYSICAL REHABILITATIVE SERVICES.

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

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

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

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

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

1. Occupational Therapy
2. Physical Therapy
3. Cognitive Rehabilitation
4. Speech-Language Therapy

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

PART II.

INPATIENT ADMISSION AUTHORIZATION.

§ 2.1. Within 72 hours of a patient's admission to an intensive rehabilitation program, or within 72 hours of notification to the facility of the patient's Medicaid eligibility, the facility shall notify the Department of Medical Assistance Services in writing of the patient's admission. This notification shall include a description of the admitting diagnoses, plan of treatment, expected progress and a physician's certification that the patient meets the admission criteria. The Department of Medical Assistance Services will make a determination as to the appropriateness of the admission for Medicaid payment

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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 requested 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. *All intensive rehabilitative services shall be provided in accordance with guidelines found in the Virginia Medicaid Rehabilitation Manual.*

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 reimbursement 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

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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-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-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 or by a licensed clinical social worker under the direct supervision of a licensed clinical psychologist or a licensed psychologist clinical;

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

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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, ear 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 individual must 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. *All hospice services shall be provided in accordance with guidelines established in the Virginia Medicaid Hospice Manual.*

§ 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

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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 psychologist, 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.

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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.

C. *Outpatient rehabilitative services shall be provided in accordance with guidelines found in the Virginia Medicaid Rehabilitation Manual, with the exception of such services provided in school divisions which shall be provided in accordance with guidelines found in the Virginia Medicaid School Division Manual.*

§ 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

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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-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. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, home health service agencies, or school divisions shall include authorization for up to 24 visits by each ordered rehabilitative service annually. 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. Documentation for medical justification must include physician orders or a plan of care signed by the 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, home health agency, 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; 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 by someone other than the skilled rehabilitation professional.

PART XII. UTILIZATION REVIEW OF CASE MANAGEMENT FOR RECIPIENTS OF AUXILIARY GRANTS.

§ 12.1. Criteria of need for case management services.

It shall be the responsibility of the assessor who identifies the individual's need for residential or assisted living in an adult care residence to assess the need for case management services. The case manager shall, at a minimum, update the assessment and make any necessary referrals for service as part of the case management annual visit. Case management services may be initiated at any time during the year that a need is identified.

§ 12.2. Coverage limits.

DMAS shall reimburse for one case management visit per year for every individual who receives an auxiliary grant. For individuals meeting the following ongoing case management criteria, DMAS shall reimburse for one case management visit per calendar quarter:

1. The individual needs the coordination of multiple services and the individual does not currently have support available that is willing to assist in the coordination of and access to services, and a referral to a formal or informal support system will not meet the individual's needs; or

2. The individual has an identified need in his physical environment, support system, financial resources, emotional or physical health which must be addressed to ensure the individual's health and welfare and other formal or informal supports have either been unsuccessful in their efforts or are unavailable to assist the individual in resolving the need.

§ 12.3. Documentation requirements.

A. The update to the assessment shall be required annually regardless of whether the individual is authorized for ongoing case management.

B. A care plan and documentation of contacts must be maintained by the case manager for persons authorized for ongoing case management.

1. The care plan must be a standardized written description of the needs which cannot be met by the adult care residence and the resident-specific goals, objectives and time frames for completion. This care plan must be updated annually at the time of reassessment, including signature by both the resident and case manager.

2. The case manager shall provide ongoing monitoring and arrangement of services according to the care plan and must maintain documentation recording all contacts made with or on behalf of the resident.

VA.R. Doc. No. R94-1091; Filed June 28, 1994, 2:48 p.m.

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DMAS 351 7/92

ATTACH DOCUMENTATION OF MEDICAL NECESSITY

INSTRUCTION FORM - PREAUTHORIZATION REQUEST

SECTION I: Transaction Type

Check appropriate Transaction:
 Original - use for new requests
 Change - use for adjustment of original request
 Delete - use for void of original request

(Original tracking number must appear on all requests for changes and/or deletions)

Address: Complete Address of Provider (Use the current address of the referral source; include box number, street address, city and zip code)

Contact Person: Identify the contact person for DMAS to call if the reviewer has questions

Telephone No.: Identify the telephone number of the contact person (Including Area Code)

SECTION II: Provider Information (Provider who will deliver and bill for requested service)

Provider Name: Complete Address of Provider

Provider No.: Complete Provider Number (7 DIGITS)

Complete Address of Provider
 Identify locality that service is being provided from; (All correspondence will be sent to the address identified on your provider agreement)

Contact Person: Identify the contact person for DMAS to call if the reviewer has questions

Telephone No.: Identify the telephone number of the contact person (Including Area Code)

SECTION V: Program Category

Check the appropriate program from which recipient is eligible to receive requested service (Select only 1 program per request)

SECTION VI: Service Category

Check the appropriate category for which request refers to (Select only 1 service category per request)

SECTION VII: Request Information

Procedure Code: Procedure code (Revenue, HCPCS, or NDC Code) which identifies the specific service being requested, must be completed for request to be considered

If specific code is not established, please provide a complete narrative description of service being requested in the Provider Comment Section

Procedure Modifier: Use appropriate Procedure Modifier; refer to Billing Chapter of the Provider Manual

Units Requested: Identify Units requested using the established Billing Units; If authorization is needed because more than the established allowable is needed, Only list the amount in excess of the allowable

Actual Cost: Must be completed when requesting service item that requires DMAS consideration for pricing (Request must include a Description, Manufacture name, Catalog number and copy of Purchase Invoice)

Total Dollar Requested: Identify Total Dollars requested based on corresponding Procedure Codes and Units Requested

Dates of Service: Identify Dates of Service for which the corresponding Procedure Codes and Units are Requested

SECTION III: Recipient Information

Recipient No.: Complete Medicaid Number (12 DIGITS)
 It is your responsibility to verify Recipient Medicaid eligibility before submitting request or providing items

Recipient: Recipient's Full Name (Last & First Name)

Address: Complete Address of Recipient (use current address of Medicaid Recipient; include box#, street address, city, state and zip code)

Telephone No.: Complete Telephone Number of Recipient (Including area code)

Date of Birth: Full Date of Birth (MONTH, DAY, YEAR)

Medicare No.: Complete Medicare Number (10 DIGITS)

Other Insurance: Identify any other insurance that the recipient has (include the name of the insurance carrier and the policy number if available)

SECTION IV: Referral Source Information (If the Provider making a referral for the requested services is not the same Provider who will deliver the service, this section should be completed)

Provider Name: Full Name of Provider

Provider No.: Complete Provider Number (7 DIGITS)

Signature of Provider and Date of Request must appear in Section VII
 ATTACH DOCUMENTATION OF MEDICAL NECESSITY; IF A HOME HEALTH PARTICIPANT, THE HOME HEALTH PLAN OF CARE MUST BE ATTACHED

SECTION VIII: DMAS USE ONLY - DO NOT WRITE IN THIS SECTION

MAIL TO: ATTENTION _____ UNIT
 DMAS - 600 EAST BROAD STREET, SUITE 1300
 RICHMOND, VA 23219

Final Regulations

**VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CERTIFICATE OF MEDICAL NECESSITY
DURABLE MEDICAL EQUIPMENT AND SUPPLIES**

SECTION I

RECIPIENT DATA	SERVICING PROVIDER	ORDERING PHYSICIAN
I.D. # _____	I.D. # _____	I.D. # _____
Name _____	Name _____	Name _____
D.O.B. _____	Contact Person _____	Phone # (____) _____
Phone # (____) _____	Phone # (____) _____	Date patient last examined by physician _____

SECTION II MUST BE COMPLETED BY PHYSICIAN

PROGRAM ELIGIBILITY FOR REQUESTED ITEMS OR SUPPLIES

<p>EPSDT <input type="checkbox"/></p> <ul style="list-style-type: none"> • Recipient under the age of 21, service not covered under any other program listed 	<p>WAIVER <input type="checkbox"/></p> <ul style="list-style-type: none"> • Recipient enrolled in either Technology Dependent or AIDS 	<p>HOME HEALTH <small>Check each category that applies</small></p> <ul style="list-style-type: none"> <input type="checkbox"/> The patient is unable to leave home without the assistance of others or the use of special equipment; <input type="checkbox"/> The patient has a mental or emotional problem which is manifested in part by refusal to leave his home environment or is of such a nature that it would not be considered safe for him to leave home unattended; <input type="checkbox"/> The patient is ordered by the physician to restrict his activity due to a weakened condition (e.g., following surgery or heart disease of such severity that stress and physical activity must be avoided); <input type="checkbox"/> The patient has an active communicable disease, and the physician restricts the patient to prevent exposing others to the disease.
--	---	--

PROGRAM ELIGIBILITY NOT REQUIRED. ITEM ORDERED:

Respiratory/O ₂	<input type="checkbox"/>
Ostomy	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>

SECTION III MUST BE COMPLETED BY PHYSICIAN

ICD9 Code	Clinical Diagnoses	Date of Onset	Prognosis

Is the item suitable for use in home, and does the patient/caregiver demonstrate willingness/ability to use the equipment? Yes _____ No _____

SECTION IV MUST BE COMPLETED BY PHYSICIAN

Begin Service Date	Item Ordered Description	ELOU	Quantity Ordered/ x1 Month	Quantity/Frequency of Use Justification/Comments

SECTION V

ADDITIONAL MEDICAL JUSTIFICATION (see back for specific information to be addressed either in this area or via an attachment)

ABG's Date of Test _____ PO2 _____ Saturation _____

See medical justification attached. Information is provided by _____

I certify treatment of this patient. This equipment is part of my course of treatment and is "reasonable and medically necessary", and is not a convenience item for the recipient, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate.

Attending Physician's Signature Date

DMAAS-362

DOCUMENTATION

Please provide the specific documentation noted for the following types of requests:

WHEELCHAIRS:

Mobility impairments, postural impairments, and cognitive ability related to specific wheelchair and/or wheelchair adaptations.

HOSPITAL BEDS:

How bed will be used to treat a medical condition, functional limitations.

COMMUNICATION DEVICES:

Speech limitations, prognosis for improvement, how needs are currently being met, patient's motivation and ability to use selected device, reason specific device was selected, conjunctive treatment.

PATIENT LIFTS:

Patient's weight, identification of caregiver and their ability to use lift, functional limitations, describe how needs were met previously, home accessibility for lift(7).

TENS-LIKE UNITS:

Physical and functional limitations, describe success/failure of alternative treatment modalities, describe patient/caregiver's ability to manage application of device, describe demonstrated benefit of unit for ongoing use.

APNEA MONITORS:

Include a comprehensive history and physical related to respiratory condition, identify final primary and secondary diagnoses related to apnea, include confirmation that patient has apnea. Requests for recording (or "smart") apnea monitors must state "recording apnea monitor", knowledge or outcome of any previous study and reason/purpose of this study.

RESPIRATORY:

- **OXYGEN:**

Flow rate, frequency and duration of use (an order for PRN use of oxygen must identify circumstances under which oxygen is to be used). For portable systems, provide a description of activities the patient participates in on a regular basis that requires a portable system in the home and the therapeutic purpose served by that portable system that cannot be met by a stationary system.

- **PULSE OXIMETERS:**

Include information regarding: patient dependency on oxygen, ventilator and/or tracheotomy; weaning status if appropriate; risk potential or actual desaturation episodes.

WOUND CARE SUPPLIES:

Location of wound, wound size, and physician orders for care.

NUTRITIONAL SUPPLEMENTS (Enteral Feedings Only):

Must identify complete diet order, to include any intake other than the prescribed supplement and the patient's response to the diet.

Section I

Recipient Data

- Complete 12-digit recipient identification number
- Complete recipient full name (last name, first name)
- Complete full date of birth (month, day, year)
- Telephone # (include area code)

Servicing Provider

- Complete provider number (7-digits)
- Complete provider name
- Complete contact identifying person to call if DMAS has questions

Ordering Physician

- Complete identification number (optional)
- Physician full name (print)
- Telephone number (include area code)
- Date last examined by physician (must be completed)

Section II

(Section must be completed by Physician)

- Appropriate program eligibility must be identified (specific Home Health eligibility criteria must be identified)
- If no program eligibility required, check item requested

Section III

(Section must be completed by Physician)

- ICD9 Code optional
- Clinical diagnoses - narrative must be identified. Diagnosis must be related to the item being requested
- Complete date of onset (month and year)
- Prognosis must be completed by a physician

Section IV

(Section must be completed by Physician)

- Begun service date (month, day and year)
- Item ordered description: must be physician's narrative description of item ordered
- ELOU (Estimated Length Of Use): Estimated length of time item will be needed for all durable equipment
- Quantity ordered: identify quantity ordered; for expendable supplies, designate supplies needed for 1 month; if items are required greater than 1 month, note time frame in the ELOU column
- Quantity/Frequency of Use, Justification/Comments: physician's order for frequency of use must be identified

Section V

Additional Medical Justification

- Refer to medical documentation requirements above. Additional medical documentation may be provided via attachment.
- Assessment made by other medical discipline may be included as long as time frames are appropriate and must be identified by name and title in space provided
- If requesting oxygen, the results of arterial blood gases must be identified
- Attending physician must sign and date form

Final Regulations

STATE WATER CONTROL BOARD

Title of Regulation: VR 680-14-22. Virginia Pollution Abatement (VPA) General Permit for Confined Concentrated or Intensified Animal Feeding Operations.

REGISTRAR'S NOTICE: The State Water Control Board is suspending the effective date of VR 680-14-22, Virginia Pollution Abatement (VPA) General Permit for Concentrated or Intensified Confined Animal Feeding Operations. The final regulation was published in 10:19 VA.R. 51298-5139 June 13, 1994.

This suspension is in response to requests from more than 25 persons for an opportunity for oral and written submittals on the changes to the regulation in accordance with § 9-6.14:7.1 J of the Administrative Process Act. The board will be seeking additional public comment on the changes made to the regulation in accordance with the Act and will reconsider the adoption of VR 680-14-22 at a future meeting. Therefore, the suspension will remain in effect until the board has acted and refiled the regulation with the Registrar of Regulations.

EMERGENCY REGULATIONS

BOARD FOR CONTRACTORS

Title of Regulation: VR 220-01-2. Rules and Regulations of the Board for Contractors.

Statutory Authority: §§ 54.1-201 and 54.1-1102 of the Code of Virginia.

Effective Dates: July 1, 1994, through June 30, 1995.

Preamble:

The Board for Contractors intends to promulgate emergency regulations as provided for in § 9-6.14:4.1(c)5 of the Code of Virginia regarding the certification of Class C contractors.

Pursuant to the Administrative Process Act, the Board for Contractors is required to promulgate these regulations in order to begin the regulation of Class C contractors as required by statutory changes enacted in House Bill 403, effective July 1, 1994.

These emergency regulations will remain in effect until June 30, 1995, the anticipated effective date of final amendments to the licensing regulations of the Board for Contractors. These amendments will include additional language governing the certification of Class C contractors.

Approved:

/s/ Ray Allen, Jr.
Director
Department of Professional and Occupational Regulation
Date: June 30, 1994

/s/ Robert T. Skunda
Secretary of Commerce and Trade
Date: June 30, 1994

/s/ Robert W. Lauterberg
Director
Department of Planning and Budget
Date: June 30, 1994

/s/ George Allen
Governor
Commonwealth of Virginia
Date: June 30, 1994

/s/ Ann M. Brown
Deputy Registrar of Regulations
Date: July 1, 1994

VR 220-01-2. Rules and Regulations of the Board for Contractors.

PART I. GENERAL.

§ 1.1. Definitions of license classifications.

The following words and terms, when used in these regulations, unless a different meaning is provided or is plainly required by the context, shall have the following meanings:

"Building contractors" (Abbr: BLD) are those whose contracts include construction on real property owned, controlled or leased by another person of commercial, industrial or institutional buildings or structures, or single or multiple-family residential buildings, including accessory-use structures, and the remodeling, repair, improvement or dismantling of any size building.

"Highway/heavy contractors" (Abbr: H/H) are those whose contracts include construction of roads, streets, bridges, railroads, public transit systems, runways, dams, parking lots, towers, tanks, structural signs and lights, foundations and miscellaneous drainage structures, or the dismantling thereof, or involve demolition, clearing, grading, excavating, paving, road markings, pile driving or nonwater well drilling. Also included are those whose contracts include the installation, maintenance or dismantling of power systems for the generation and primary and secondary distribution of electric current ahead of the customer's meter; the installation, maintenance or dismantling of telephone, telegraph or signal systems for public utilities; and the installation, maintenance or dismantling of water, gas, and sewer lines, pumping stations, and treatment plants.

"Electrical contractors" (Abbr: ELE) are those whose contracts include construction or removal which falls within the provisions of the National Electrical Code.

"Plumbing contractors" (Abbr: PLB) are those whose contracts include the installation, maintenance, extension, alteration or removal of all piping, fixtures, appliances, and appurtenances in connection with any of the following: sanitary or storm drainage facilities; the venting system and the public or private water supply systems within or adjacent to any building, structure or conveyance; also the practice and materials used in the installation, maintenance, extension, or alteration of storm-water, liquid waste, or sewerage, and water supply systems of any premises to their connection with any point of public disposal or other acceptable terminal.

"HVAC contractors" (Abbr: HVA) are those whose work includes the installation, alteration, or repair of heating systems, ventilating systems, cooling systems, steam and hot water heating systems, boilers, and mechanical refrigeration systems.

"Specialty contractors" (Abbr: SVC) are those whose contracts are for specialty services which do not substantially fall within the scope of any other classification within these regulations.

§ 1.2. Definitions of specialty services performed under the

Emergency Regulations

specialty contractors license classification.

The following words and terms shall have the following meanings with regard to specialty services:

“Alarm/security systems contracting” (Abbr: ALS) is that service which provides for the installation, repair, improvement or removal of alarm systems or security systems annexed to real property. (Note: Excluding the installation of applicable and incidental locking devices, no other license classification or specialty service provides for this function.)

“Appliance/fixture contracting” (Abbr: APF) is that service which provides for the installation, addition, repair, improvement or removal of appliances or fixtures annexed to real property, excluding gas appliances or fixtures. (Note: No other license classification or specialty service provides for this function.)

“Asbestos contracting” (Abbr: ASB) is that service which provides for the removal, encapsulation or installation of asbestos containing materials annexed to real property. (Note: No other license classification or specialty service provides for this function.)

“Billboard/sign contracting” (Abbr: BSC) is that service which provides for the installation, repair, improvement or dismantling of any billboard or structural sign permanently annexed to real property. (Note: The highway/heavy license classification also provides for this function.)

“Blast/explosive contracting” (Abbr: BEC) is that service which provides for the use of explosive charges for the repair, improvement, alteration or demolition of any real property or any structure annexed to real property. (Note: This function can only be performed in conjunction with the highway/heavy license classification.)

“Commercial improvement contracting” (Abbr: CIC) is that service which provides for additions, repairs or improvements to nonresidential buildings or structures or nonresidential accessory-use structures annexed to real property. (Note: The building license classification also provides for this function.)

“Electronic/communication service contracting” (Abbr: ESC) is that service which provides for the installation, repair, improvement or removal of electronic or communication systems annexed to real property. (Note: No other license classification or specialty service provides for this function.)

“Elevator/escalator contracting” (Abbr: EEC) is that service which provides for the installation, repair, improvement or removal of elevators or escalators permanently annexed to real property. (Note: No other license classification or specialty service provides for this function.)

“Environmental systems contracting” (Abbr: EVS) is that

service which provides for the installation, repair, improvement or removal of septic tanks and systems annexed to real property. (Note: The plumbing license classification also provides for this function when the septic tanks or systems are adjacent to any building, structure or conveyance. The highway/heavy classification also provides for this function when the septic tanks or systems are not adjacent to any building, structure or conveyance.)

“Equipment/machinery contracting” (Abbr: EMC) is that service which provides for the installation or removal of equipment or machinery from the customer’s meter. (Note: No other license classification or specialty service provides for this function.)

“Farm improvement contracting” (Abbr: FIC) is that service which provides for the installation, repair or improvement of a nonresidential farm building or structure, or nonresidential farm accessory-use structure, or additions thereto. (Note: The building license classification also provides for this function.)

“Fire-alarm-extinguishing systems contracting” (Abbr: FAE) is that service which provides for the installation, repair or improvement of fire alarm systems, fire extinguishing systems and fire alarm extinguishing systems annexed to real property. (Note: Excluding the installation of single-unit stand-alone smoke detectors, no other license classification or specialty service provides for this function.)

“Gas fitting contracting” (Abbr: GFC) is that service, performed by plumbing or HVAC contractors, which provides for the installation, repair or improvement of gas pipes and appliances annexed to real property. (Note: This function can only be performed in conjunction with the plumbing or HVAC license classification.)

“Home improvement contracting” (Abbr: HIC) is that service which provides for additions, repairs or improvements to residential buildings or structures or residential accessory-use structures. (Note: The building license classification also provides for this function.)

“Landscape irrigation contracting” (Abbr: ISC) is that service which provides for the installation, repair, improvement or removal of irrigation systems or outdoor sprinkler systems. (Note: The plumbing license classification also provides for this function when the irrigation system is adjacent to any building, structure or conveyance. The highway/heavy classification also provides for this function when the irrigation system is not adjacent to any building, structure or conveyance

“Landscape service contracting” (Abbr: LSC) is that service which provides for the alteration or improvement of a land area not related to any other classification or service activity by means of excavation, clearing, grading or other means of site preparation. (Note: The highway/heavy license classification also provides for this

Emergency Regulations

function.)

"*Miscellaneous contracting*" (Abbr: MSC) is that service which does not fall under any other license classification or specialty service. (Note: No other license classification or specialty service provides for this function.)

"*Modular/mobile building contracting*" (Abbr: MBC) is that service which provides for the installation or removal of a modular or mobile building. (Note: The building and highway/heavy license classifications also provide for this function.)

"*Marine facility contracting*" (Abbr: MCC) is that service which provides for the construction, repair, improvement or removal of any structure the purpose of which is to access, impede or alter a body of surface water. (Note: The highway/heavy license classification also provides for this function.)

"*Passive energy systems contracting*" (Abbr: PES) is that service which provides for the installation, repair or improvement, from the customer's meter, of passive energy generation systems or passive supplemental energy systems annexed to real property. (Note: No other license classification or specialty service provides for this function.)

"*Radon mitigation contracting*" (Abbr: RMC) is that service which provides for additions, repairs or improvements to commercial, industrial or institutional buildings or structures, or single or multiple-family residential buildings for the purpose of mitigating or preventing the effects of radon gas. (Note: This function can only be performed in conjunction with the building license classification or commercial improvement, farm improvement or home improvement specialty services.)

"*Recreational facility contracting*" (Abbr: RFC) is that service which provides for the construction, repair or improvement of any recreational facility, excluding paving and the construction of buildings. (Note: The building license classification also provides for this function.)

"*Striping/driveway contracting*" (Abbr: SDC) is that service which provides for the striping of roadways or parking lots or the construction of limited access driveways. (Note: The highway/heavy license classification also provides for this function.)

"*Vessel construction contracting*" (Abbr: VCC) is that service which provides for the construction, repair or improvement of a nonresidential vessel to hold or convey fluid bodies. (Note: The highway/heavy license classification also provides for this function.)

"*Water well contracting*" (Abbr: WWC) is that service which provides for the construction of a water well to reach groundwater as defined in § 62.1-44.85(8) of the Code of Virginia. (Note: No other license classification or specialty service provides for this function.)

Note: Specialty contractors engaging in construction which involves the following activities or items or similar activities or items may fall under the specialty service of commercial improvement, home improvement or farm improvement:

Awnings	Marble
Blinds	Masonry
Bricks	Metal Work
Bulkheads	Millwrighting
Cabinetry	Mirrors
Carpentry	Miscellaneous Iron
Carpeting	Ornamental Iron
Casework	Painting
Caulking	Partitions
Ceilings	Plastic Wall Finishing
Chimneys	Protective Coatings
Chutes	Rigging
Concrete	Roofing
Conduit Rodding	Rubber Linings
Curtains	Railings
Curtain Walls	Sandblasting
Decks	Scaffolding
Doors	Screens
Drapes	Siding
Drywall	Sheet Metal
Epoxy	Shingles
Exterior Decoration	Shutters
Facings	Skylights
Fences	Special Coatings
Fiberglass	Stone
Fireplaces	Storage Bins & Lockers
Fireproofing	Stucco
Floor Coverings	Temperature Controls
Flooring	Terrazzo
Floors	Tile
Glass	Vaults
Glazing	Vinyl Flooring
Grouting	Waterproofing
Grubbing	Wall Coverings
Guttering	Wall Panels
Illumination	Wall Tile
Insulation	Weatherstripping
Interior Decorating	Welding
Lighting	Windows
Lubrication	Wood Floors

PART II. ENTRY.

§ 2.1. Requirements for licensure as a Class A sole proprietorship, partnership, association or corporation.

Each sole proprietorship, general partnership, limited partnership, association or corporation seeking a Class A license shall complete an application furnished by the Department of Commerce *Professional and Occupational Regulation* and shall meet or exceed the requirements set forth below prior to issuance of the license.

A. Each applicant shall have a designated employee who is a sole proprietor, partner of the general partnership, managing partner of the limited partnership, member of the association, officer of the corporation or an individual in the full-time employ of the firm, who is at least 18

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years of age and who has successfully completed or who has been deemed to have fulfilled the written or oral licensure examination required by the board.

B. The board, in its discretion, may deny any application for licensure in which the sole proprietor, officers of the corporation, partners of the general partnership, managing partners of the limited partnership members of the association, or designated employee have not maintained good standing in every jurisdiction where licensed as a contractor and shall not have had that license suspended, revoked or surrendered in connection with a disciplinary action in any jurisdiction within five years prior to applying for licensure in Virginia.

C. Each applicant will be required to provide information for the past five years including, but not limited to, outstanding past-due debts, judgments, outstanding state or federal tax obligations, and defaults on bonds. (Evidence of a pattern of failure to pay debts or noncompliance with contractual obligations sufficient to warrant the conclusion that the contracting business applying for a license is not likely to meet the financial responsibilities of a contractor shall be a basis for the denial of a license.)

D. Each applicant will be required to submit, on a form provided by the board, information on the financial position of the contracting firm. Excluding any jointly owned residence, each applicant will also be required to state a net worth or net equity of \$45,000 or more.

E. Each applicant shall have in its full-time employ a qualified individual who is a sole proprietor, partner of the general partnership, managing partner of the limited partnership, member of the association, officer of the corporation or an individual in the full-time employ of the firm, who is at least 18 years of age and who has five years experience in the license classification or specialty service sought by the firm. For license classifications or specialty services in which the board also requires an examination to demonstrate experience, the qualified individual for the firm shall have also successfully completed or been deemed to have fulfilled the trade-related examination approved by the board.

F. Any Class A contractor licensed in the Commonwealth of Virginia prior to January 1, 1991, and in business on December 31, 1990, shall, within their current period of licensure, provide to the board in writing the name of one full-time employee who is at least 18 years of age and that employee shall be deemed to have fulfilled the requirement for examination in § 2.1 of these regulations, so long as he remains a full-time employee of that contractor. Upon the departure of that employee, the contractor shall name another full-time employee in accordance with § 2.1 A. A fee shall be required for a declaration of a designated employee in accordance with § 2.5 2.6 D of these regulations.

G. The board, in its discretion, may deny licensure to

any firm in which the sole proprietor, officers of the corporation, partners of the general partnership, managing partners of the limited partnership, members of the association, or designated employee have been convicted in any jurisdiction of a misdemeanor involving lying, cheating or stealing; or of any felony. Any plea of nolo contendere shall be considered a conviction for the purposes of this subsection. The record of a conviction, authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where convicted, shall be admissible as prima facie evidence of such conviction.

§ 2.2. Requirements for licensure as a Class B sole proprietorship, partnership, association or corporation.

Each sole proprietorship, general partnership, limited partnership, association or corporation seeking a Class B license shall complete an application furnished by the Department of Commerce and shall meet or exceed the requirements set forth below prior to issuance of the license.

A. Each applicant shall have a designated employee who is a sole proprietor, partner of the general partnership, managing partner of the limited partnership, member of the association, officer of the corporation or an individual in the full-time employ of the firm, who is at least 18 years of age and who has successfully completed or who has been deemed to have fulfilled the written or oral licensure examination required by the board.

B. The board, in its discretion, may deny any application for licensure in which the sole proprietor, officers of the corporation, partners of the general partnership, managing partners of the limited partnership, members of the association, or designated employee have not maintained good standing in every jurisdiction where licensed as a contractor and shall not have had that license suspended, revoked or surrendered in connection with a disciplinary action in any jurisdiction within five years prior to applying for licensure in Virginia.

C. Each applicant will be required to provide information for the past three years including, but not limited to, outstanding past-due debts, judgments, outstanding state or federal tax obligations, and defaults on bonds. (Evidence of a pattern of failure to pay debts or noncompliance with contractual obligations sufficient to warrant the conclusion that the contracting business applying for a license is not likely to meet the financial responsibilities of a contractor shall be a basis for the denial of a license.)

D. Each applicant who was not registered in the Commonwealth of Virginia prior to January 1, 1991, and in business on December 31, 1990, will be required to submit, on a form provided by the board, information on the financial position of the contracting firm. Excluding any jointly owned residence, each applicant will also be required to state a net worth or net equity of \$15,000 or more.

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E. Each applicant shall have in its full-time employ a qualified individual who is a sole proprietor, partner of the general partnership, managing partner of the limited partnership, member of the association, officer of the corporation or an individual in the full-time employ of the firm, who is at least 18 years of age and who has three years experience in the license classification or specialty service sought by the firm. For license classifications or specialty services in which the board also requires an examination to demonstrate experience, the qualified individual for the firm shall have also successfully completed or been deemed to have fulfilled the trade-related examination approved by the board.

F. Any Class B contractor registered in the Commonwealth of Virginia prior to January 1, 1991, and in business on December 31, 1990, shall, within their registration period, provide to the board in writing the name of one full-time employee who is at least 18 years of age and that employee shall be deemed to have fulfilled the requirement for examination in § 2.2 of these regulations, so long as he remains a full-time employee of that contractor. Upon the departure of that designated employee, the contractor shall name another full-time employee in accordance with § 2.2 A. A fee shall be required for a declaration of a designated employee in accordance with § 2.5 2.6 D of these regulations.

G. The board, in its discretion, may deny licensure to any firm in which the sole proprietor, officers of the corporation, partners of the general partnership, managing partners of the limited partnership, members of the association, or designated employee have been convicted in any jurisdiction of a misdemeanor involving lying, cheating or stealing; or of any felony. Any plea of nolo contendere shall be considered a conviction for the purposes of this subsection. The record of a conviction, authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where convicted, shall be admissible as prima facie evidence of such conviction.

§ 2.3. Registration for a Class C Certificate.

Every firm applying for a Class C Certificate must meet the following requirements:

A. Qualified individual - for every classification or specialty in which the firm seeks to be licensed, the firm shall name a qualified individual who meets the following requirements:

1. is at least 18 years old.
2. has a minimum of two years experience in the classification or specialty for which he is the qualifier,
3. is a full-time employee of the firm as defined in these regulations or is a member of the responsible management of the firm,
4. where appropriate, has passed the trade-related

examination approved by the board and required for the classification and specialties listed below:

blast/explosive contracting

radon mitigation

water well drilling.

B. Each firm shall provide information for the past five years prior to application on any outstanding, past-due debts and judgments, outstanding tax obligations or defaults on bonds. The firm, its qualified individual(s) and all members of the responsible management of the firm shall submit information on any past-due debts and judgments or defaults on bonds directly related to the practice of contracting as defined in § 54.1-1100 of the Code of Virginia.

C. The firm, the qualified individual and all members of the responsible management of the firm shall disclose at the time of application any current or previous contractor licenses held in Virginia or in any other jurisdictions and any disciplinary actions taken on these licenses, including but not limited to any monetary penalties, fines, suspension, revocation or surrender of a license in connection with a disciplinary action in Virginia or any other jurisdiction within the five years immediately prior to applying for a Virginia contractor license.

D. In accordance with § 54.1-204 of the Code of Virginia, each applicant shall disclose the following information about the firm, any member of the responsible management and the qualified individual(s) for the firm:

1. a conviction in any jurisdiction of any felony,
2. a conviction in any jurisdiction of a misdemeanor related to the practice of contracting, as defined in § 54.1-1100 of the Code of Virginia, within the five years immediately prior to application.

Any plea of nolo contendere shall be considered a conviction for purposes of this paragraph. The record of a conviction received from a court shall be accepted as prima facie evidence of a conviction or finding of guilt. The board, in its discretion, may deny certification to any applicant in accordance with § 54.1-204 of the Code of Virginia.

§ 2.3. 2.4. Examination requirements.

A. The designated employee for a Class A firm, except as provided in § 2.1 F, shall attain a passing grade established by the board on a licensure examination the subject of which shall be the regulations and statutes of the board and the general knowledge necessary to engage in the administrative and business activities of the Class A firm. The Class A licensure examination shall consist of the Virginia section, General section, and Advanced section. The Virginia section will test the candidate's

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knowledge of statutory and regulatory requirements. The General section will test the candidate's general administrative and business knowledge necessary to engage in contracting activities. The Advanced section will test the candidate's general administrative and business knowledge necessary to engage in Class A contracting activities.

B. The designated employee for a Class B firm, except as provided in § 2.2 F, shall attain a passing grade established by the board on a licensure examination the subject of which shall be the regulations and statutes of the board and the general knowledge necessary to engage in the administrative and business activities of the Class B firm. The Class B licensure examination shall consist of the Virginia section and General section. The Virginia section will test the candidate's knowledge of statutory and regulatory requirements. The General section will test the candidate's general administrative and business knowledge necessary to engage in contracting activities.

C. Licensure examinations which are required by the board shall be approved by the board and provided by the board or by a testing service acting on behalf of the board. (Note: An individual fulfilling the licensure examination requirement for a contracting firm is referred to as that designated employee.)

D. Trade-related examinations which are also required by the board to demonstrate experience for a license classification or specialty service shall be approved by the board and provided by the board, a testing service acting on behalf of the board, or another governmental agency or organization. The board currently requires trade-related examinations in the electrical, plumbing and HVAC license classifications and the blast/explosive, gas fitting, radon mitigation and water well contracting specialty services. (Note: An individual fulfilling a trade-related examination requirement for a contracting firm must also serve as a firm's qualified individual.)

§ ~~2.4~~ 2.5. License by reciprocity.

A. Applicants for Class A licensure by reciprocity shall meet the requirements set forth in § 2.1 of these regulations. A designated employee, for the firm seeking reciprocal licensure, who has passed in the jurisdiction of original licensure an examination deemed to be substantially equivalent to the licensure examination required by the board shall only be required to successfully complete the Virginia section, and when deemed necessary, the Advanced section of the licensure examination. A qualified individual, for the firm seeking reciprocal licensure, who has passed in the jurisdiction of original licensure an examination deemed to be substantially equivalent to a trade-related examination required by the board shall be deemed to have fulfilled the trade-related examination requirement.

B. Applicants for Class B licensure by reciprocity shall meet the requirements set forth in § 2.2 of these regulations. A designated employee, for the firm seeking

reciprocal licensure, who has passed in the jurisdiction of original licensure an examination deemed to be substantially equivalent to the licensure examination required by the board shall only be required to successfully complete the Virginia section of the licensure examination. A qualified individual for the firm seeking reciprocal licensure who has passed in the jurisdiction of original licensure an examination deemed to be substantially equivalent to a trade-related examination required by the board shall be deemed to have fulfilled the trade-related examination requirement.

C. No license /*certificate* shall be issued to an applicant whose previous license/registration has been suspended for nonpayment of a Virginia Contractor Transaction Recovery Fund assessment until all past-due assessments have been paid.

§ ~~2.5~~ 2.6. Fees for licensing, designated employee declaration, and examination.

A. Fee payments.

Each check or money order shall be made payable to the Treasurer of Virginia. All fees required by the board are nonrefundable.

B. Class A original license fee.

The fee for an initial Class A license shall be \$85.

C. Class B original license fee.

The fee for an initial Class B license shall be \$65.

D. Designated employee declaration fee.

The fee for declaring a designated employee for Class A or B licensure shall be \$25.

E. Class C original certification fee.

The fee for an original Class C certificate shall be \$65.

E. F. Class A licensure examination fee.

The fee for a Class A licensure examination shall be \$60. The fee for an examination in any individual section of the Class A licensure examination package shall be \$20 for the Virginia section, \$20 for the General section, and \$20 for the Advanced section. Individuals who successfully complete one or more but not all of the sections upon initial examination shall have 12 months from the date of that initial examination to successfully complete the remaining sections of the Class A examination package.

F. G. Class B licensure examination fee.

The fee for a Class B licensure examination shall be \$40. The fee for an examination in any individual section of the Class B licensure examination package shall be \$20

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for the Virginia section and \$20 for the General section. Individuals who successfully complete only one section upon initial examination shall have 12 months from the date of that initial examination to successfully complete the remaining section of the Class B examination package.

G. H. Class A reciprocity licensure examination fees.

The fee for a Class A reciprocity licensure examination shall be \$20 for individuals required to take only the Virginia section of the Class A licensure examination package and \$40 for individuals required to take both the Virginia section and Advanced section of the Class A licensure examination package.

H. I. Class B reciprocity licensure examination fee.

The fee for a Class B reciprocity licensure examination shall be \$20 for individuals required to take the Virginia section of the Class B licensure examination package.

I. J. Upgrade licensure examination fees.

The fee for the Advanced section of the licensure examination shall be \$20 when a designated employee for a Class B contractor seeks to successfully complete the Class A licensure examination requirement.

J. K. License /certificate classification or specialty service trade-related examination fees.

The fees for trade-related examinations, when offered by the board or a testing service on behalf of the board, are as follows:

The fee for a specialty examination in the service of water well contracting is \$40.

(Note: Examination fees for license classification or specialty service examinations, which are required but not administered by the board or a testing service on behalf of the board, pursuant to § 2-3 2.4 D of these regulations, shall be determined by the governmental agency or organization administering the applicable license classification or specialty service exam.)

PART III. RENEWAL AND REINSTATEMENT.

§ 3.1. Renewal.

All Class A and Class B licensees and Class C certificate holders wishing to renew their licenses /certificates must apply for license /certificate renewal every two years. After January 1, 1991, Class B registrations are not renewable in accordance with § 54.1-1108.1 of the Code of Virginia.

A. Fees.

The application fee for renewal of a Class A license is

\$65 and the application fee for renewal of a Class B license is \$45. The fee for renewal of a Class C certificate is \$45. All fees required by the board are nonrefundable.

B. Procedures.

The Department of Commerce Professional and Occupational Regulation will mail a renewal notice to the licensee /certificate holder outlining procedures for renewal. Failure to receive this notice, however, shall not relieve the licensee /certificate holder of the obligation to renew. If the licensee /certificate holder fails to receive the renewal notice, a copy of the license /certificate may be submitted with the required fee as an application for renewal within 30 days of the expiration date of the license /certificate.

C. Applicants for renewal of a license (expiring on or after January 31, 1991) shall certify on a form provided by the board that they meet the current standards for entry as follows:

1. Those applying for renewal of a Class A license shall meet the requirements of §§ 2.1 A, 2.1 B, 2.1 G, and, where applicable, § 2.1 E.

2. Those applying for renewal of a Class B license shall meet the requirements of §§ 2.2 A, 2.2 B, 2.2 G, and, where applicable, § 2.2 E.

D. The date on which the renewal fee is received by the department or its agent will determine whether the licensee /certificate holder is eligible for renewal or required to apply for reinstatement.

§ 3.2. Reinstatement.

Should the Department of Commerce Professional and Occupational Regulation fail to receive a licensee's /certificate holder's renewal application or fees within 30 days of the license /certificate expiration date, the licensee will be required to reinstate the license /certificate.

A. Fees.

The application fee for reinstatement of a Class A license is \$75 and the application fee for reinstatement of a Class B license is \$60. The application fee for reinstatement of a Class C certificate is \$60. All fees required by the board are nonrefundable.

B. Applicants for reinstatement shall meet the requirements of § 3.1 of these regulations.

C. The date on which the reinstatement fee is received by the Department of Commerce Professional and Occupational Regulation or its agent will determine whether the license /certificate is reinstated or a new application for licensure /certification is required.

D. In order to ensure that licensees /certificate holders

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are qualified to practice as contractors, no reinstatement will be permitted once six months from the expiration date of the license /certificate has passed. After that date the applicant must apply for a new license /certificate and meet the then current entry requirements.

§ 3.3. Board discretion to deny renewal or reinstatement.

The board may deny renewal or reinstatement of a license /certificate for the same reasons as it may refuse initial licensure /certification or discipline a licensee /certificate holder .

PART IV. STANDARDS OF PRACTICE.

§ 4.1. Management personnel.

A. Reporting of Management Personnel.

Class A licensees and , Class B licensees /registrants and Class C certificate holders shall report in writing or on a form provided by the board the following personnel:

- Sole proprietor;
- Partners of a general partnership;
- Managing partners of a limited partnership;
- Members of an association;
- Officers of the corporation;
- Designated employee (Class A and Class B licensees only) ;
- Qualified individual.

B. Changes in management personnel.

Should any change occur in the management personnel, the licensee/ ~~registrant~~ certificate holder is required to report those changes to the board within 90 days of the change. A change in management personnel shall be reported as follows:

1. When there is a change in the sole proprietor, the partners of a general partnership, managing partners of a limited partnership, or members of an association, the licensee/ ~~registrant~~ certificate holder will report those changes in a signed statement to the board. (A change in the sole proprietor, the partners of a general partnership, managing partners of a limited partnership, or members of an association will result in the termination of the license/ ~~registration~~ certificate .)
2. When there is a change in the officers of the corporation, the licensee/ ~~registrant~~ certificate holder shall report those changes on a form provided by the

board.

3. When there is a change in the designated employee, the licensee shall declare, on a form provided by the board, a new designated employee. New designated employees shall be declared as follows:

- a. Individuals declared as designated employees for Class A firms shall meet the requirements of § 2.1 A, § ~~2-3~~ 2.4 A or §§ 2.4 2.5 A and 2.5 2.6 D.
- b. Individuals declared as designated employees for Class B firms shall meet the requirement of § 2.1 B, § ~~2-3~~ 2.4 B or §§ 2.4 2.5 B and 2.5 2.6 D.

4. When there is a change in a qualified individual, the licensee /certificate holder shall report, on a form provided by the board, a new qualified individual. New qualified individuals shall be reported as follows:

- a. Individuals reported as qualified individuals for Class A firms shall meet the requirements of § 2.1 E.
- b. Individuals reported as qualified individuals for Class B firms shall meet the requirements of § 2.2 E.
- c. Individuals reported as qualified individuals for Class C firms shall meet the requirements of § 2.3 A.

C. Status of license /certificate due to changes in the officers of a corporation, designated employee, or qualified individuals.

In the event that a reported change of personnel affects the status of the contracting firm's license/ ~~registration~~ certificate the board shall promptly notify the licensed/ ~~registered~~ certified firm in writing that the continuation of its license/ ~~registration~~ certification has been deferred for the board's review and consideration. Subsequent to the board's consideration, the firm will further be notified in writing that its license/ ~~registration~~ certification has been granted or denied in accordance with these regulations.

D. Restrictions for designated employees.

Designated employees are required to be in the full-time employ of the contracting firm, which means they may not, as designated employees , represent more than two firms at one time unless they also serve as the sole proprietor, partner in the general partnership, managing partner in limited partnership, member of the association, or officer of the corporation for those same contracting firms.

E. Restrictions for qualified individuals.

Qualified individuals are required to be in the full-time employ of the contracting firm, which means they may

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not, as qualified individuals, represent more than two firms at one time.

§ 4.2. Firm names.

A licensee/ ~~registrant~~ *certificate holder* must operate under the name in which the license/ ~~registration~~ *certificate* is issued. As long as there is no change in the legal entity, a licensee/ ~~registrant~~ *certificate holder* may secure a name change by submitting a written request to the board for such a change. The request must show the name as it then appears on the license/ ~~registration~~ *certificate* and the new name, and must be accompanied by a Certificate of Amendment from the State Corporation Commission if the licensee/ ~~registrant~~ *certificate holder* is a corporation, or authorization from the appropriate local court, if a licensee/ ~~registrant~~ *certificate holder* other than a corporation is trading under a fictitious name.

§ 4.3. Changes, additions, or deletions to license classifications or specialty services.

A licensee */certificate holder* may change a license classification or specialty service or obtain additional license classifications or specialty services by demonstrating, on a form provided by the board, acceptable evidence of experience in the license classifications or specialty services sought. The experience necessary for a Class A firm may be demonstrated by meeting the requirements of § 2.1 E. The experience necessary for a Class B firm may be demonstrated by meeting the requirements of § 2.2 E. *The experience necessary for a Class C firm may be demonstrated by meeting the requirements of § 2.3 A.* The fee for each change or addition is \$25. All fees required by the board are nonrefundable. If a licensee */certificate holder* is seeking to delete a license classification or specialty service, then it shall provide a signed statement listing the license classifications or specialty services to be deleted. There is no fee for the deletion of a license classification or specialty service. (If the licensee */certificate holder* only has one license classification or specialty service, the deletion of that classification or service will result in the termination of the license */certificate*.)

§ 4.4. Change of address.

Licensees/ ~~registrants~~ *certificate holders* shall report any change of address to the board in writing within 30 days of the change.

§ 4.5. Transfer of license/ ~~registration~~ *certificate* prohibited.

No license/ ~~registration~~ *certificate* issued by the board shall be assigned or otherwise transferred. Licenses/ ~~registrations~~ *certificates* are issued to the legal business entities whether they be proprietorships, general partnerships, limited partnerships, associations, or corporations. Whenever there is any change in the ownership of a sole proprietorship, general partnership, or

association, a new license */certificate* is required. Also, whenever the managing partners of a limited partnership change or when a corporation is dissolved and a new corporation formed, a new license */certificate* is required.

PART V. STANDARDS OF CONDUCT.

§ 5.1. Filing of charges.

All complaints against contractors may be filed with the Department of Commerce at any time during business hours pursuant to § 54.1-1114 of the Code of Virginia.

§ 5.2. Prohibited acts.

The following are cause for disciplinary action:

1. Failure in any material way to comply with provisions of Chapter 1 or Chapter 11 of Title 54.1 of the Code of Virginia or the regulations of the board.
2. Furnishing substantially inaccurate or incomplete information to the board in obtaining, renewing, reinstating, or maintaining a license */certificate*.
3. Where the sole proprietor, officer of the corporation, partner in the partnership, members of the association, or designated employee have failed to report to the board, in writing, the suspension or revocation of a contractor license by another state or his conviction in a court of competent jurisdiction of a building code violation.
4. Publishing or causing to be published any advertisement relating to contracting which contains an assertion, representation, or statement of fact that is false, deceptive, or misleading.
5. Gross negligence, or continued incompetence, or misconduct in the practice of his profession.
6. A finding of improper or dishonest conduct in the practice of his profession by a court of competent jurisdiction.
7. Failure of all those who engage in residential contracting, excluding subcontractors to the contracting parties and those who engage in routine maintenance or service contracts, to make use of a legible written contract clearly specifying the terms and conditions of the work to be performed. For the purposes of these regulations, residential contracting means construction, removal, repair, or improvements to single-family or multiple-family residential buildings, including accessory-use structures. Prior to commencement of work or acceptance of payments, the contract shall be signed by both the consumer and the licensee/ ~~registrant~~ *certificate holder* or his agent. At a minimum the contract shall specify or disclose the following:

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- a. When work is to begin and the estimated completion date;
 - b. A statement of the total cost of the contract and the amounts and schedule for progress payments including a specific statement on the amount of the down payment;
 - c. A listing of materials and work to be performed, which is specifically requested by the consumer;
 - d. A "plain-language" exculpatory clause concerning events beyond the control of the contractor and a statement explaining that delays caused by such events do not constitute abandonment and are not included in calculating time frames for payment or performance;
 - e. A statement of assurance that the contractor will comply with all local requirements for building permits, inspections, and zoning;
 - f. Disclosure of the cancellation rights of the parties;
 - g. For contracts resulting from a door to door solicitation, a signed acknowledgement by the consumer that he has been provided with and read the Department of ~~Commerce~~ *Professional and Occupational Regulation* statement of protections available to him through the Board for Contractors;
 - h. Contractor's name, address, license/ ~~registration~~ *certificate* number, expiration date, class of license/ ~~registration~~ *certificate*, and license classifications or specialty services;
 - i. Statement providing that any modification to the contract, which changes the cost, materials, work to be performed, or estimated completion date, must be in writing and signed by all parties.
8. Failure to make prompt delivery to the consumer before commencement of work of a fully executed copy of the contract as described in subdivision 7 of this section for construction or contracting work.
 9. Failure of the contractor to maintain, for a period of three years from the date of contract, a complete and legible copy of all documents relating to that contract, including, but not limited to, the contract and any addenda or change orders.
 10. Refusing or failing, upon request or demand, to produce to the board, or any of its agents, any document, book, record or copy thereof in the licensee's/ ~~registrant's~~ *certificate holder's* possession concerning a transaction covered by these regulations or for which the licensee/ ~~registrant~~ *certificate holder* is required to maintain records, or failing to cooperate in the investigation of a complaint filed with the board against the contractor.
 11. Abandonment, or the intentional and unjustified failure to complete work contracted for, or the retention or misapplication of funds paid, for which work is either not performed or performed only in part. (Unjustified cessation of work under the contract for a period of 30 days or more shall be considered evidence of abandonment.)
 12. Making any misrepresentation or making a false promise of a character likely to influence, persuade, or induce.
 13. Aiding or abetting an unlicensed/ ~~unregistered~~ *uncertified* contractor to violate any provision of Chapter 1 or Chapter 11 of Title 54.1 of the Code of Virginia, or these regulations; or combining or conspiring with, or acting as agent, partner, or associate for, an unlicensed/ ~~unregistered~~ *uncertified* contractor; or allowing a firm's license/ ~~registration~~ *certificate* to be used by an unlicensed/ ~~unregistered~~ *uncertified* contractor; or acting as or being an ostensible licensee/ ~~registrant~~ *certificate holder* for undisclosed persons who do or will control or direct, directly or indirectly, the operations of the licensee's/ ~~registrant's~~ *certificate holder's* business.
 14. Where the sole proprietor, officers of the corporation, partners in the general partnership, members of the association, or designated employee have offered, given or promised anything of value or benefit to any federal, state, or local employee for the purpose of influencing that employee to circumvent, in the performance of his duties, any federal, state, or local law, regulation, or ordinance governing the construction industry.
 15. Where the firm, sole proprietor, partners in the general partnership, managing partners in the limited partnership, member of the association, officers of the corporation or designated employee have been convicted or found guilty, after initial licensure, regardless of adjudication, in any jurisdiction of any felony or of a misdemeanor involving lying, cheating or stealing, there being no appeal pending therefrom or the time of appeal having elapsed. Any plea of guilty or nolo contendere shall be considered a conviction for the purposes of this subdivision. The record of a conviction certified or authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where convicted shall be admissible as prima facie evidence of such guilt.
 16. Having failed to inform the board in writing within 30 days that the firm or its sole proprietor or one of its partners in the general partnership, managing partners in the limited partnership, members of the association, officers of the corporation or that its designated employee has pleaded guilty or nolo contendere or was convicted and found guilty of any felony or of a misdemeanor involving lying, cheating or stealing.

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17. Having been disciplined by any county, city, town, or any state or federal governing body, which action shall be reviewed by the board before it takes any disciplinary action of its own.

18. Failure to comply with the Virginia Uniform Statewide Building Code, as amended.

19. Failure of a contractor to notify Miss Utility prior to excavation, as required by the Underground Utility Damage Prevention Act (§ 56-265.14 et seq. of the Code of Virginia).

20. Practicing in a license classification or specialty service for which the contractor is not licensed /certified .

VA.R. Doc. No. R94-1093; Filed July 1, 1994, 11:37 a.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulations: Emergency Regulation for Definition of State Plan Health Maintenance Organizations.
VR 460-01-11. Application, Determination of Eligibility and Furnishing Medicaid (§ 2.1(b)).
VR 460-02-2.1100. Definition of Medicaid State Plan Health Maintenance Organizations (Attachment 2.1-A).

Statutory Authority: § 32.1-324 of the Code of Virginia.

Effective Date: July 1, 1994, through June 30, 1995.

Summary:

1. **REQUEST:** The Governor is hereby requested to approve this agency's adoption of the emergency regulation entitled Definition of Medicaid State Plan Health Maintenance Organizations (HMOs). This regulation defines HMOs, a step that is needed to initiate contracting as required by the 1994 Appropriations Act.

2. **RECOMMENDATION:** Recommend approval of the Department's request to take an emergency adoption action regarding Definition of State Plan HMOs. The Department intends to initiate the public notice and comment requirements contained in the Code of Virginia § 9-6.14:7.1.

/s/ Bruce U. Kozlowski
Director
Date: May 26, 1994

3. CONCURRENCES:

/s/ Kay Coles James
Secretary of Health and Human Resources
Date: June 10, 1994

4. GOVERNOR'S ACTION:

/s/ George Allen
Governor
Date: June 28, 1994

5. FILED WITH:

/s/ Ann M. Brown
Deputy Registrar of Regulations
Date: July 1, 1994

DISCUSSION

6. **BACKGROUND:** The sections of the State Plan affected by this action are § 2.1 (c), Coverage and Eligibility (VR 460-01-11) and Attachment 2.1 A, Definition of Medicaid State Plan HMO (VR 460-02-2.1100).

The Appropriations Act, passed by the 1994 General Assembly, requires the Department of Medical Assistance Services (DMAS) to implement an HMO contracting program effective May 1, 1994. Federal regulations at 42 CFR 434.20 (c) require that the state define HMOs in the State Plan prior to entering into risk contracts with entities that are not Federally qualified HMOs and that are providing comprehensive services. The regulations define extensive requirements for HMOs, which the Virginia State Corporation Commission Bureau of Insurance has promulgated as Regulation 28. Rather than promulgate a separate set of regulations, DMAS is incorporating by reference Regulation 28. A new Attachment (2.1 A) is being added to the State Plan to define a Medicaid HMO as required.

The Medicaid services covered by the HMOs will be specifically defined in provider contracts. Applicable State Plan services not provided in these contracts will be covered through fee-for-service Medicaid providers.

7. **AUTHORITY TO ACT:** The Code of Virginia (1950) as amended, § 32.1-324, 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) § 9-6.14:4.1(C)(5)(ii), for an agency's adoption of emergency regulations subject to the Governor's prior approval. Subsequent to the emergency adoption action and filing with the Registrar of Regulations, this agency intends to initiate the public notice and comment process contained in Article 2 of the APA.

Without an emergency regulation, this amendment cannot become effective until the publication and concurrent comment and review period requirements of the APA's Article 2 are met. Therefore, an emergency regulation is needed to make this regulation as soon as possible as required by the General Assembly. The Appropriations Act was not signed by the Governor by the required effective date of May 1, 1994, so this regulation will become effective as soon as possible after that date.

Emergency Regulations

8. **FISCAL/BUDGETARY IMPACT:** This regulation will allow DMAS to contract with HMOs. The rate of payment to HMOs will be 5 percent below the cost to the Department of providing those services outside the HMO. The 1994 Appropriations Act reflects a savings from HMO contracting of \$1 million (\$500,000 General Funds, \$500,000 Non-General Funds) in fiscal year 1995 and \$5 million (\$2.5 million GF, \$2.5 million NGF) in fiscal year 1996.

9. **RECOMMENDATION:** Recommend approval of this request to adopt this emergency regulation to become effective upon filing with the Registrar of Regulations. From its effective date, this regulation is to remain in force for one full year or until superseded by final regulations promulgated through the APA. Without an effective emergency regulation, the Department would lack the authority to contract with HMOs that are not Federally qualified.

10. Approval Sought for VR 460-01-11, VR 460-02-2.1100.

Approval of the Governor is sought for an emergency modification of the Medicaid State Plan in accordance with the Code of Virginia § 9-6.14:4.1(C)(5)(ii) to adopt the following regulation:

VR 460-01-11. Application, Determination of Eligibility and Furnishing Medicaid (§ 2.1 (b)).

Citation: 42 CFR 435.914, 1902(a)(34) of the Act

2.1(b) (1) Except as provided in § 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.

Citation: 1902(e)(8) and 1905(a) of the Act

(2) For individuals who are eligible for Medicaid cost-sharing expenses as qualified Medicare beneficiaries under § 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

Citation: 1902(a)(47) and 1920 of the Act

(3) Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with § 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

Citation: 42 CFR 434.20

2.1(c) The Medicaid agency elects to enter into a risk

contract with an HMO that is:

Qualified under Title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to § 1903(m)(3) of the Social Security Act.

Not federally qualified, but meets the requirements of 42 CFR 434.20(c) and is defined in Attachment 2.1-A.

Not applicable.

VR 460-02-2.1100. Definition of Medicaid State Plan Health Maintenance Organizations (Attachment 2.1-A).

§ 1.0. A Virginia Medicaid Qualifying Health Maintenance Organization (HMO) is defined as an entity which has a license to operate as a health maintenance organization issued by the Bureau of Insurance of the State Corporation Commission.

§ 2.0. The Bureau of Insurance of the Virginia State Corporation Commission (Regulation 28 (June 24, 1987, as revised)) provides licensing only to HMOs meeting the requirements of 42 CFR 434.20 (c).

A. Virginia Medicaid Qualifying HMOs shall be primarily organized for the purpose of providing health care services. As provided for in Regulation 28, an HMO is an organization which undertakes to provide or arrange for one or more health care plans. A health care plan is any arrangement in which any health maintenance organization undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

B. Virginia Medicaid Qualifying HMOs shall make the services they provide as accessible to Medicaid enrollees as those services are available to non-enrolled Medicaid recipients within the area served by the Virginia Medicaid Qualifying HMO. As provided for in Regulation 28, all Virginia Medicaid Qualifying HMOs must establish and maintain arrangements satisfactory to the Medicaid Agency to assure both availability and accessibility of personnel and facilities providing health care services including:

1. reasonable hours of operation and after-hours emergency health care,

2. reasonable proximity to enrollees within the service area, so as not to result in unreasonable barriers to accessibility,

3. sufficient personnel, including health professionals, administrators, and support staff, to reasonably assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollee, and

4. adequate arrangements to provide inpatient

hospital services for basic health care.

C. Regulation 28 provides controls limiting the risk of insolvency of Virginia Medicaid Qualifying HMOs, and assuring that Medicaid enrollees will not be liable for any Virginia Medicaid Qualifying HMO's debts should it become insolvent. Specifically, Regulation 28 sets forth the requirements for a Virginia Medicaid Qualifying HMO's minimum net worth, deposits with the State Treasurer, mandated liability insurance, enrollee hold harmless provisions in subcontracts, and accounting and reporting responsibilities.

§ 3.0. The Medicaid Agency shall, through the terms and conditions of risk contracts with Virginia Medicaid Qualifying HMOs, make provisions for meeting the additional requirements provided for in 42 CFR 434.

VA.R. Doc. No. R94-1092; Filed July 1, 1994, 9:30 a.m.

STATE CORPORATION COMMISSION

AT RICHMOND, JUNE 28, 1994

SINGLE PREMIUM CREDIT ACCIDENT AND
SICKNESS INSURANCE RATES PER \$100 OF
INITIAL INSURED INDEBTEDNESS REPAYABLE
IN EQUAL MONTHLY INSTALLMENTS

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

CASE NO. INS940096

Ex Parte, in re: adoption of adjusted prima facie rates for credit life and credit accident and sickness insurance pursuant to Virginia Code Sections 38.2-3725, 38.2-3726, 38.2-3727 and 38.2-3730

TAKE NOTICE ORDER

TAKE NOTICE that, pursuant to Virginia Code Section 38.2-3730.B., that the Commission shall conduct a hearing on July 28, 1994 at 10:00 a.m. in its courtroom, Tyler Building, 2nd Floor, 1300 East Main Street, Richmond, Virginia 23219 for the purpose of receiving comments from interested parties with respect to proposed adjusted prima facie rates for credit life insurance and credit accident and sickness insurance. The adjusted prima facie rates have been proposed to the Commission by the Bureau of Insurance and are attached hereto and made a part hereof.

AN ATTESTED COPY hereof together with the attached proposed adjusted prima facie rates shall be sent by the Clerk of the Commission to Deputy Commission of Insurance Gerald A. Milsky who shall cause forthwith a copy thereof to be sent to every insurance company licensed by the Bureau of Insurance to transact the business of credit life insurance and/or the business of credit accident and sickness in the Commonwealth of Virginia.

PROPOSED ADJUSTED PRIMA FACIE CREDIT LIFE
AND CREDIT ACCIDENT AND SICKNESS
INSURANCE RATES TO BE EFFECTIVE
JANUARY 1, 1995

CREDIT LIFE INSURANCE RATES

\$6485 per month per \$1,000.00 of outstanding insured indebtedness if premiums are payable on a monthly outstanding balance basis.

\$4140 per \$100 of initial indebtedness repayable in twelve equal monthly installments.

Benefit Period (Months)	7 Day Coverages		14 Day Coverages		30 Day Coverages	
	Retro	Elim	Retro	Elim	Retro	Elim
1	1.58	1.20	1.47	0.91	1.11	0.50
2	1.90	1.53	1.73	1.18	1.26	0.66
3	2.13	1.76	1.92	1.37	1.39	0.78
4	2.30	1.93	2.07	1.53	1.48	0.89
5	2.43	2.07	2.19	1.65	1.56	0.97
6	2.55	2.19	2.29	1.76	1.63	1.04
7	2.63	2.27	2.37	1.84	1.69	1.11
8	2.70	2.35	2.44	1.91	1.75	1.16
9	2.77	2.42	2.50	1.97	1.79	1.21
10	2.83	2.48	2.55	2.04	1.83	1.26
11	2.87	2.53	2.61	2.09	1.87	1.30
12	2.91	2.57	2.65	2.13	1.90	1.33
13	2.96	2.62	2.69	2.18	1.94	1.37
14	3.00	2.66	2.73	2.22	1.97	1.40
15	3.05	2.70	2.77	2.26	2.00	1.43
16	3.09	2.75	2.81	2.30	2.04	1.47
17	3.13	2.79	2.85	2.34	2.06	1.50
18	3.18	2.84	2.90	2.39	2.10	1.53
19	3.22	2.88	2.93	2.43	2.13	1.56
20	3.27	2.92	2.98	2.48	2.16	1.60
21	3.31	2.97	3.02	2.51	2.19	1.63
22	3.35	3.01	3.06	2.55	2.23	1.66
23	3.40	3.05	3.10	2.60	2.26	1.69
24	3.44	3.11	3.14	2.64	2.29	1.73
25	3.47	3.13	3.17	2.67	2.31	1.75
26	3.49	3.16	3.20	2.70	2.33	1.77
27	3.53	3.20	3.23	2.73	2.36	1.80
28	3.55	3.22	3.26	2.76	2.38	1.83
29	3.58	3.26	3.28	2.79	2.41	1.84
30	3.62	3.28	3.31	2.82	2.42	1.87
31	3.64	3.32	3.34	2.84	2.45	1.90
32	3.67	3.34	3.37	2.88	2.48	1.91
33	3.70	3.37	3.40	2.91	2.49	1.94
34	3.73	3.41	3.42	2.93	2.52	1.97
35	3.76	3.43	3.46	2.97	2.55	1.99
36	3.79	3.47	3.48	2.99	2.56	2.01
37	3.82	3.49	3.51	3.02	2.58	2.04
38	3.84	3.51	3.53	3.05	2.61	2.05
39	3.86	3.54	3.55	3.06	2.62	2.07
40	3.89	3.56	3.58	3.09	2.64	2.09
41	3.91	3.59	3.60	3.12	2.66	2.12
42	3.93	3.61	3.63	3.14	2.68	2.13
43	3.96	3.63	3.65	3.17	2.70	2.15
44	3.98	3.66	3.67	3.19	2.72	2.18
45	4.00	3.69	3.70	3.21	2.74	2.19
46	4.03	3.71	3.72	3.24	2.76	2.21
47	4.06	3.73	3.74	3.27	2.77	2.24
48	4.07	3.76	3.77	3.28	2.80	2.26
49	4.10	3.78	3.78	3.31	2.81	2.27
50	4.12	3.80	3.81	3.33	2.83	2.29
51	4.13	3.82	3.83	3.35	2.84	2.31
52	4.16	3.84	3.84	3.37	2.86	2.33
53	4.18	3.86	3.87	3.40	2.88	2.34
54	4.20	3.89	3.89	3.41	2.90	2.36
55	4.22	3.91	3.91	3.43	2.91	2.38
56	4.24	3.93	3.92	3.46	2.93	2.40
57	4.27	3.95	3.95	3.48	2.95	2.41
58	4.28	3.97	3.97	3.50	2.97	2.43
59	4.30	3.99	3.98	3.52	2.98	2.45
60	4.33	4.01	4.01	3.54	3.00	2.47
61	4.34	4.03	4.03	3.56	3.02	2.48
62	4.36	4.06	4.05	3.58	3.03	2.50
63	4.38	4.07	4.06	3.60	3.05	2.52
64	4.40	4.09	4.08	3.62	3.06	2.54
65	4.42	4.11	4.10	3.63	3.08	2.55
66	4.43	4.13	4.12	3.65	3.09	2.56

State Corporation Commission

67	4.45	4.14	4.13	3.68	3.11	2.58
68	4.47	4.17	4.15	3.70	3.12	2.60
69	4.49	4.19	4.17	3.71	3.14	2.62
70	4.51	4.20	4.20	3.73	3.15	2.63
71	4.53	4.22	4.21	3.75	3.17	2.65
72	4.55	4.24	4.23	3.77	3.19	2.66
73	4.56	4.26	4.25	3.79	3.20	2.68
74	4.58	4.27	4.26	3.81	3.21	2.69
75	4.59	4.29	4.27	3.83	3.23	2.71
76	4.61	4.31	4.29	3.84	3.25	2.72
77	4.63	4.33	4.31	3.85	3.26	2.74
78	4.64	4.34	4.33	3.87	3.27	2.76
79	4.66	4.36	4.34	3.89	3.28	2.76
80	4.68	4.38	4.36	3.91	3.30	2.78
81	4.70	4.40	4.38	3.92	3.32	2.80
82	4.71	4.42	4.40	3.94	3.33	2.82
83	4.73	4.43	4.42	3.96	3.34	2.83
84	4.75	4.45	4.42	3.98	3.36	2.84
85	4.76	4.47	4.44	3.99	3.37	2.86
86	4.77	4.49	4.46	4.01	3.39	2.87
87	4.79	4.49	4.48	4.03	3.40	2.89
88	4.81	4.51	4.49	4.05	3.41	2.90
89	4.82	4.53	4.50	4.06	3.42	2.91
90	4.84	4.55	4.52	4.07	3.44	2.93
91	4.85	4.56	4.54	4.09	3.45	2.94
92	4.87	4.57	4.55	4.11	3.47	2.96
93	4.88	4.59	4.56	4.13	3.48	2.97
94	4.90	4.61	4.58	4.14	3.49	2.98
95	4.92	4.63	4.60	4.16	3.50	3.00
96	4.93	4.64	4.61	4.17	3.52	3.01
97	4.94	4.65	4.63	4.19	3.53	3.03
98	4.96	4.67	4.64	4.20	3.54	3.04
99	4.97	4.69	4.65	4.22	3.55	3.05
100	4.99	4.70	4.67	4.23	3.56	3.06
101	5.00	4.71	4.68	4.25	3.58	3.08
102	5.01	4.73	4.70	4.27	3.59	3.09
103	5.03	4.75	4.71	4.27	3.60	3.11
104	5.05	4.76	4.72	4.29	3.62	3.12
105	5.06	4.77	4.74	4.31	3.63	3.13
106	5.07	4.79	4.76	4.33	3.64	3.14
107	5.08	4.80	4.77	4.34	3.65	3.16
108	5.10	4.82	4.78	4.35	3.67	3.17
109	5.12	4.84	4.79	4.37	3.68	3.18
110	5.13	4.85	4.81	4.38	3.69	3.20
111	5.14	4.86	4.82	4.40	3.70	3.20
112	5.15	4.87	4.84	4.41	3.71	3.22
113	5.17	4.89	4.85	4.42	3.72	3.23
114	5.18	4.90	4.86	4.43	3.73	3.24
115	5.20	4.92	4.87	4.45	3.75	3.26
116	5.21	4.92	4.89	4.47	3.76	3.27
117	5.22	4.94	4.90	4.48	3.77	3.28
118	5.23	4.96	4.92	4.49	3.78	3.29
119	5.25	4.97	4.92	4.50	3.79	3.30
120	5.26	4.99	4.94	4.52	3.80	3.32

VA.R. Doc. No. R94-1096; Filed July 5, 1994, 11:43 a.m.

AT RICHMOND, JULY 1, 1994

APPLICATION OF

NATIONAL ASSOCIATION OF
SECURITIES DEALERS, INC.

CASE NO. SEC940031

For promulgation of a rule
pursuant to Virginia Code
§ 13.1-523 (Securities Act)

ORDER REPEALING AND ADOPTING RULE

On April 5, 1994, the National Association of Securities

Dealers, Inc. ("NASD") filed a petition requesting the Commission to amend its Securities Act Rule 504. On or about May 12, 1994, the Division mailed to the broker-dealers registered under the Securities Act and to other interested parties summary notice of the contents of the Rule changes proposed by the NASD, of the possibility that the NASD may file an amendment to its proposed changes and of the opportunity to file comments and request to be heard with respect to any objections to the proposals. In accordance with the Commission's order entered herein on June 2, 1994, similar notice was published in several newspapers in general circulation throughout the Commonwealth. This notice, as well as the text of the proposed amended Rule, also was published in "The Virginia Register of Regulations," Vol. 10, Issue 18, May 30, 1994, pp. 4914-15; 4916-19. The only person who filed comments was the Virginia Securities Industry Association, which endorsed the application. No requests for a hearing were received.

On June 13, 1994, the NASD filed a revised Rule proposal and an ancillary agreement related to providing certain information to the Commission. It has been represented to the Commission that the revisions and agreement resulted from discussions between the NASD and the Division of Securities and Retail Franchising ("Division"). Shortly after this filing was made, the Virginia Securities Industry Association submitted a second letter supporting the NASD proposal, as revised. On June 22, 1994, the NASD submitted by facsimile an amended agreement.

The Commission has been advised by the Division that it is satisfied with the NASD proposed Rule and the agreement, as amended, and recommends that the Commission adopt the revised Rule.

The Commission, upon consideration of the revised Rule and agreement and the recommendations of the Division, is of the opinion and finds that the proposed amendment of Rule 504, as revised, should be adopted and that the ancillary agreement should be utilized in conjunction with the Rule. Accordingly, it is

ORDERED:

(1) That evidence of mailing and publication of notice of the proposed amendment of Securities Act Rule 504 be filed in this case as Exhibit A;

(2) That Securities Act Rule 504 as currently in effect be, and it hereby is, repealed as of July 25, 1994;

(3) That proposed Securities Act Rule 504, as revised, a copy of which is attached hereto, be, and it hereby is, adopted and shall become effective as of July 25, 1994; and

(4) That this matter is dismissed from the docket and the papers herein be placed in the file for ended causes.

State Corporation Commission

AN ATTESTED COPY hereof, including the attachment, shall be sent to each of the following by the Clerk of the Commission: National Association of Securities Dealers, Inc., c/o Frank Formica, Vice President, 1735 K Street, N.W., Washington, D.C. 20006; every person who filed comments in this proceeding; the Commission's Division of Information Resources; Securities Regulation and Law Report, c/o The Bureau of National Affairs, Inc., 1231 25th Street, N.W., Washington, D.C. 20037; and, Blue Sky Law Reporter, c/o Commerce Clearing House, Inc., 4025 West Peterson Avenue, Chicago, Illinois 60646.

Rule 504 Nasdaq/National Market System Exemption

In accordance with Section 13.1-514 A.12. of the Act, the following are exempt from the securities registration requirements of the Act: any security listed or approved for listing upon notice of issuance on the National Association of Securities Dealers Automated Quotation National Market System (Nasdaq/National Market System); any other security of the same issuer that is of senior or substantially equal rank; any security called for by subscription rights or warrants so listed or approved; or any warrant or right to purchase or subscribe to any of the foregoing.

A. The Commission shall have authority by rule or order to deny, suspend or revoke the exemption created by this Rule as to a specific issue or category of securities when necessitated by the public interest and for the protection of investors.

B. The Commission may rescind this Rule by order if it determines that the Nasdaq/National Market System's requirements for listing or maintenance of securities of an issuer as set forth in the Memorandum of Understanding: The Uniform Model Marketplace Exemption from State Securities Registration Requirements, adopted April 28, 1990 by membership of the North American Securities Administrators Association, Inc., published in The Commerce Clearing House NASAA Reports, paragraph 2351, have been so changed or insufficiently applied that the protection of investors contemplated by the exemption no longer is afforded.

C. The Commission may rescind this Rule by order if it determines that the NASD has not provided on a timely basis to the Commission upon its request materially complete prospectuses in the form most recently filed with the SEC as well as any other relevant information the Commission may deem to be necessary pertaining to initial public offerings that the NASD ordinarily obtains in regulating issuers listed on the Nasdaq/National Market System, based on agreement with the Commission concerning the information to be provided.

V.A.R. Doc. No. R94-1097; Filed July 5, 1994, 11:43 a.m.

GUBERNATORIAL OBJECTION

REGISTRAR'S NOTICE: Pursuant to subsections C and D of § 9-6.14:9.1 of the Code of Virginia, Governor George Allen has determined that changes with substantial impact were made to the proposed regulation and is requiring the Board of Dentistry to suspend the implementation of VR 255-01-1, Virginia Board of Dentistry Regulations, until after an additional 30-day public comment period. The Governor indicated his concern with the large amount of opposition to the "licensure by endorsement" provisions of the regulation.

VA.R. Doc. No. R94-1107; Filed July 12, 1994, 4:39 p.m.



COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

July 12, 1994

Ms. Joan W. Smith
Registrar of Regulations
910 Capital Street
General Assembly Building
Richmond, Virginia 23219

Dear Ms. Smith:

I have attached a copy of a letter to Dr. Patricia Lee Speer, Chairman of the Board of Dentistry. As noted in that letter, I am exercising my authority provided in *Virginia Code §9-6.14:9.1C* to require the promulgating agency to suspend the implementation of VR 255-01-1 until after an additional thirty-day public comment period.

Your attention to this matter is greatly appreciated.

With kind regards, I am,

Sincerely,

A handwritten signature in cursive script that reads "George Allen".

George Allen

GA:map

State Capitol • Richmond, Virginia 23219 • 804-786-2211 • 786-2211

Gubernatorial Objection



COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

July 12, 1994

Patricia Lee Speer, D.D.S.
Chairman, Board of Dentistry
Department of Health Professions
6606 W. Broad Street
Richmond, Virginia 23230-1717

Dear Dr. Speer:

I have reviewed the final proposed regulation and have also reviewed the voluminous public comment received. My main concerns relate to a possible lowering of the standards of quality to practice dentistry in Virginia and a change that has not emanated from any compelling request from Virginians. I note with deep concern the large amount of opposition to the "licensure by endorsement" provisions of this proposed regulation. Clearly, many of Virginia's dentists are strongly opposed to this proposal and for that reason alone, I believe it merits further consideration and study by the Board of Dentistry.

Accordingly, upon finding that one or more changes with substantial impact have been made to the proposed regulation, I am exercising the authority provided in *Virginia Code* §9-6.14:9.1C to require the promulgating agency to suspend the implementation of VR 255-01-1 until after an additional thirty-day public comment period.

I urge the agency to give appropriate consideration and weight to any additional comment it receives and to modify or withdraw the regulation as such reconsideration warrants.

With kind regards, I am,

Sincerely,

A handwritten signature in cursive script that reads "George Allen".

George Allen

GA:map

c:Joan Smith

State Capitol • Richmond, Virginia 23219 • (804) 786-2211 • TDD (804) 371-8015

GOVERNOR

EXECUTIVE MEMORANDUM 9-94

PROCEDURES AND POLICIES FOR "HOUSE BILL 776 EMPLOYEES"

Purpose:

This memorandum provides provides guidance to the Governor's Secretaries and executive agencies regarding the policies and procedures to be applied in implementing and administering House Bill 776, adopted during the 1994 Regular Session of the General Assembly (Chapter 653, 1994 Virginia Acts of Assembly), relating to the exclusion of certain positions from the Virginia Personnel Act.

Applicability:

This memorandum applies to all executive branch agencies, institutions and employees.

Definition:

For the purpose of this Executive Memorandum, an employee or position is "covered by House Bill 776" or is a "House Bill 776 employee" or "House Bill 776 position" if excluded from coverage under the Virginia Personnel Act by virtue of House Bill 776 (Chapter 653, 1994 Virginia Acts of Assembly) and designation pursuant thereto.

Effective Date:

July 1, 1994.

General Policy:

Under the provisions of House Bill 776, which becomes effective on July 1, 1994, state employees occupying designated positions will serve at the pleasure and will of their appointing authority. Agency heads and supervisory boards are thereby provided with an additional management tool to help ensure accountability and effective performance by employees in key policy, communications and/or managerial roles, thus advancing the accomplishment of the agency's mission and the effective implementation of official policies.

When personnel actions pursuant to House Bill 776 are necessary, agencies must adhere to the explicit requirements in the legislation. Specifically, such personnel actions shall be taken without regard to race, sex, color, national origin, religion, age, handicap, or political affiliation.

Requirements:

I. Non-Applicable State Policies

Employees in House Bill 776 positions are not covered

by the following personnel policies:

- Grievance Procedure: Such employees do not have access to the grievance procedure and have no right to use the procedures to appeal disciplinary actions, including dismissal.

- Standards of Conduct: The standards of conduct are not applicable to such employees, and agencies are not to apply the processes or forms associated with the standards. Agencies should, however, consider the offenses listed in the Standards of Conduct as a guide to identifying unacceptable behavior for House Bill 776 employees.

- Layoff Policy: Such employees do not have access to the layoff policy.

- Recall - Administrative and Pay Procedures: Recall is only available to employees covered by the layoff policy, and thus is not available to employees covered by House Bill 776.

II. Applicable State Policies

Except for those policies listed above, employees in positions covered by House Bill 776 will be treated in accordance with other policies currently included in the Department of Personnel and Training's policy and procedures manual.

Policies applicable to House Bill 776 employees include:

- House Bill 776 provides that dismissal shall not affect retirement and accrued annual and sick leave benefits, and House Bill 776 employees shall not be subject to diminution of other employee benefits.

- House Bill 776 also specifies that recruitment and selection of individuals covered by the legislation shall be handled in a manner consistent with policies applicable to classified positions. Applicable provisions include:

- - Recruitment must be in accordance with equal opportunity and employment practices, listed in Recruit, and appropriately announced.

- - Recruitment and selection shall be based on an applicant's knowledge, skills, and abilities (KSAs) necessary to perform a job, and KSAs will be used in the updating of job descriptions.

- Employees in House Bill 776 positions shall fall under the same compensation and classification policies as employees not covered by House Bill 776. Applicable provisions include:

- - Positions will be classified as at present, according to classes as listed in the Compensation

Governor

Plan issued by the Department of Personnel and Training (DPT).

- - Salary will not be affected when a position becomes covered by House Bill 776. Employees will retain the ability to receive performance increases (if not at the maximum step of a grade), as well as salary regrades and structure adjustments.

- - Accrual rates and earned leave balances will not be affected when positions become excluded.

- In addition to DPT policies, House Bill 776 positions will continue to be covered by state benefits such as the Virginia Retirement System and health insurance plans.

- Employees occupying House Bill 776 positions shall have access to the resources and procedures of the Office of Equal Employment Opportunity and Program Evaluation.

III. Policies and Procedures for Dismissal

Employees who occupy House Bill 776 positions may be removed at any time by their appointing authority as long as the action is not based on race, sex, color, national origin, religion, age, handicap, or political affiliation. However, whenever possible, the appointing authority shall strive to give at least two weeks written notice to the employee.

The ultimate authority for personnel actions is vested in the appointing authority. However, the agency must provide the respective Secretary with advance notice of any proposed dismissal of an employee in a position covered by House Bill 776.

IV. Procedures for Identification of Covered Positions

House Bill 776 assigns the Governor's Secretaries final authority to determine on an ongoing basis the officers and employees covered by the provisions of the legislation. DPT is responsible for advising and assisting each Secretary and for maintaining an ongoing and up-to-date list of positions covered by House Bill 776. Specific responsibilities include:

- DPT shall carry out its usual procedures for reviewing proposed personnel actions based on established policies and procedures. DPT will inform the Secretary of its findings regarding a proposal that affects positions covered by House Bill 776.

- Agency heads shall apprise the appropriate Secretary whenever any organizational change within the agency will affect coverage under House Bill 776.

- Secretaries shall transmit to DPT written lists of the positions designated as covered under House Bill

776 based on the criteria set forth in the legislation, and shall promptly revise and transmit such lists whenever organizational changes in the agencies affect coverage under the legislation.

- DPT shall update the list to reflect personnel actions by agencies that add to, delete, or substitute positions covered by House Bill 776.

- Appointing authorities should make reasonable efforts to keep employees informed of any change in their employment status under the Virginia Personnel Act.

This Executive Memorandum rescinds Executive Policy Memorandum 1-85 issued by Governor Charles S. Robb on May 2, 1985.

This Executive Memorandum shall be effective on the date stated herein and shall remain in full force and effect unless rescinded or amended by further executive action.

/s/ George Allen
Governor

V.A.R. Doc. No. R94-1098; Filed July 5, 1994, 11:04 a.m.

EXECUTIVE ORDER NUMBER ELEVEN (94)

DECLARATION OF AN EMERGENCY ARISING FROM A FIRE IN THE HAMPTON ROADS AREA OF VIRGINIA

On April 15, 1994, a sea-going barge filled with approximately 300 large containers, including three filled with hazardous materials, caught fire near Old Point Comfort in Hampton Roads harbor. The fire, of unknown origin, was located in the center of the barge; the barge was positioned near the mouth of the harbor endangering other shipping and also the Hampton Roads Bridge Tunnel. The United States Coast Guard in charge at the scene of the fire, requested use of a Virginia Army National Guard helicopter outfitted with a clamshell in order to pour water on the fire and help to extinguish it. One National Guard helicopter was activated on April 16, 1994 for the purpose of rendering state fire suppression assistance. The fire was successfully contained on April 17, 1994.

The health and general welfare of the citizens in the general area of Hampton Roads required that state action be taken to help alleviate the conditions brought about by this situation, which constituted a man-made disaster as contemplated under the provisions of Section 44-146.16 of the Code of Virginia.

Therefore, by virtue of the authority vested in me by Sections 44-75.1 and 44-146.17 of the Code of Virginia, as Governor, as Commander-in-Chief of the armed forces of the Commonwealth, and as Director of Emergency

Services, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I do hereby confirm, ratify and memorialize in writing my verbal orders issued on April 16, 1994, wherein I proclaimed that a state of emergency existed in the affected areas of the Commonwealth and directed that appropriate assistance be rendered by the agencies of the state government to alleviate these conditions.

The following conditions apply to the employment of the Virginia National Guard:

1. The Adjutant General of Virginia, after consultation with the State Coordinator of Emergency Services, and with the approval of the Secretary of Public Safety, shall make available on state active duty such units and members of the Virginia National Guard and such equipment as may be desirable to assist in alleviating any human suffering and damage to property as a result of the burning barge.

2. In all instances, members of the Virginia Army National Guard shall remain subject to military command as prescribed by Section 44-78.1 of the Code of Virginia and not subject to the civilian authorities of the state or local governments.

3. Should service under this Executive Order result in the injury or death of any member of the Virginia National Guard, the following will be provided to the member and the member's dependents or survivors:

(a) Workers' Compensation benefits provided to members of the National Guard by the Virginia Workers' Compensation Act, subject to the requirements and limitations thereof; and, in addition,

(b) The same benefits, or their equivalent, for injury, disability and/or death, as would be provided by the federal government if the member were serving on federal active duty at the time of the injury or death. Any such federal-type benefits due to a member and his or her dependents or survivors during any calendar month shall be reduced by any payments due under the Virginia Workers' Compensation Act during the same month. If and when the time period for payment of Workers' Compensation benefits has elapsed, the member and his or her dependents or survivors shall thereafter receive full federal-type benefits for as long as they would have received such benefits if the member had been serving on federal active duty at the time of injury or death. Any federal-type benefits due shall be computed on the basis of military pay grade E-5 or the member's military grade at the time of injury or death, whichever produces the greater benefit amount. Pursuant to Section 44-14 of the Code of Virginia, and subject to the concurrence of the Board of Military Affairs, and subject to the availability of future appropriations which may be

lawfully applied to this purpose, I now approve of future expenditures out of appropriations to the Department of Military Affairs for such federal-type benefits as being manifestly for the benefit of the military service.

4. The cost incurred by the Department of Military Affairs in performing this mission shall be paid out of the Sum Sufficient appropriation for Disaster Planning and Operations contained in Item 555 of Chapter 994 of the 1993 Acts of Assembly, with any reimbursement thereof from nonstate agencies for partial or full reimbursement of this cost to be paid to the general fund of the state treasury.

This Executive Order shall be effective retroactively to April 16, 1994, upon its signing, and shall remain in full force and effect until June 30, 1994, unless sooner amended or rescinded by further executive order. That portion providing for benefits for members of the National Guard in the event of injury or death shall continue to remain in effect after termination of this Executive Order as a whole.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 8th day of June, 1994.

/s/ George Allen
Governor

V.A.R. Doc. No. R94-1089; Filed June 23, 1994, 4:41 p.m.

EXECUTIVE ORDER NUMBER SEVENTEEN (94)

PURCHASE, ASSIGNMENT, AND USE OF
STATE-OWNED VEHICLES

By virtue of the authority vested in me as Governor under Article V of the Constitution of the Commonwealth of Virginia and under the laws of the Commonwealth, including but not limited to Sections 2.1-47, 2.1-48, and Chapter 12 of Title 33.1 of the Code of Virginia, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby establish policies and procedures for the purchase, assignment, and use of state-owned motor vehicles.

Preamble

The people of Virginia have a right to expect use of state-owned vehicles to be strictly limited to the necessary performance of official business. Motor vehicles are not to be purchased by agencies or permanently assigned to agencies from the "centralized fleet" (as defined in Chapter 12 of Title 33.1 of the Code of Virginia) for reasons of convenience or perquisite. The purchase, assignment and use of such vehicles is to be determined solely according to whether it will promote efficiency and economy in state government.

Governor

Pursuant to my Executive Memorandum 6-94 issued on May 20, 1994, the Governor's Secretaries have inventoried the motor vehicles owned by the Commonwealth of Virginia and have assessed practices regarding the purchase, assignment, and use of such vehicles. The Commissioner of the Virginia Department of Transportation has reported that the centralized fleet consists of 2,925 vehicles. Based on the inventories completed by the Governor's Secretaries, the Secretary of Administration has reported that passenger-type vehicles acquired and owned by agencies of the Commonwealth independent of the centralized fleet number 5,146. This yields a total of 8,071 state-owned passenger-type vehicles – on average, one for every eleven full-time state employees.

From this inventory and assessment, it is apparent that the goals of efficiency and economy in state government can be advanced by a reduction in the number of passenger-type vehicles in permanent use by state agencies. Under Section 33.1-401 of the Code of Virginia, all passenger-type vehicles purchased with public funds on behalf of the Commonwealth are to be part of the centralized fleet, subject to three limited exceptions. Yet, the recently compiled data indicate that many more state-owned passenger-type vehicles are outside the centralized fleet than are part of it. This means that the Commonwealth and its taxpayers have not had the benefit of the economy and efficiency associated with the central coordinating and supervisory function of the Commissioner of Transportation envisioned in Chapter 12 of Title 33.1 of the Code of Virginia.

To eliminate unnecessary expense associated with excessive use of state-owned motor vehicles and to set an example of frugality, I am issuing directives for certain short-term corrective measures and to establish policies and procedures to govern the purchase, assignment and use of state-owned passenger-type motor vehicles in the future.

Specific Directives

1. Effective immediately, the assignment of all "passenger-type vehicles" (as defined in Chapter 12 of Title 33.1 of the Code of Virginia) purchased with public funds by any department, agency, institution, or commission of the Commonwealth, or any officer or employee on behalf of the Commonwealth, shall revert to the centralized fleet. The Commissioner of Transportation shall, in consultation with the head of the affected agency or institution, proceed to determine for each such vehicle whether there is an actual need for the vehicle to be assigned to the agency or institution pursuant to Section 33.1-405 of the Code of Virginia, and shall make such assignments. The Commissioner of Transportation shall make his determination for each vehicle reverting to the centralized fleet by virtue of this Executive Order and shall report his determinations to the Secretary of Transportation, the Secretary of Administration, and the Governor not later than October 1, 1994.

2. During the pendency of the review by the Commissioner of Transportation described in the foregoing paragraph, and until the Commissioner of Transportation shall otherwise direct, the affected vehicles shall remain within the control of the agency or institution that controlled them at the time this Executive Order was signed.

3. After making the determinations described in paragraph one (1) above, the Commissioner of Transportation shall provide for the disposition as surplus property of all vehicles that he neither assigns to agencies nor deems necessary for the ongoing operation of the centralized fleet. The Commissioner of Transportation shall include in the report required under paragraph one (1) above a listing of the vehicles to be surplus.

4. There shall be a one-year moratorium on the purchase or lease of passenger-type vehicles by or on behalf of the Commonwealth. This moratorium shall not apply to vehicles approved for purchase or lease prior to the signing of this Executive Order, nor shall it apply to vehicles which have special equipment or performance requirements related to use by law enforcement officers.

5. The one-year moratorium described in the preceding paragraph may be extended by the Governor. Upon termination of the moratorium, the requirements of Section 33.1-403 of the Code of Virginia relating to written approval by the Commissioner of Transportation before the purchase or lease of new motor vehicles by or on behalf of the Commonwealth) and Section 33.1-401 of the Code (relating to assignment of vehicles to the centralized fleet subject to specified exceptions) shall be strictly observed.

6. The head of each agency or institution of the Commonwealth shall limit authorization of commuting in state-owned vehicles to those employees whose job travel requirements make commuting the only cost-effective or practical alternative. The Commissioner of Transportation shall ensure that regulations applicable to commuting are uniformly applied and meet the criteria stated herein. For the purpose of this Executive Order and as used in Section 33.1-406 of the Code of Virginia, "commuting" shall mean driving between home and office where it is not connected to a departure for, or return from, a trip on official state business.

7. Notwithstanding the foregoing paragraph, no appointee serving at the pleasure of the Governor shall use a state-owned vehicle for the purpose of commuting. Such appointees may use a state-owned vehicle for driving between home and office only when connected to a departure for, or return from, a trip on official state business. The limitation of this paragraph shall not apply to the Superintendent of the

Virginia State Police nor to those appointees who, in the judgment of the Secretary of Public Safety, need access to state-owned vehicles for the purpose of responding to job-related emergency situations from their homes.

8. The head of each agency or institution of the Commonwealth shall be directly responsible for ensuring compliance with this Executive Order and all applicable statutes and regulations governing the use of state-owned vehicles, including the requirement that such vehicles be used strictly for official business only. Each agency head shall ensure that due consideration is given to the economy of reimbursing employees for mileage in their personal vehicles in lieu of use of state-owned vehicles, and shall assist the Commissioner of Transportation in eliminating the use of state-owned vehicles where such use does not advance the goals of efficient and economical operation of state government.

9. The criteria governing the assignment of centralized fleet vehicles (see Rules and Regulations Governing the Use, Operation and Maintenance of State-Owned Fleet Vehicles," published by the Department of Transportation) shall apply to all passenger-type vehicles owned by the Commonwealth, subject to such exceptions as the Commissioner of Transportation shall make. The authority of the Commissioner of Transportation under Section 33.1-407 to promulgate regulations governing the centralized fleet shall extend to all passenger-type vehicles owned by the Commonwealth.

10. The Commissioner of Motor Vehicles shall assess the use of blind tags on state-owned vehicles, and shall restrict such use to law enforcement vehicles and to such other vehicles as he determines are regularly used in the course of official business the effective performance of which makes blind tags essential.

11. The Commission on Government Reform (Blue Ribbon Strike Force) shall examine and report to the Governor not later than December 1, 1994, on the feasibility of privatizing all or a portion of the functions associated with the operation and maintenance of the centralized fleet and the operation and maintenance of vehicles assigned to state agencies and institutions.

12. Subject to the foregoing paragraph, the Commission on Government Reform (Blue Ribbon Strike Force) shall examine the current assignment of responsibility to the Commissioner of Transportation for administering the centralized fleet, and shall report to the Governor not later than December 1, 1994, on the feasibility and desirability of shifting responsibility for supervision and administration of the state motor vehicle pool to the Secretariat of Administration.

All agencies, institutions, and employees must comply with this Executive Order.

This Executive Order rescinds Executive Order Number Fifty-Three (92), issued by Governor Lawrence Douglas Wilder on August 6, 1992, and Executive Memorandum 6 (94), issued by me on May 20, 1994.

This Executive Order shall be effective upon its signing and shall remain in full force and effect until June 30, 1998, unless amended or rescinded by further Executive Order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 27th day of June, 1994.

/s/ George Allen
Governor

VA.R. Doc. No. R94-1094; Filed June 30, 1994, 11:45 a.m.

GOVERNOR'S COMMENTS ON PROPOSED REGULATIONS

(Required by § 9-6.12:9.1 of the Code of Virginia)

DEPARTMENT OF CORRECTIONS (STATE BOARD OF)

Title of Regulation: **VR 230-01-004. Regulations for Human Subject Research.**

Governor's Comment:

The proposed regulation is required by state law. However, the Attorney General's Office has raised some issues about the proposed exclusions from the proposed regulation. Hence, I recommend the agency and Secretary Kilgore work with the Attorney General's Office to resolve the issues before the adoption of the final regulation.

/s/ George Allen
Governor
Date: June 30, 1994

VA.R. Doc. No. R94-1099; Filed July 5, 1994, 11:04 a.m.

BOARD FOR GEOLOGY

Title of Regulation: **VR 335-01-2. Rules and Regulations for the Virginia Board for Geology.**

Governor's Comment:

I reserve my right to make final comments on this regulation after review of the public's comments.

/s/ George Allen
Governor
Date: June 27, 1994

VA.R. Doc. No. R94-1100; Filed July 5, 1994, 11:04 a.m.

GENERAL NOTICES/ERRATA

Symbol Key †

† Indicates entries since last publication of the Virginia Register

GENERAL NOTICES

DEPARTMENT OF GENERAL SERVICES

Division of Forensic Science

† Notice to the Public

Title of Regulation: VR 330-02-01. Regulations for Breath Alcohol Testing.

Statutory Authority: §§ 18.2-267 and 18.2-268 of the Code of Virginia.

In accordance with § 3.2 of the Regulations for Breath Alcohol Testing and under the authority of § 18.2-267 of the Code of Virginia, the following devices are approved for use as preliminary breath test devices:

1. The ALCOLYSER, manufactured by Lyon Laboratories, Ltd., Cardiff, Wales, United Kingdom.
2. The PREVENT, manufactured by BHP Diagnostix, West Chester, Pennsylvania.
3. The A.L.E.R.T. (Alcohol Level Evaluation Road Tester), Models J2A, J3A, and J3AC, manufactured by Alcohol Countermeasure Systems, Inc., Port Huron, Michigan.
4. The ALCO-SENSOR, ALCO-SENSOR II, ALCO-SENSOR III, and ALCO-SENSOR IV, manufactured by Intoximeters, Inc., St. Louis, Missouri.
5. The CMI SD 2, manufactured by Lyon Laboratories, Barry, United Kingdom.
6. The LIFE LOC PBA 3000*, manufactured by Life Loc Inc., Wheat Ridge, Colorado.

* When used in the direct sensing mode only.

In accordance with § 2.6 of the Regulations for Breath Alcohol Testing and under the authority of § 18.2-268 of the Code of Virginia, the following ampuls are approved for use in conducting breath tests on approved breath test devices:

1. Breathalyzer ampuls, manufactured by National Draeger, Inc., Pittsburgh, Pennsylvania.

2. Guth ampuls, manufactured by Guth Laboratories, Inc., Harrisburg, Pennsylvania.

In accordance with § 2.6 of the Regulations for Breath Alcohol Testing and under the authority of § 18.2-268 of the Code of Virginia, the following breath test devices are approved for use in conducting breath tests:

1. The Breathalyzer, Model 900A, manufactured by the Stephenson Corporation, Red Bank, New Jersey.
2. The Breathalyzer, Model 900A, manufactured by Smith & Wesson, Corp., Springfield, Massachusetts.
3. The Breathalyzer, Model 900A, manufactured by National Draeger, Inc., Pittsburgh, Pennsylvania.
4. The Intoximeter, Model 3000, equipped with the Virginia field module and external printer, manufactured by Intoximeters, Inc., Richmond, California.
5. The Intoxilyzer, Model 5000, Series 768VA, equipped with the Virginia test protocol, simulator monitor, and external printer, manufactured by CMI, Inc., Owensboro, Kentucky.

DEPARTMENT OF LABOR AND INDUSTRY

† Notice to the Public

The Virginia State Plan for the enforcement of Virginia Occupational Safety and Health (VOSH) laws 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.

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 Parts 1910, 1915, 1926, and 1928
(Docket No. H-122)

Indoor Air Quality; Proposed Rule

Agency: Occupational Safety and Health Administration (OSHA)

Action: Extension of Comment Period and Rescheduling of Hearing.

Summary: The Occupational Safety and Health Administration (OSHA) is extending the comment period and dates for submitting notices of intention to appear, as well as hearing testimony and evidence, and is postponing the public hearing on the proposed rule on indoor air quality which was published on April 5, 1994 (59 FR 15968). The comment period was to end on June 29, 1994; public hearings were scheduled to begin on July 12, 1994. Following publication of the proposal, 13 written requests to extend the comment period or postpone the public hearing were received. As a result of these requests, OSHA is extending the comment period to August 13, 1994. Public hearings will be scheduled to begin on September 20, 1994.

Text: Full text of the proposed rulemaking can be found in Volume 59, No. 113, pg. 30560 of the Federal Register.

Dates: Comments must be postmarked on or before August 13, 1994. Notices of intention to appear at the public hearing must be postmarked on or before August 5, 1994. Testimony and evidence to be submitted at the hearing must be postmarked by August 13, 1994. The hearing will commence at 9:30 a.m., Tuesday, September 20, 1994, in Washington, D.C.

Addresses: Comments are to be submitted in quadruplicate or one original (hard copy) and one disk (5 1/4 or 3 1/2) in WP 5.0, 5.1, 6.0 or Ascii to the Docket Office, Docket No. H-122, Room N-2625, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210, telephone (202) 219-7894. Any material not submitted on disk, e.g., studies, articles, etc., must be submitted in quadruplicate.

An additional copy of the comments should be submitted to the Director of Enforcement Policy, Virginia Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia 23219.

Notices of intention to appear and testimony and evidence are to be submitted in quadruplicate to Mr. Thomas Hall, Division of Consumer Affairs, Occupational Safety and Health Administration, 200 Constitution Avenue, N.W., Room N-3649, Washington, D.C. 20210, telephone (202) 219-8615.

The hearing will be held in the auditorium of the U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C.

For further information contact: Mr. James F. Foster, Office of Public Affairs, OSHA, Room N-3647, U.S. Department of Labor, 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 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

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

VIRGINIA AGRICULTURAL COUNCIL

August 22, 1994 - 9 a.m. – Open Meeting
Embassy Suites Hotel, 2925 Emerywood Parkway,
Richmond, Virginia ♿ (Interpreter for the deaf provided
upon request)

An annual business meeting. The agenda will consist of an annual review of finances, progress reports on approved projects, and general business matters. The council will allot 30 minutes at the conclusion of the business meeting for the public to appear before the council. Any person who needs any accommodation in order to participate at the meeting should contact Thomas R. Yates at least 10 days before the meeting date so that suitable arrangements can be made for any appropriate accommodations.

Contact: Thomas R. Yates, Assistant Secretary, Virginia Agricultural Council, 1100 Bank St., Suite 203, Richmond, VA 23219, telephone (804) 786-6060.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES (STATE BOARD OF)

July 26, 1994 - 9 a.m. – Open Meeting
Henry County Administration Building, Board Meeting
Room, King's Mountain Road, Collinsville, Virginia. ♿

At this regular meeting, the board plans to discuss legislation, regulations and fiscal matters and will

receive reports from the staff of the Department of Agriculture and Consumer Services. The board may consider other matters relating to its responsibilities. At the conclusion of the other business, the board will review public comments for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact Roy E. Seward at least five days before the meeting date so that suitable arrangements can be made for any appropriate accommodation.

Contact: Roy E. Seward, Secretary to the Board, Department of Agriculture and Consumer Services, Washington Building, 1100 Bank St., Room 211, Richmond, VA 23219, telephone (804) 786-3535 or (804) 371-6344/TDD ☎

ALCOHOLIC BEVERAGE CONTROL BOARD

July 25, 1994 - 9:30 a.m. – Open Meeting
August 8, 1994 - 9:30 a.m. – Open Meeting
August 22, 1994 - 9:30 a.m. – Open Meeting
September 7, 1994 - 9:30 a.m. – Open Meeting
September 19, 1994 - 9:30 a.m. – Open Meeting
Alcoholic Beverage Control Board, 2901 Hermitage Road,
Richmond, Virginia. ♿

A meeting to receive and discuss reports and activities from staff members. Other matters not yet determined.

Contact: Robert N. Swinson, Secretary to the Board, Alcoholic Beverage Control Board, 2901 Hermitage Road, P. O. Box 27491, Richmond, VA 23261, telephone (804) 367-0616.

VIRGINIA ASBESTOS LICENSING BOARD

September 21, 1994 - 9 a.m. – Open Meeting
Department of Professional and Occupational Regulation,
3600 W. Broad St., Conference Room 3, Richmond, Virginia
♿

A general meeting.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595 or (804) 367-9753/TDD ☎

AUCTIONEERS BOARD

September 9, 1994 – Written comments may be submitted through this date.

September 20, 1994 - 9 a.m. – Public Hearing
Department of Professional and Occupational Regulation,
3600 West Broad Street, Conference Room 2, Richmond,
Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Auctioneers Board intends to repeal regulations entitled: **VR 150-01-2. Rules and Regulations for the Virginia Board of Auctioneers** and adopt regulations entitled: **VR 150-01-2:1. Rules and Regulations for the Virginia Board of Auctioneers**. The proposed regulations establish entry requirements for licensure of auctioneers and auction firms, examination for licensure, licensure by reciprocity, standards of practice regarding advertising, contract, escrow accounts, records and the standards of conduct for auctioneers. The proposed regulations are a result of legislative amendments enacted to § 54.1-603 of the Code of Virginia, which repealed the registration and certification program for auctioneers and established a single licensure program.

Statutory Authority: §§ 54.1-201 and 54.1-602 of the Code of Virginia.

Contact: Willie Fobbs, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514.

BOARD FOR BARBERS

August 8, 1994 - 9 a.m. – Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, 4th Floor, Richmond, Virginia. ☒

A meeting to:

1. Review correspondence
2. Review examination contract
3. Conduct review and disposition of enforcement cases
4. Conduct routine board business

A public comment period will be scheduled during the meeting. No public comment will be accepted after that period. However, the meeting is open to the public. Any person who needs any accommodations in order to participate at the meeting should contact Karen O'Neal at least 10 days before the meeting date so that suitable arrangements can be made for an appropriate accommodation.

Contact: Karen O'Neal, Assistant Director, Board for Barbers, 3600 W. Broad St., Richmond, VA 23230-4917,

telephone (804) 367-0500.

CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

Central Area Review Committee

August 18, 1994 - 2 p.m. – Open Meeting
September 15, 1994 - 2 p.m. – CANCELLED
Chesapeake Bay Local Assistance Department, 8th Street Office Building, 8th and Broad Streets, 7th Floor, Conference Room, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area programs for the Central Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. Public comment will not be received at the committee meeting. Written comments, however, 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

August 18, 1994 - 10 a.m. – Open Meeting
September 15, 1994 - 10 a.m. – CANCELLED
Chesapeake Bay Local Assistance Department, 8th Street Office Building, 8th and Broad Streets, 7th Floor, Conference Room, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area programs for the Northern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. Public comment will not be received at the committee meeting. Written comments, however, 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

July 27, 1994 - 10 a.m. – Open Meeting
August 24, 1994 - 10 a.m. – Open Meeting
September 28, 1994 - 10 a.m. – Open Meeting
Chesapeake Bay Local Assistance Department, 8th Street Office Building, 8th and Broad Streets, 7th Floor, Conference Room, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The committee will review local Chesapeake Bay Preservation Area programs for the Southern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify

Calendar of Events

meeting time, location and schedule. Public comment will not be received at the committee meeting. Written comments, however, 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

† **August 11, 1994 - 9:30 a.m.** – Open Meeting
Theater Row Building, 730 East Broad Street, Lower Level, Conference Room 1, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The council will meet to discuss issues, concerns and programs that impact child day programs, camps, school age programs, and preschool/nursery schools. The public comment period will begin at 10 a.m. Please call ahead of time for possible changes in meeting time.

Contact: Peggy Friedenber, Legislative Analyst, Office of Governmental Affairs, Department of Social Services, Theater Row Bldg., 730 E. Broad St., Richmond, VA 23219, telephone (804) 692-1820.

COUNCIL ON CHILD DAY AND EARLY CHILDHOOD PROGRAMS

† **August 9, 1994 - 10 a.m.** – Open Meeting
State Capitol, Capitol Square, House Room 4, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

A quarterly business meeting. Public comment will not be accepted.

Contact: Peggy O. Harrelson, Acting Director, Washington Bldg., 1100 Bank St., Suite 1116, Richmond, VA 23219, telephone (804) 371-8603.

COMPENSATION BOARD

July 28, 1994 - 1 p.m. – Open Meeting
August 25, 1994 - 1 p.m. – Open Meeting
Ninth Street Office Building, 202 North Ninth Street, 9th Floor, Room 913/913A, 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 710, Richmond, VA 23206-0686, telephone (804) 786-3886/TDD ☎

BOARD FOR CONTRACTORS

† **August 1, 1994 - 9 a.m.** – Open Meeting
† **August 2, 1994 - 9 a.m.** – Open Meeting
† **August 3, 1994 - 9 a.m.** – Open Meeting
† **August 4, 1994 - 9 a.m.** – Open Meeting
† **August 5, 1995 - 9 a.m.** – Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 5th Floor, Richmond, Virginia. ☒

A meeting to conduct informal fact-finding conferences pursuant to the Administrative Process Act in order for the board to determine case decisions for contractors.

Contact: A.R. Wade, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 367-0946.

Recovery Fund Committee

† **September 21, 1994 - 9 a.m.** – Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. ☒

A meeting to consider claims filed against the Virginia Contractor Transaction Recovery Fund. This meeting will be open to the public; however, a portion of the discussion may be conducted in executive session. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact Christine Martine at (804) 367-8561. The department fully complies with the Americans with Disabilities Act. Please notify the department of your request for accommodation at least two weeks in advance for consideration of your request.

Contact: Holly Erickson, Assistant Administrator, Board for Contractors, 3600 W. Broad St., Richmond, VA 23219, telephone (804) 367-8561.

STATE CORPORATION COMMISSION

July 28, 1994 - 10 a.m. – Public Hearing
Tyler Building, 1300 East Main Street, 2nd Floor, Commission Courtroom, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The Virginia State Corporation Commission will conduct a public hearing for the purpose of receiving comments from interested parties with respect to adjusted prima facie rates proposed by the Commission's Bureau of Insurance for credit life insurance and credit accident and sickness insurance pursuant to the provisions of Chapter 37.1 (§ 38.2-3717 et seq.) of Title 38.2 of the Code of Virginia. Copies of the proposed adjusted prima facie credit life and credit accident and sickness insurance rates may be

obtained from the Office of the Clerk of the Commission.

Contact: Robert L. Wright, III, Principal Insurance Market Examiner, State Corporation Commission, P. O. Box 1197, Richmond, VA 23209, telephone (804) 371-9154, toll free 1-800-552-7945 or (804) 371-9206/TDD ☎

DEPARTMENT OF CORRECTIONS (STATE BOARD OF)

August 17, 1994 - 10 a.m. – Open Meeting
Department of Corrections, 6900 Atmore Drive, Board Room, Richmond, Virginia. ☒

A meeting to discuss matters as may be presented to the board.

Contact: Vivian Toler, Secretary to the Board, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3235.

DEPARTMENT OF CRIMINAL JUSTICE SERVICES (CRIMINAL JUSTICE SERVICES BOARD)

August 26, 1994 – Written comments may be submitted through this date.

October 5, 1994 - 9 a.m. – Public Hearing
General Assembly Building, 910 Capitol Street, House Room D, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Criminal Justice Services Board intends to adopt regulations entitled: **VR 240-01-15. Rules Relating to Compulsory Minimum Training Standards For Radar Operators.** The proposed regulations include specific training requirements for public law-enforcement officers employed by state and local law-enforcement agencies who operate radar as part of their assigned duties. These training standards include 18 performance based training objectives which each officer required to operate radar must meet prior to being able to operate the unit. Training for radar operators under the proposed regulations may be done at the employing agency by a certified radar operator instructor and records of the training provided are to be maintained by the employing agency. Retraining is required by December 31 of every third calendar year to ensure that the operating officer has retained proficiency in the operation of the speed measurement device. Provisions are available for the exemption or partial exemption of the training requirement based upon previous training and experience.

Statutory Authority: § 9-170(3a) of the Code of Virginia.

Written comments may be submitted through August 26, 1994, to L.T. Eckenrode, Department of Criminal Justice Services, 805 E. Broad St., Richmond, VA 23219.

Contact: Paula Scott-Dehetre, Executive Assistant, Department of Criminal Justice Services, 805 E. Broad St., Richmond, VA 23219, telephone (804) 786-4000.

Private Security Services Advisory Board

July 27, 1994 - 10 a.m. – Open Meeting
Fairfax County Public Safety Center, 4100 Chain Bridge Road, Fairfax, Virginia ☒

A meeting to discuss private security industry issues.

Contact: Roy Huhta, Assistant, Department of Criminal Justice Services, Private Security Section, P. O. Box 10110, Richmond, VA 23240-9998, telephone (804) 786-4700.

BOARD OF DENTISTRY

† **August 3, 1994 - 9 a.m. – Public Hearing**
Department of Health Professions, 6606 West Broad Street, Richmond, Virginia.

Pursuant to subsections C and D § 9-6.14:9.1 of the Code of Virginia, Governor George Allen has determined that changes with substantial impact were made to the proposed regulations and is suspending the implementation of VR 255-01-1, Virginia Board of Dentistry Regulations, until after an additional 30-day public comment period. The Governor indicated his concern with the large amount of opposition to the "licensure by endorsement" provisions of the regulation.

These regulations establish continuing education for dentists and dental hygienists; licensure by endorsement for dentists and amend advertising a speciality.

Public comment may be submitted until August 13, 1994.

Contact: Marcia J. Miller, Executive Director, Board of Dentistry, 6606 W. Broad St., Richmond, VA 23230-1717, telephone (804) 662-9906.

BOARD OF EDUCATION

July 28, 1994 - 8:30 a.m. – Open Meeting
General Assembly Building, 910 Capitol 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. William C. Boshier, Jr., Superintendent of Public Instruction, Department of Education, P. O. Box 2120, Richmond, VA 23216-2120, telephone (804) 225-2023

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or toll free 1-800-292-3820.

STATE BOARD OF ELECTIONS

† July 25, 1994 - 9 a.m. - Open Meeting
† July 26, 1994 - 9 a.m. - Open Meeting
Richmond Center, 400 East Marshall Street, Richmond, Virginia.

The board will observe demonstrations of voting equipment by vendors requesting certification for use in the Commonwealth.

Contact: Michael G. Brown, Secretary of the State Board of Elections, 200 N. 9th St., Room 101, Richmond, VA 23219, telephone (804) 786-6551 or toll-free 1-800-552-9745.

LOCAL EMERGENCY PLANNING COMMITTEE - COUNTY OF MONTGOMERY/TOWN OF BLACKSBURG

September 13, 1994 - 3 p.m. - Open Meeting
Montgomery County Courthouse, 3rd Floor, Board of Supervisors Room, Christiansburg, Virginia. ☒

A meeting to discuss the development of a Hazardous Materials Emergency Response Plan for Montgomery County and the Town of Blacksburg.

Contact: Steve Via, New River Valley Planning District Commission, P. O. Box 3726, Radford, VA 24143, telephone (703) 639-9313 or FAX (703) 831-6093.

LOCAL EMERGENCY PLANNING COMMITTEE - PRINCE WILLIAM COUNTY, MANASSAS CITY, AND MANASSAS PARK CITY

July 18, 1994 - 1:30 p.m. - Open Meeting
One County Complex Court, Potomac Conference Room, Prince William, Virginia. ☒

A multi-jurisdictional local emergency planning committee to discuss issues related to hazardous substances in the jurisdictions. SARA Title III provisions and responsibilities for hazardous material emergency response planning.

Contact: John E. Medici, Hazardous Materials Officer, One County Complex Court, Internal Zip MC470, Prince William, VA 22192, telephone (703) 792-6800.

LOCAL EMERGENCY PLANNING COMMITTEE - WINCHESTER

† August 3, 1994 - 3 p.m. - Open Meeting
Shawnee Fire Company, 2333 Roosevelt Boulevard, Winchester, Virginia.

A general meeting.

Contact: L.A. Miller, Fire Chief, Winchester Fire and Rescue Dept., 126 N. Cameron St., Winchester, VA 22601, telephone (703) 662-2298.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Technical Advisory Committee

August 11, 1994 - 10 a.m. - Open Meeting
September 1, 1994 - 10 a.m. - Open Meeting
Department of Environmental Quality, 629 East Main Street, 4th Floor Conference Room, Richmond, Virginia. ☒

The committee will meet in three sessions to assist the development of amendments to Financial Assurance Regulations for Solid Waste Disposal Facilities (Sanitary Landfills), VR 672-20-1. The draft of amended regulations developed as a result of these meetings will be presented to the Virginia Waste Management Board for consideration. If approved by the board, the proposed amendments will be further considered in public participation proceedings in accord with Public Participation Guidelines, VR 672-01-01:1.

Contact: Wladimir Gulevich, Ph.D., P.E., ORPD, Department of Environmental Quality, P. O. Box 10009, Richmond, VA 23240-0009, telephone (804) 762-4218 or (804) 762-4021/TDD ☒

Work Group on Detection/Quantitation Levels

September 14, 1994 - 1:30 p.m. - Open Meeting
Department of Environmental Quality, 4949 Cox Road, Lab Training Room, Room 111, Glen Allen, Virginia.

The department has established a work group on detection quantitation levels for pollutants in the regulatory and enforcement programs. The work group will advise the Director of Environmental Quality. Other meetings of the work group have been scheduled at the same time and location for September 28, October 12, October 26, November 9, November 30, and December 14. However, these dates are not firm. Persons interested in the meetings of this work group should confirm the date with the contact person below.

Contact: Alan J. Anthony, Chairman, Department of Environmental Quality, 4900 Cox Road, Glen Allen, VA 23060, telephone (804) 527-5070.

Virginia Pollution Prevention Advisory Committee

August 18, 1994 - 1 p.m. - Open Meeting
Department of Environmental Quality, Innsbrook Corporate Center, 4900 Cox Road, Glen Allen, Virginia. ☒

A quarterly meeting. The advisory committee has been established to assist the Department of Environmental Quality in its implementation of voluntary pollution prevention technical assistance throughout the Commonwealth.

Contact: Bill Sarnecky, Environmental Engineer Senior, Department of Environmental Quality, P. O. Box 10009, Richmond, VA 23240-0009, telephone (804) 762-4347.

BOARD OF GAME AND INLAND FISHERIES

† August 25, 1994 - 9 a.m. - Open Meeting

† August 26, 1994 - 9 a.m. - Open Meeting

Department of Game and Inland Fisheries, 4010 West Broad Street, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

The Board of Game and Inland Fisheries will meet to set the 1994-95 migratory waterfowl seasons and propose regulation changes governing seasons, bag limits, methods of take and possession of fish and nongame wildlife. In addition, regulation proposals may be considered regarding the operation of shooting preserves, permitting of wolf hybrids and to allow taxidermists, with the proper permits from the Department of Game and Inland Fisheries, to sell unclaimed taxidermy specimens, including whole mounts or parts thereof. The board may also consider regulation changes that will provide for the transport of certain nuisance species by animal control officers and businesses that specialize in nuisance animal damage control.

Administrative matters to be considered by the board include the setting of the 1995 meeting schedule, a review of the agency's budget, a discussion on the agency's audit report and an update on the agency's proposed information management system. Other general and administrative matters, as necessary, may be discussed, and appropriate actions may be taken. The board will also hold an executive session during this meeting.

The appropriate chairman of board committees may request a committee meeting in conjunction with its August meeting or thereafter.

Please note: The board has changed its meeting procedure. Public comment is now accepted on the first meeting day. If the board completes its meeting agenda on August 25, it will not convene a meeting on August 26.

Contact: Belle Harding, Secretary to the Director, Board of Game and Inland Fisheries, 4010 W. Broad St., P.O. Box 11104, Richmond, VA 23230, telephone (804) 367-1000.

BOARD FOR GEOLOGY

August 11, 1994 - 9 a.m. - Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 2, Richmond, Virginia. ☎

August 12, 1994 - 10 a.m. - Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 3, Richmond, Virginia. ☎

A general meeting.

Contact: David A. Vest, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8307 or (804) 367-9753/TDD ☎

DEPARTMENT OF HEALTH (STATE BOARD OF)

August 1, 1994 - 10 a.m. - Public Hearing
James Madison Building, 109 Governor Street, Richmond, Virginia.

September 9, 1994 - 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 355-29-100. Board of Health Regulations Governing Vital Records.** Section 32.1-273 of the Code of Virginia authorizes the Board of Health to prescribe a fee, not to exceed \$5.00, for searching and certification of vital records of birth, death, marriage, and divorce. Senate Bill 402, passed by the 1994 General Assembly, raises the maximum limit on vital records fees to \$8.00. Accordingly, the proposed regulations raise the current fee of \$5.00 to the new fee of \$8.00. Comments on the costs and benefits of the proposal are requested.

Statutory Authority: § 32.1-273 of the Code of Virginia.

Contact: Deborah M. Little, Director, Office of Vital Records and Health Statistics, P. O. Box 1000, Richmond, VA 23208-1000, telephone (804) 371-6077 or FAX (804) 371-4800.

* * * * *

August 3, 1994 - 9:30 a.m. - Public Hearing
Department of Health, Office of Emergency Medical Services, 1538 East Parham Road, Richmond, Virginia.

August 27, 1994 - Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Health

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intends to amend regulations entitled: **VR 355-33-500. Rules and Regulations for the Licensure of Hospitals in Virginia.** Pursuant to the Commonwealth's efforts to increase organ, tissue and eye donation, the routine contact protocol regulations are an effort to ensure all families of medically suitable donors are given the opportunity to consider organ, tissue and eye donation. The regulations strengthen the donor program through the application of uniform requirements for hospitals to inform families of organ donor options. Implementation of the proposed regulations will help ensure families of donor candidates are advised of the options available and give them the opportunity to make their own decisions to donate. Comments on the costs and benefits of the proposal are requested.

Statutory Authority: §§ 32.1-12 and 32.1-127 of the Code of Virginia.

Written comments may be submitted until August 27, 1994, to Nancy Hofheimer, Director, Office of Health Facilities Regulation, 3600 W. Broad St., Suite 216, Richmond, VA 23230 or FAX (804) 367-2149.

Contact: Carrie Eddy, Policy Analyst, Department of Health, Office of Health Facilities Regulation, 3600 W. Broad St., Suite 216, Richmond, VA 23230, telephone (804) 367-2102 or FAX (804) 367-2149.

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August 3, 1994 - 1 p.m. – Public Hearing
Department of Health, Office of Emergency Medical Services, 1538 East Parham Road, Richmond, Virginia.

August 27, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Health intends to amend regulations entitled: **VR 355-33-500. Rules and Regulations for the Licensure of Hospitals in Virginia.** Discharge planning services link patients departing the hospital with appropriate community resources, a service that is especially important for drug-exposed infants and their mothers. Implementation of the proposed regulations will strengthen hospital discharge planning for substance abusing postpartum women through the application of uniform requirements for informing substance abusing women of treatment services available in the community. Comments on the cost and benefits of the proposal are requested.

Statutory Authority: §§ 32.1-12 and 32.1-127 of the Code of Virginia.

Written comments may be submitted until August 27, 1994, to Nancy Hofheimer, Director, Office of Health Facilities Regulation, 3600 W. Broad St., Suite 216, Richmond, VA 23230 or FAX (804) 367-2149.

Contact: Carrie Eddy, Policy Analyst, Department of Health, Office of Health Facilities Regulation, 3600 W. Broad St., Suite 216, Richmond, VA 23230, telephone (804) 367-2102 or FAX (804) 367-2149.

† **August 12, 1994 - 11 a.m. – Open Meeting**
Department of Health, 1500 East Main Street, Suite 214, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The Executive Committee will conduct a planning session for 94-95.

Contact: Susan R. Rowland, MPA, Assistant to the Commissioner, Department of Health, 1500 E. Main St, Richmond, VA 23219, telephone (804) 786-3564.

Food Service Advisory Committee

July 28, 1994 - 10 a.m. – Open Meeting
Department of Housing and Community Development, Jackson Center, 501 N. Second Street, Second Floor Conference Room, Richmond, Virginia. ☒

A regular meeting. This committee meets at least once a year to discuss and recommend food service policy, regulation and programmatic changes to the Commissioner of Health for implementation.

Contact: John E. Benko, Division Director, Division of Food and Environmental Health, 1500 E. Main St., P. O. Box 2448, Suite 115, Richmond, VA 23218, telephone (804) 786-3559.

VIRGINIA HEALTH SERVICES COST REVIEW COUNCIL

† **July 26, 1994 - 9:30 a.m. – Open Meeting**
August 30, 1994 - 9:30 a.m. – Open Meeting
Blue Cross/Blue Shield, 2015 Staples Mill Road, Richmond, Virginia. ☒

A monthly meeting.

Contact: Kim Bolden Walker, Public Relations Coordinator, Virginia Health Services Cost Review Council, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371.

COMMISSION ON THE FUTURE OF HIGHER EDUCATION IN VIRGINIA

† **September 14, 1994 - 10 a.m. – Open Meeting**
General Assembly Building, 910 Capitol Square, Senate Room A, Richmond, Virginia. ☒

The commission was created by SJR 139 and is charged with considering a variety of topics that are of interest to higher education in Virginia.

Contact: Anne M. Pratt, Associate Director, 101 N. 14th St., 9th Floor, Richmond, VA 23219, telephone (804) 225-2629.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

† July 25, 1994 - 11 a.m. – Public Hearing
Northern Virginia Community College, Cultural Center Forum, Annandale, Virginia.

† July 26, 1994 - 11 a.m. – Public Hearing
Old Dominion University, Mills Godwin Building, Room 102, Norfolk, Virginia.

† July 27, 1994 - 11 a.m. – Public Hearing
State Council of Higher Education, James Monroe Building, Conference Room C, 1st Floor, Richmond, Virginia.

† July 28, 1994 - 11 a.m. – Public Hearing
Virginia Polytechnic Institute and State University, The German Club Manor, Blacksburg, Virginia.

† September 25, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Council of Higher Education for Virginia intends to adopt regulations entitled: **VR 380-04-01. Virginia Postsecondary Review Entity Regulations.** The proposed regulations establish the procedures and standards by which the SPRE may review institutions participating in the Title IV, HEA programs.

Statutory Authority: §§ 23-9.6:1 and 23-261 of the Code of Virginia.

Contact: Richard Myers, State Council of Higher Education for Virginia, James Monroe Bldg., 101 N. 14th St., Richmond, VA 23219, telephone (804) 225-3189.

VIRGINIA HIV PREVENTION COMMUNITY PLANNING COMMITTEE

† July 25, 1994 - 7:30 p.m. – Public Hearing
Southwest Virginia Higher Education Center, 15856 Porterfield Highway, Room 8, Abingdon, Virginia. ☒ (Interpreter for the deaf provided upon request)

† July 26, 1994 - 7:30 p.m. – Public Hearing
Roanoke City Main Branch Library, 706 South Jefferson Street, Roanoke, Virginia. ☒ (Interpreter for the deaf provided upon request)

† July 28, 1994 - 7:30 p.m. – Public Hearing
American Red Cross, 409 East Main Street, Massey Conference Room, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

† August 1, 1994 - 7:30 p.m. – Public Hearing
Augusta County Government Office Building, 4801 Lee Highway, Training Room, 2nd Floor, Verona, Virginia. ☒ (Interpreter for the deaf provided upon request)

† August 2, 1994 - 7:30 p.m. – Public Hearing
Fairfax High School, 3500 Old Lee Highway, Fairfax, Virginia. ☒ (Interpreter for the deaf provided upon request)

† August 3, 1994 - 7:30 p.m. – Public Hearing
Nandua High School, Lankford Highway, Onley, Virginia. ☒ (Interpreter for the deaf provided upon request)

† August 4, 1994 - 7:30 p.m. – Public Hearing
American Red Cross, 611 West Brambleton Avenue, Multipurpose Room A, Norfolk, Virginia. ☒ (Interpreter for the deaf provided upon request)

The committee will hold a public hearing on HIV prevention.

Contact: Elaine G. Martin, Coordinator, AIDS Education, Department of Health, P.O. Box 2448, Room 112, Richmond, VA, telephone (804) 786-0877 or toll-free 1-800-533-4148/TDD ☎

August 11, 1994 - 8 a.m. – Open Meeting
The Sheraton Inn-Richmond Airport, 4700 South Laburnum Avenue, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The committee will continue to work on a comprehensive HIV Prevention Plan for the Commonwealth.

Contact: Elaine Martin, Coordinator, AIDS Education, P. O. Box 2448, Richmond, VA 23218, telephone (804) 786-0877 or toll free 1-800-533-4148/TDD ☎

HOPEWELL INDUSTRIAL SAFETY COUNCIL

August 2, 1994 - 9 a.m. – Open Meeting
September 6, 1994 - 9 a.m. – Open Meeting
Hopewell Community Center, Second and City Point Road, Hopewell, Virginia. ☒ (Interpreter for the deaf provided upon request)

Local Emergency Preparedness Committee Meeting on emergency preparedness as required by SARA Title III.

Contact: Robert Brown, Emergency Service Coordinator, 300 North Main Street, Hopewell, VA 23860, telephone (804) 541-2298.

HJR NO. 76 INTERNET STAFF STUDY TEAM

† July 28, 1994 - 10 a.m. – Open Meeting

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Department of Information Technology, Richmond Plaza Building, 3rd Floor, Richmond, Virginia. ☒

Pursuant to HJR 76 the study team will study whether the Commonwealth needs to establish protocols and guidelines regarding in-state access to the myriad files and components available through the Internet.

Contact: Marty Gillespie, Department of Information Technology, Director of Security, 110 S. 7th St., 3rd Floor, Richmond, VA 23219, telephone (804) 344-5705.

STATE LAND EVALUATION ADVISORY COUNCIL

August 12, 1994 - 10 a.m. – Open Meeting

Department of Taxation, 2220 West Broad Street, Richmond, Virginia. ☒

A meeting to adopt suggested ranges of values for agricultural, horticultural, forest and open-space land use and the use-value assessment program.

Contact: Ronald W. Wheeler, Executive Assistant, Department of Taxation, 3600 W. Broad St., Richmond, VA 23219, telephone (804) 367-6920.

STATE COUNCIL ON LOCAL DEBT

† **August 17, 1994 - 11 a.m. – Open Meeting**

† **September 21, 1994 - 11 a.m. – Open Meeting**

James Monroe Building, 101 N. 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 the 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 1879, Richmond, VA 23215, telephone (804) 225-4928.

LONGWOOD COLLEGE

Executive Committee

† **July 28, 1994 - 12:30 p.m. – Open Meeting**

Longwood College, Ruffner Building, Farmville, Virginia. ☒

A meeting to conduct routine business of the Board of Visitors.

Contact: William F. Dorrill, President, Longwood College, 201 High St., Farmville, VA 23909-1899, telephone (804) 395-2001.

Facilities and Services Committee

† **July 28, 1994 - 11:30 a.m. – Open Meeting**

Longwood College, Ruffner Building, Farmville, Virginia. ☒

A meeting to conduct routine business of the Board of Visitors.

Contact: William F. Dorrill, President, Longwood College, 201 High St., Farmville, VA 23909-1899, telephone (804) 395-2001.

Student Affairs Committee

July 25, 1994 - 4 p.m. – Open Meeting

Longwood College, Ruffner Building, Farmville, Virginia. ☒

A meeting to conduct routine business of the Board of Visitors.

Contact: William F. Dorrill, President, Longwood College, 201 High St., Farmville, VA 23909-1899, telephone (804) 395-2001.

Board of Visitors

July 29, 1994 - 9 a.m. – Open Meeting

Longwood College, Ruffner Building, Virginia Room, Farmville, Virginia. ☒ (Interpreter for the deaf provided upon request)

A meeting to conduct routine business of the Board of Visitors.

Contact: William F. Dorrill, President, Longwood College, 201 High St., Farmville, VA 23909-1899, telephone (804) 395-2001.

STATE LOTTERY BOARD

July 25, 1994 - 10 a.m. – Open Meeting

State Lottery Department, 2201 West Broad Street, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

A regular monthly meeting. Business will be conducted according to items listed on the agenda which has not yet been determined. Two periods for public comment are scheduled.

Contact: Barbara L. Robertson, Lottery Staff Officer, State Lottery Department, 2201 W. Broad St., Richmond, VA 23220, telephone (804) 367-3106 or (804) 367-3000/TDD ☒

VIRGINIA MANUFACTURED HOUSING BOARD

August 17, 1994 - 1 p.m. – Open Meeting

The Cavalier Hotel, Oceanfront at 42nd Street, Virginia Beach, Virginia. ☒ (Interpreter for the deaf provided upon request)

request)

A regular monthly meeting.

Contact: Curtis L. McIver, Associate Director, Department of Housing and Community Development, Code Enforcement and Manufactured Housing Office, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7160 or (804) 371-7089/TDD ☎

MARINE RESOURCES COMMISSION

July 29, 1994 - 9:30 a.m. - Open Meeting
Marine Resources Commission, 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.; permit applications for projects in wetlands, bottom lands, coastal primary sand dunes and beaches; appeals of local wetland board decisions; policy and regulatory issues.

The commission will hear and decide fishery management items at approximately noon. Items to be heard are as follows: regulatory proposals, fishery management plans, fishery conservation issues, licensing, and 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, Marine Resources Commission, P. O. Box 756, Newport News, VA 23607-0756, telephone (804) 247-8088, toll free 1-800-541-4646 or (804) 247-2292/TDD ☎

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
(BOARD OF)

August 12, 1994 - 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 Medical Assistance Services intends to amend regulations entitled: 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 Used to Establish Payment Rates - Other Types of Care; and VR 460-04-3.1300. Regulations for

Outpatient Physical Rehabilitative Services: Physical Therapy and Related Services. The purpose of this proposal is to amend the State Plan for Medical Assistance and VR 460-04-3.1300 concerning the authorization and utilization review of physical therapy and related services, and to provide guidelines for the provision of psychological and psychiatric services in schools.

DMAS has provided reimbursement for physical therapy and related services since 1978 under two major programs: general physical rehabilitative and intensive rehabilitative services. This regulation will allow DMAS to categorize general physical outpatient rehabilitation (physical therapy, occupational therapy, and speech-language pathology services) into two subgroups.

Physician orders are required and must be in place before any services are initiated. Guidelines are provided when physical therapy and related conditions are to be considered for termination regardless of the already preauthorized number of visits or services. Guidelines are also provided for psychological and psychiatric services, and school divisions are added as an entity which can provide these services. In addition, revisions are made to the intensive rehabilitation regulations by moving detailed language for these services from the State Plan to state-only regulations. Finally, language is added to the reimbursement (fee-for-service) methodology section of the Plan to describe payment for physical therapy and related services that may be provided by schools and home health agencies. Language was added on the recommendation of the Health Care Financing Administration because this area had not been adequately described in the Plan previously.

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

Written comments may be submitted through August 12, 1994, to Mary Chiles, Manager, Division of Quality Care Assurance, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 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.

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August 26, 1994 - 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 Medical Assistance Services intends to adopt regulations entitled: VR 460-04-8.16. DMAS-122 Adjustment Process. The purpose of this action is to establish and clarify by regulation the DMAS-122

Calendar of Events

adjustment process for Medicaid recipients in long-term care facilities. Specifically, the roles of the Department of Medical Assistance Services and the Department of Social Services will be clarified. This process is federally mandated and is not a new requirement.

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

Written comments may be submitted through August 26, 1994, to Mary Chiles, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 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.

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August 26, 1994 – 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 Medical Assistance Services intends to adopt regulations entitled: **VR 460-10-2500. Medicaid Financial Eligibility Requirements - Families and Children.** The purpose of this action is to promulgate state regulations which describe the methods and procedures to be used in setting standards and determining eligibility for Aid to Families With Dependent Children-related medical assistance.

Because eligibility for receipt of Title XIX services is based on income and resources, when determining Medicaid eligibility it is necessary to determine the income and resources available to each individual in a family to determine whether that individual is eligible for Medicaid. Presently, Medicaid eligibility is determined in "family and children" cases by dividing the family unit into separate budget units when children have their own income to ensure that the income of the child is not deemed available to the support of his parent or his sibling. These regulations revise the methodologies for determining income and resource eligibility under Medicaid, including the financial responsibility of relatives, and for determining how the income and resources of members of families are to be considered during the determination of eligibility for Medicaid.

These proposed regulations track federal regulations published January 1, 1993, except in one significant area, "deeming," which is specifically prohibited under § 1902(a)(17)(D) of the Social Security Act. Only the income and resources of a parent for a child or of a spouse for a spouse may be deemed to be available if they are living together. In order to assure that the individual standards of Medicaid applicants are not reduced by the presence of any nonlegally responsible

relative in the assistance unit, these individuals will be removed from the unit before the standards are prorated for individuals remaining in the unit.

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

Written comments may be submitted through August 26, 1994, to Ann Cook, Eligibility Consultant, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 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.

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† **September 23, 1994** – 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 Medical Assistance Services intends to adopt regulations entitled: **VR 460-01-53, 460-01-53.1, 460-01-53.2, and 460-02-4.1730. Liens and Recoveries: OBRA 93 Estate Recoveries.** The purpose of this action is to amend the Plan for Medical Assistance concerning estate recoveries consistent with the requirements of OBRA 93 § 13612 and of §§ 32.1-326.1 and 32.1-327 of the Code of Virginia. The process of recovering funds when they have been expended for persons who had their own resources, but did not use them for their own medical care, returns general fund dollars to the Commonwealth.

Sections 32.1-326.1 and 32.1-327 of the Code of Virginia provide for the recovery, by the Title XIX agency, of expenditures for certain services from the estates of recipients. The Omnibus Budget Reconciliation Act of 1993 § 13612 (OBRA 93) permitted the recovery of Title XIX expended funds from the estates of individuals for all Medicaid covered services. The inclusion of states' estate recovery policies in their state plans for medical assistance was required by the cited OBRA section. Since 1984, DMAS has exercised its authority under state law and recovered expenditures for all Medicaid covered services. The fact that the new federal law makes recovery of institutional payments mandatory, but this degree of recovery an option for states lacking similar state authority, is what causes this regulatory action to be subject to the Article 2 requirements of the Administrative Process Act.

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

Written comments may be submitted through September 23, 1994, to Jesse R. Garland, Director, Fiscal Division, 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.

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† **September 23, 1994** – 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 Medical Assistance Services intends to amend regulations entitled: **VR 460-02-4.1920, Methods and Standards for Establishing Payment Rates—Other Types of Care; VR 460-03-4.1921, Fees for Pediatric and Obstetric CPT Procedures; VR 460-03-4.1924, State Agency Fee Schedule: Resource Based Relative Value Scale.** The purpose of this proposal is to implement a new medical and surgical fee schedule for the agency which is based on the federal RBRVS. The program reimburses fee-for-service providers the lower of the state agency fee schedule or their actual charge to the general public. The 1994 Appropriations Act § 1-88(313)(W) directs the Board of Medical Assistance Services (BMAS) to develop a RBRVS-based physician fee schedule for approval by the HCFA. RBRVS-based reimbursement links the fee for a service to research-based estimates of the resources necessary to provide that service.

Prior to January 1, 1992, HCFA also used a fee schedule based on provider charges to reimburse physicians for their services rendered to Medicare beneficiaries. However, HCFA concluded that the fees it paid for services did not have a consistent, rational relationship to the actual resources utilized to provide those services. Therefore, HCFA developed a RBRVS-based fee schedule. HCFA assigned a "relative value" to each service expressed in relative value units (RVUs). HCFA computes the fee for a service by multiplying its RVUs times one of three conversion factors (CFs) which it developed for different types of services. The Department of Medical Assistance Services (DMAS) is amending HCFA's RVUs for its RBRVS-based fee schedule. DMAS will use HCFA's CFs after they have been adjusted by an additional factor to maintain budget neutrality. DMAS may revise the additional factor whenever HCFA updates its RVUs or CFs so that no change in expenditure will result solely from such update. DMAS will estimate RBRVS-type fees for services that have no HCFA RVUs and use existing fees for services for which it is unable to estimate an RBRVS-type fee. The RBRVS-based fees will be effective July 1, 1995, and will be phased in over a three-year period. There will be one fee schedule for the entire state with no geographic adjusters.

Implementation of the RBRVS-based fee schedule will affect each provider differently depending on the

types of services provided since the allowable fee will increase for some services and decrease for others. The agency projects no significant negative issues involved in implementing this proposed change. The primary advantage of this regulation is that reimbursement for primary care services will be enhanced.

This change to the fee schedule is undertaken only after obtaining input from the physician community. During 1993, DMAS convened an advisory committee composed of physicians selected by professional societies throughout the state. After several months of deliberation, a majority of this group voted to recommend to the department that it proceed to seek authorization to implement a RBRVS-based fee schedule. The details of the present proposal are consistent with the recommendations of the committee. All physician providers and some nonphysician providers (such as nurse practitioners) throughout the state will be affected. Provided there are no changes in the types of services provided as a result of the new fee schedule, there should be no impact on Medicaid recipients and the implementation of the new fee schedule should be budget neutral. Medicaid spent approximately \$205 million (total funds) for these services in SFY 94, and expects to spend \$244.8 million (total funds) in SFY 95. There are no localities which are uniquely affected by these regulations as they apply statewide.

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

Written comments may be submitted through September 23, 1994, to Scott Crawford, 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

Credentials Committee

† **August 13, 1994 - 8:15 a.m.** – Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Rooms 3 and 4, Richmond, Virginia. ☎

The committee will meet in open and closed session to conduct general business, interview and review medical credentials of applicants applying for licensure in Virginia, and to discuss any other items which may come before the committee. The committee will receive public comments of those persons appearing on behalf of candidates.

Calendar of Events

Contact: Eugenia K. Dorson, Deputy Executive Director of Discipline, Department of Health Professions, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923 or (804) 662-7197/TDD ☎

Executive Committee

† **August 12, 1994 - 9 a.m.** – Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Rooms 1 and 2, Richmond, Virginia. ☎

The committee will meet in open and closed session to review cases of files requiring administrative action, adopt amendments for approval of promulgation of regulations as presented. The full board may meet at 1 p.m. to hold a formal hearing regarding a pending matter. The chairman will entertain public comments following the adoption of the agenda for 10 minutes on agenda items.

Contact: Eugenia K. Dorson, Deputy Executive Director of Discipline, Department of Health Professions, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923 or (804) 662-7197/TDD ☎

Informal Conference Committee

July 28, 1994 - 9:30 a.m. – Open Meeting
Sheraton Inn, I-95 and Route 3, Commonwealth Room, Fredericksburg, Virginia. ☎

August 5, 1994 - 9 a.m. – Open Meeting
The Tysons Westpark Hotel, 8401 Westpark Drive, McLean, 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, Discipline, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9908 or (804) 662-9943/TDD ☎

Legislative Committee

† **September 9, 1994 - 10 a.m.** – Open Meeting
Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 3, Richmond, Virginia. ☎

The committee will meet to develop a recommendation to the full board on "short term use" of pharmacotherapy for weight loss; develop regulations for licensure by endorsement for doctors of chiropractic; develop regulations for implementation of House Bill 266 relating to unprofessional conduct; develop regulations for implementation of Senate Bill 474; and such other business that may be presented.

The chairperson will entertain public comments following the adoption of the agenda for 10 minutes on any agenda items.

Contact: Eugenia K. Dorson, Deputy Executive Director of Discipline, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923 or (804) 662-7197/TDD ☎

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

July 27, 1994 - 10 a.m. – Open Meeting
Department of Mental Health, Mental Retardation and Substance Abuse Services, James Madison Building, 109 Governor Street, 13th Floor Conference Room, Richmond, Virginia. ☎

A regular monthly meeting. 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 location.

Contact: Jane V. Helfrich, Board Administrator, State Mental Health, Mental Retardation and Substance Abuse Services Board, P. O. Box 1797, Richmond, VA 23214, telephone (804) 786-3921.

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September 11, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Mental Health, Mental Retardation and Substance Abuse Services Board intends to **repeal** regulations entitled: **VR 470-01-01. Public Participation Guidelines** and **adopt** regulations entitled: **VR 470-01-01:1. Public Participation Guidelines**. The purpose of this regulation is to adopt Public Participation Guidelines in conformance with § 9-6.14:7.1 of the Code of Virginia.

Statutory Authority: §§ 9-6.14:7.1 and 37.1-10 of the Code of Virginia.

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

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August 16, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Mental Health, Mental Retardation and Substance Abuse Services Board intends to repeal regulations entitled: VR 470-02-03. Rules and Regulations for the Licensure of Private Psychiatric Hospitals; VR 470-02-07. Rules and Regulations for the Licensure of Correctional Psychiatric Facilities; VR 470-02-08. Rules and Regulations for the Licensure of Supported Residential Programs and Residential Respite Care/Emergency Services Facilities; VR 470-02-09. Rules and Regulations for the Licensure of Outpatient Facilities; VR 470-02-10. Rules and Regulations for the Licensure of Day Support Programs; and VR 470-02-11. Rules and Regulations for the Licensure of Residential Facilities and adopt regulations entitled: VR 470-02-13. Regulations for the Licensure of Facilities and Providers of Mental Health, Mental Retardation and Substance Abuse Services. The purpose of these regulatory actions is to redraft and consolidate six current licensure regulations for all licensable facilities except residential facilities for children.

Statutory Authority: § 37.1-10(6) and Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 of the Code of Virginia.

Written comments may be submitted until August 16, 1994, to Jacqueline M. Ennis, Assistant Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services, P. O. Box 1797, Richmond, VA 23214.

Contact: Edith Smith, Manager, Licensure Operations, Department of Mental Health, Mental Retardation and Substance Abuse Services, P. O. Box 1797, Richmond, VA 23214, telephone (804) 371-6885.

VIRGINIA MENTAL HEALTH PLANNING COUNCIL

July 28, 1994 - 10 a.m. – Open Meeting

Henrico Area Mental Health and Retardation Services, 10299 Woodman Road, Glen Allen, Virginia. ☒ (Interpreter for the deaf provided upon request)

The council meets at least four times per year. Its mission is to advocate for a consumer and family oriented, integrated and community-based system of mental health care of the highest quality. The council continuously monitors and evaluates the implementation of the state's mental health plan.

Contact: Jeanette DuVal, Policy Analyst, Department of Mental Health, Mental Retardation and Substance Abuse Services, P. O. Box 1797, Richmond, VA 23214, telephone (804) 371-0359 or (804) 371-8977/TDD ☎

VIRGINIA MILITARY INSTITUTE

Board of Visitors

August 6, 1994 - 8:30 a.m. – Open Meeting
The Jefferson Hotel, Franklin and Adams Streets, Richmond, Virginia. ☒

A regular meeting of VMI Board of Visitors to include:

1. Election of President
2. Committee appointments
3. Committee reports

The Board of Visitors provides an opportunity for public comment at this meeting immediately after the Superintendent's comments (about 9 a.m.).

Contact: Colonel Edwin L. Dooley, Jr., Secretary to the Board, Superintendent's Office, Virginia Military Institute, Lexington, VA 24450, telephone (703) 464-7206 or FAX (703) 464-7660.

BOARD OF NURSING

† **July 27, 1994 - 10 a.m. – Open Meeting**
Department of Social Services, Division of Child Support, 8515 Phoenix Drive, Manassas, Virginia. (Interpreter for the deaf provided upon request)

† **July 27, 1994 - 2 p.m. – Open Meeting**
George Mason University, 4400 University Drive, Robinson Hall, Room A-303, Fairfax, Virginia. (Interpreter for the deaf provided upon request)

A formal hearing with certified nurse aides. Public comment will not be received.

Contact: Corinne F. Dorsey, R.N., Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9909 or (804) 662-7197/TDD ☎

† **August 5, 1994 - 9:30 a.m. – Open Meeting**
House, Davidson and Telegakes, Koger Center, 8100 Three Chopt Road, Suite 101, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

A formal hearing. Public comment will not be received.

Contact: M. Teresa Mullin, R.N., Assistant Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9909 or (804) 662-7197/TDD ☎

Special Conference Committee

† **July 28, 1994 - 10 a.m. – Open Meeting**
† **July 28, 1994 - 11:30 a.m. – Open Meeting**

Calendar of Events

Arlington County Courthouse, #1 Courthouse Plaza, 2100 Clarendon Boulevard, Arlington, Virginia. (Interpreter for the deaf provided upon request)

A special conference committee comprised of three members of the Virginia Board of Nursing will conduct an informal conference with certified nurse aides to determine if any action should be recommended to the Board of Nursing. Public comment will not be received.

Contact: Corinne F. Dorsey, R.N., Executive Director, Board of Nursing, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-9909 or (804) 662-7197/TDD ☎

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE

July 29, 1994 - 9 a.m. – Open Meeting
Department of Health Professions, 6606 West Broad Street, Conference Room 2, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

Three members will conduct informal conferences from 9 a.m. until 12:30 p.m. At 1:30 p.m., the full committee will consider matters related to the licensure of nurse practitioners. A review of comments on existing regulations received prior to the April 15, 1994, deadline will occur and plans will be made to complete the biennial review of the Regulations Governing the Licensure of Nurse Practitioners. Public comment will be received at 3 p.m.

Contact: Corinne F. Dorsey, R.N., Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9909 or (804) 662-7197/TDD ☎

BOARD OF PHARMACY

† **August 10, 1994 - 8:30 a.m. – Open Meeting**
Department of Health Professions, 6606 West Broad Street, 5th Floor, Conference Room 2, Richmond, Virginia. ☒

A board meeting and formal hearings. The board will ratify the Notice of Intent to promulgate regulations for foreign pharmacy graduates. This is a public meeting and there will be a 15 minute public comment period from 8:30 a.m. to 8:45 a.m.

Contact: Scotti W. Milley, Executive Director, Board of Pharmacy, 6606 W. Broad St., 4th Floor, Richmond, VA 23230, telephone (804) 662-9911.

POLYGRAPH EXAMINERS ADVISORY BOARD

July 26, 1994 - 10 a.m. – Open Meeting
Department of Professional and Occupational Regulation,

3600 West Broad Street, Richmond, Virginia. ☒

The meeting is for the purpose of administering the polygraph examiners licensing examination to eligible polygraph examiner interns and to consider other matters which may require board action.

Contact: Nancy T. Feldman, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590.

BOARD OF PROFESSIONAL COUNSELORS

July 25, 1994 - 9 a.m. – Open Meeting
July 25, 1994 - 11 a.m. – Open Meeting
July 25, 1994 - 1 p.m. – Open Meeting
Department of Health Professions, 6606 West Broad Street, Richmond, Virginia. ☒

Informal conferences. Public comment will not be received.

Contact: Evelyn B. Brown, Executive Director or Bernice Parker, Administrative Assistant, Department of Health Professions, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9967.

PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS ADVISORY COUNCIL

† **August 18, 1994 - 9 a.m. – Open Meeting**
Shoney's Inn, 7007 West Broad Street, Conference Room, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

A regular bimonthly meeting. Time is provided for public comment at the start of the meeting.

Contact: Kenneth Shores, Department for Rights of Virginians with Disabilities, James Monroe Bldg., 101 N. 14th St., 17th Floor, Richmond, VA 23219, telephone (804) 225-2042 Voice or TDD ☎

REAL ESTATE APPRAISER BOARD

July 26, 1994 - 10 a.m. – Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. ☒

A general business meeting. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact Karen W. O'Neal. The department fully complies with the Americans with Disabilities Act. Please notify the department of your request for accommodation at least two weeks in advance for consideration of your request.

Contact: Karen W. O'Neal, Assistant Director, Real Estate Appraiser Board, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-0500 or (804) 367-9753/TDD ☎

Complaints Committee

August 31, 1994 - 10 a.m. – Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. ☎

A meeting to review complaints. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact Karen W. O'Neal. The department fully complies with the Americans with Disabilities Act. Please notify the department of your request for accommodation at least two weeks in advance for consideration of your request.

Contact: Karen W. O'Neal, Assistant Director, Real Estate Appraiser Board, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-0500 or (804) 367-9753/TDD ☎

REAL ESTATE BOARD

† **August 4, 1994 - 10:30 a.m. – Open Meeting**

701 Princess Anne Street, Fredericksburg, Virginia.

A formal hearing in regard to the Real Estate Board v. Clayton D. Boutchyard. File Number 91-00371.

Contact: Stacie G. Camden, Legal Assistant, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2393.

† **August 15, 1994 - 9 a.m. – Open Meeting**

Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. ☎

A formal hearing in regard to the Real Estate Board v. Linda P. Hackett. File Number 93-00242.

Contact: Barbara B. Tinsley, Legal Assistant, Real Estate Board, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8589.

† **August 23, 1994 - 9 a.m. – Open Meeting**

Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. ☎

A formal hearing in regard to the Real Estate Board v. Larry J. Timbrook. File Number 93-00594.

Contact: Barbara B. Tinsley, Legal Assistant, Real Estate Board, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8589.

STATE REHABILITATION ADVISORY COUNCIL

† **September 23, 1994 - 10 a.m. – Open Meeting**

Department of Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, Virginia.

A regular quarterly meeting.

Contact: Dr. Ronald C. Gordon, Commissioner, Department of Rehabilitative Services, 8004 Franklin Farms Dr., Richmond, VA 23230, telephone (804) 662-7010, toll-free 1-800-552-5019 or (804) 662-9040/TDD ☎

BOARD OF REHABILITATIVE SERVICES

July 28, 1994 - 10 a.m. – Open Meeting

Department of Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, Virginia.

A regular monthly business meeting.

Contact: Ronald C. Gordon, Commissioner, Department of Rehabilitative Services, 8004 Franklin Farms Dr., Richmond, VA 23230, telephone (804) 662-7010, toll free 1-800-552-5019/TDD and Voice or (804) 662-9040/TDD ☎

VIRGINIA RESOURCES AUTHORITY

August 9, 1994 - 9:30 a.m. – Open Meeting

Virginia Resources Authority, The Mutual Building, 909 East Main Street, Board Room, Suite 607, Richmond, Virginia.

The board will meet to approve minutes of the meeting of July 12, 1994; 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, 909 E. Main St., Suite 607, Richmond, VA 23219, telephone (804) 644-3100 or FAX (804) 644-3109.

SEWAGE HANDLING AND DISPOSAL APPEALS REVIEW BOARD

August 10, 1994 - 10 a.m. – Open Meeting

General Assembly Building, 910 Capitol Street, Senate Room A, Richmond, Virginia. ☎

A meeting to hear all administrative appeals of denials of onsite sewage disposal systems permits pursuant to §§ 32.1-166.1 et seq. and 9-6.14:12 of the Code of Virginia and VR 355-34-02.

Calendar of Events

Contact: Constance G. Talbert, Secretary to the Board, 1500 E. Main St., P.O. Box 2448, Suite 117, Richmond, VA 23218, telephone (804) 786-1750.

DEPARTMENT OF SOCIAL SERVICES (STATE BOARD OF)

August 13, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Social Services intends to repeal regulations entitled: **VR 615-01-01. Public Participation Guidelines**. The purpose of this action is to repeal existing public participation guidelines.

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

Contact: Margaret J. Friedenber, Policy Analyst, Department of Social Services, 730 E. Broad St., Richmond, VA 23219, telephone (804) 692-1820.

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August 13, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Social Services intends to adopt regulations entitled: **VR 615-01-01.1. Public Participation Guidelines**. This regulation describes the ways in which the state board and department will solicit and consider public comments.

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

Contact: Margaret J. Friedenber, Policy Analyst, Department of Social Services, 730 E. Broad St., Richmond, VA 23219, telephone (804) 692-1820.

VIRGINIA SOIL AND WATER CONSERVATION BOARD

† **August 3, 1994 - 7 p.m.** – Public Hearing
General Assembly Building, 910 Capitol Square, Senate Room B, Richmond, Virginia.

† **August 4, 1994 - 7 p.m.** – Public Hearing
Salem Civic Center, Parlor A, Salem, Virginia.

† **September 26, 1994** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Soil and Water Conservation Board intends to amend regulations entitled: **VR 625-02-00. Erosion and Sediment Control Regulations**. Sections 10.1-502 and

10.1-561 of the Code of Virginia authorize the Virginia Soil and Water Conservation Board to promulgate regulations to implement the Erosion and Sediment Control Law. This action is necessary to amend the existing regulations which became effective September 13, 1990, due to the passage of Chapter 925 of the 1993 Virginia Acts of Assembly and other legislative changes since last amendment. The regulations establish minimum statewide standards for the control of soil erosion, sediment deposition and nonagricultural runoff from land-disturbing activities that must be met in local erosion and sediment control programs, and also by state agencies that conduct land-disturbing activities. Land-disturbing activities include, but are not limited to, clearing, grading, excavating, transporting and filling of land.

Statutory Authority: §§ 10.1-502 and 10.1-561 of the Code of Virginia.

Contact: James P. Edmonds, Urban Conservation Engineer, Department of Conservation and Recreation, 203 Governor St., Suite 206, Richmond, VA 23219, telephone (804) 786-3997 or FAX (804) 786-1798.

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† **August 3, 1994 - 7 p.m.** – Public Hearing
General Assembly Building, 910 Capitol Square, Senate Room B, Richmond, Virginia.

† **August 4, 1994 - 7 p.m.** – Public Hearing
Salem Civic Center, Parlor A, Salem, Virginia.

† **September 26, 1994** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Soil and Water Conservation Board intends to adopt regulations entitled: **VR 625-02-01. Erosion and Sediment Control Certification Regulations**. The proposed regulations establish minimum statewide standards for the certification of erosion and sediment control plan reviewers, inspectors, and program administrators. The regulations provide four classifications of certification: Program Administrator, Plan Reviewer, Inspector, and Combined Administrator. In addition, the regulations provide for eligibility requirements, fees, examinations, applications, and discipline of certified personnel. Training will be based upon the Erosion and Sediment Control Law and attendant regulations which establish minimum statewide standards for the control of soil erosion, sediment deposition and nonagricultural runoff from land-disturbing activities. Land-disturbing activities include, but are not limited to, clearing, grading, excavating, transporting and filling of land. Certification will be based upon completion of the training programs, work experience or combination thereof, plus obtaining a passing grade on the certification test. Recertification and decertification

are also covered by the regulations.

Statutory Authority: §§ 10.1-502 and 10.1-561 of the Code of Virginia.

Contact: James P. Edmonds, Urban Conservation Engineer, Department of Conservation and Recreation, 203 Governor St., Suite 206, Richmond, VA 23219, telephone (804) 786-3997 or FAX (804) 786-1798.

SECRETARY OF TRANSPORTATION

† **August 1, 1994 - 1 p.m.** – Open Meeting
Central Virginia Community College, Amherst Building, Room 2123, Lynchburg, Virginia.

† **August 10, 1994 - 1 p.m.** – Open Meeting
J. Sargeant Reynolds Community College, North Run Business Park Auditorium, Richmond, Virginia.

The Secretary of Transportation is conducting a strategic planning process to develop strategies to improve the efficiency and effectiveness of the Commonwealth's transportation system. Transportation, business and community leaders and the public are asked to provide their suggestions and ideas.

Contact: Kevin Landergan, Senior Policy Analyst, 1401 E. Broad St., Richmond, VA 23219, telephone (804) 371-7632.

TREASURY BOARD

† **August 17, 1994 - 9 a.m.** – Open Meeting
† **September 21, 1994 - 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: Gloria J. Hatchel, Administrative Assistant to the Treasurer, Department of the Treasury, 101 N. 14th St., 3rd Floor, Richmond, VA 23219, telephone (804) 371-6011.

VIRGINIA COUNCIL ON VOCATIONAL EDUCATION

† **August 3, 1994 - Noon** – Open Meeting
Holiday Inn, Culpeper, Virginia.

Opening session and committee meetings.

† **August 4, 1994 - 8:30 a.m.** – Open Meeting
Holiday Inn, Culpeper, Virginia.

A business session.

Contact: Jerry Hicks, Executive Director, 7420-A Whitepine Road, Richmond, VA 23237, telephone (804) 275-6218.

STATE WATER CONTROL BOARD

July 26, 1994 - 7 p.m. – Public Hearing

Mary Bethune Administrative Complex, Cowford Road, Halifax County Board of Supervisors Meeting Room, 2nd Floor, Halifax, Virginia. ☒

The State Water Control Board will hold a public hearing to receive comments on the issuance or denial of Virginia Pollutant Abatement Permit No. VPA000547 for Brian Farm, Rt. 720, Scottsburg, VA 24589. The waste generated by a finishing swine operation will be land applied at agronomic rates to approved sites in Halifax County. There will be no discharge allowed by the permit.

Contact: Doneva A. Dalton, Hearings Reporter, Department of Environmental Quality, P. O. Box 10009, Richmond, VA 23240, telephone (804) 762-4379.

† **August 22, 1994 - 10 a.m.** – Open Meeting

Department of Environmental Quality, Innsbrook Corporate Center, 4900 Cox Road, Glen Allen, Virginia. ☒

A regular meeting.

Contact: Doneva A. Dalton, Hearings Reporter, 629 E. Main St., P.O. Box 10009, Richmond, VA 23240, telephone (804) 762-4379.

LEGISLATIVE

HOUSE COMMITTEE ON AGRICULTURE

† **August 24, 1994 - 10 a.m.** – Open Meeting

† **August 25, 1994 - 10 a.m.** – Open Meeting

Stratford Inn, 2500 Riverside Drive, Danville, Virginia.

A two day retreat is scheduled beginning with Commissioner Courter describing possible policy initiatives and future plans for the agency. There will also be presentations by representatives of the various sectors of the tobacco industry. On the second day, there will be a tour of a tobacco farm and processing plant. At 1:30 p.m. on the 25th, there will be a meeting of HJR 224 (Tobacco Farming) at the Stratford Inn.

Contact: Martin Farber, Research Associate, Division of Legislative Services, 910 Capitol St., Richmond, VA 23219, telephone (804) 786-3591.

Calendar of Events

JOINT SUBCOMMITTEE STUDYING STATE AND FEDERAL LAW ON PRIVACY, CONFIDENTIALITY AND MANDATORY DISCLOSURE OF INFORMATION HELD OR USED BY GOVERNMENTAL AGENCIES

† **August 22, 1994 - 10 a.m.** — Open Meeting
General Assembly Building, 910 Capitol Street, House Room C, Richmond, Virginia.

The subcommittee will meet for the purpose of hearing recommendations. HJR 66.

Contact: Ginny Edwards, Staff Attorney, Division of Legislative Services, 910 Capitol St., Richmond, VA 23219, telephone (804) 786-3591.

JOINT COMMISSION ON HEALTH CARE

† **August 1, 1994 - 9:30 a.m.** — Open Meeting
General Assembly Building, 910 Capitol Street, Senate Room B, Richmond, Virginia.

An open meeting.

Contact: Joint Commission on Health Care, 1001 E. Broad St., Suite 115, Richmond, VA 23219, telephone (804) 786-5445.

VIRGINIA HOUSING STUDY COMMISSION

August 11, 1994 - 10 a.m. — Public Hearing
Clinch Valley College, Theatre/Drama Building, Wise, Virginia.

Public hearings will be held on the following issues:

HJR 241 pursuant to the health and safety issues of residential rental property not covered under the Virginia Residential Landlord and Tenant Act.

HJR 251 pursuant to the need for legislation to authorize local governments to inspect rental property between occupancies to ensure compliance with applicable state codes and their enforcement authority when violations are found.

HJR 489 (1993) pursuant to blighted and deteriorated neighborhoods in the Commonwealth.

HJR 163 (1992) pursuant to homelessness in Virginia, specifically, appeal bond reform (HB 501) and terrorized tenants (HB 1381).

Other issues related to affordable housing in Virginia.

Persons wishing to speak should contact Nancy M. Ambler, Esquire, Executive Director, Virginia Housing Study Commission, 601 S. Belvidere St., Richmond, VA 23220, telephone (804) 225-3797.

Contact: Nancy D. Blanchard, Virginia Housing Study Commission, 601 S. Belvidere St., Richmond, VA 23220, telephone (804) 782-1986, Ext. 565.

JOINT SUBCOMMITTEE STUDYING THE CONTINUATION OF SERVICES FOR YOUNG ADULTS WHO ARE EXITING PUBLICLY FUNDED SERVICE PROGRAMS

August 2, 1994 - 10 a.m. — Open Meeting
General Assembly Building, 910 Capitol Street, House Room C, Richmond, Virginia.

This subcommittee will meet to set its agenda for the interim and to hear from some of the servicing programs.

Contact: Brenda Edwards, Research Associate, Division of Legislative Services, 910 Capitol Street, Richmond, VA 23219, telephone (804) 786-3591.

STATE WATER COMMISSION

August 8, 1994 - 10 a.m. — Open Meeting
General Assembly Building, 910 Capitol Street, House Room C, Richmond, Virginia.

The commission will be reviewing options for role in state water development and utilization and hearing from some localities on their views.

Contact: Shannon Varner, Staff Attorney, Division of Legislative Services, 910 Capitol Street, Richmond, VA 23219, telephone (804) 786-3591.

CHRONOLOGICAL LIST

OPEN MEETINGS

July 25

Alcoholic Beverage Control Board
† Elections, State Board of
Longwood College
- Student Affairs Committee
Lottery Department, State
Professional Counselors, Board of

July 26

Agriculture and Consumer Services, Board of
† Elections, State Board of
† Health Services Cost Review Council
† HIV Prevention Community Planning Committee,
Virginia
Polygraph Examiners Advisory Board

Calendar of Events

Real Estate Appraiser Board
Water Control Board, State

July 27

Chesapeake Bay Local Assistance Board
- Southern Area Review Committee
Criminal Justice Services, Department of
- Private Security Services Advisory Board
Mental Health, Mental Retardation and Substance
Abuse Services Board, State
† Nursing, Board of

July 28

Compensation Board
Education, Board of
Health, State Board of
- Food Service Advisory Committee
† Internet Staff Study Team, HJR No. 76
† Longwood College
- Executive Committee
- Facilities and Services Committee
Medicine, Board of
- Informal Conference Committee
Mental Health Planning Council, Virginia
† Nursing, Board of
- Special Conference Committee
Rehabilitative Services, Board of

July 29

Longwood College
- Board of Visitors
Marine Resources Commission
Nursing and Medicine, Committee of the Joint Boards
of

July 30

Natural History, Virginia Museum of
- Board of Trustees

August 1

† Contractors, Board for
† Health Care, Joint Commission on
† Transportation, Secretary of

August 2

† Contractors, Board for
Hopewell Industrial Safety Council
Publicly Funded Programs, Joint Subcommittee
Studying The Continuation of Services for Young
Adults Who Are Exiting

August 3

† Contractors, Board for
† Emergency Planning Committee, Local - Winchester
† Vocational Education Council, Virginia

August 4

† Contractors, Board for
† Real Estate Board
† Vocational Education Council, Virginia

August 5

† Contractors, Board for
Board of Medicine
- Informal Conference Committee
† Nursing, Board of

August 6

Virginia Military Institute
- Board of Visitors

August 8

Alcoholic Beverage Control Board
Barbers, Board for
Water Commission, State

August 9

† Child Day and Early Childhood Programs, Virginia
Council on
Resources Authority, Virginia

August 10

† Pharmacy, Board of
Sewage Handling and Disposal Appeals Review Board
† Transportation, Secretary of

August 11

† Child Day-Care Council
Environmental Quality, Department of
- Technical Advisory Committee
Geology, Board for
Health, Department of
- HIV Prevention Community Planning Committee,
Virginia

August 12

Geology, Board for
† Health, Department of
Land Evaluation Advisory Council, State
† Medicine, Board of
- Executive Committee

August 13

† Medicine, Board of
- Credentials Committee

August 15

† Real Estate Board

August 17

Corrections, Board of
† Local Debt, State Council on
Manufactured Housing Board, Virginia
† Treasury Board

August 18

Chesapeake Bay Local Assistance Board
- Central Area Review Committee
- Northern Area Review Committee
Environmental Quality, Department of
- Pollution Prevention Advisory Committee
† Protection and Advocacy for Individuals with Mental

Calendar of Events

Illness Advisory Council

August 22

Alcoholic Beverage Control Board
Agricultural Council, Virginia
† Disclosure of Information Held or Used by
Governmental Agencies, Joint Subcommittee Studying
State and Federal Law on Privacy, Confidentiality and
Mandatory
† Water Control Board, State

August 23

† Real Estate Board

August 24

† Agriculture, House Committee on
Chesapeake Bay Local Assistance Board
- Southern Area Review Committee

August 25

† Agriculture, House Committee on
Compensation Board
† Game and Inland Fisheries, Board of

August 26

† Game and Inland Fisheries, Board of

August 30

Health Services Cost Review Council

August 31

Real Estate Appraiser Board
- Complaints Committee

September 1

Environmental Quality, Department of
- Technical Advisory Committee

September 6

Hopewell Industrial Safety Council

September 7

Alcoholic Beverage Control Board

September 9

† Medicine, Board of
- Legislative Committee

September 13

Emergency Planning Committee - Local, County of
Montgomery/Town of Blacksburg

September 14

Environmental Quality, Department of
- Work Group on Detection/Quantitation Levels
† Higher Education in Virginia, Commission on the
Future of

September 17

Visually Handicapped, Department for the
- Vocational Rehabilitation Advisory Council

September 19

Alcoholic Beverage Control Board

September 21

Asbestos Licensing Board, Virginia
† Contractors, Board for
† Local Debt, State Council on
† Treasury Board

September 23

† Rehabilitation Advisory Council, State

September 28

Chesapeake Bay Local Assistance Board
- Southern Area Review Committee

PUBLIC HEARINGS

July 25

† Higher Education, State Council of
† HIV Prevention Community Planning Committee,
Virginia

July 26

† Higher Education, State Council of
† HIV Prevention Community Planning Committee,
Virginia
Water Control Board, State

July 27

† Higher Education, State Council of

July 28

Corporation Commission, State
† Higher Education, State Council of
† HIV Prevention Community Planning Committee,
Virginia

August 1

Health, Department of
† HIV Prevention Community Planning Committee,
Virginia

August 2

† HIV Prevention Community Planning Committee,
Virginia

August 3

† Dentistry, Board of
Health, Department of
† HIV Prevention Community Planning Committee,
Virginia
† Soil and Water Conservation Board, Virginia

August 4

† HIV Prevention Community Planning Committee,
Virginia
† Soil and Water Conservation Board, Virginia

Calendar of Events

August 11

Housing Study Commission, Virginia

September 20

Auctioneers Board

October 5

Criminal Justice Services, Department of (Board)

Calendar of Events
