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The table printed below lists regulation sections, by Virginia Administrative Code (VAC) title, that have been amended, added or repealed in the *Virginia Register* since the regulations were originally published or last supplemented in VAC (the Spring 2004 VAC Supplement includes final regulations published through *Virginia Register* Volume 20, Issue 11, dated February 9, 2004). Emergency regulations, if any, are listed, followed by the designation "emer," and errata pertaining to final regulations are listed. Proposed regulations are not listed here. The table lists the sections in numerical order and shows action taken, the volume, issue and page number where the section appeared, and the effective date of the section.

| SECTION NUMBER                                     | ACTION   | CITE                  | EFFECTIVE DATE |
|--|----------|-----------------------|----------------|
| <b>Title 1. Administration</b>                     |          |                       |                |
| 1 VAC 55-20-10                                     | Repealed | 20:20 VA.R. 2159      | 7/16/04        |
| 1 VAC 55-20-20                                     | Amended  | 20:20 VA.R. 2159      | 7/16/04        |
| 1 VAC 55-20-30                                     | Amended  | 20:20 VA.R. 2159      | 7/16/04        |
| 1 VAC 55-20-40                                     | Amended  | 20:20 VA.R. 2159      | 7/16/04        |
| 1 VAC 55-20-50                                     | Repealed | 20:20 VA.R. 2159      | 7/16/04        |
| 1 VAC 55-20-60 through 1 VAC 55-20-90              | Amended  | 20:20 VA.R. 2159-2161 | 7/16/04        |
| 1 VAC 55-20-110                                    | Amended  | 20:20 VA.R. 2161      | 7/16/04        |
| 1 VAC 55-20-120                                    | Repealed | 20:20 VA.R. 2161      | 7/16/04        |
| 1 VAC 55-20-130                                    | Amended  | 20:20 VA.R. 2161      | 7/16/04        |
| 1 VAC 55-20-160                                    | Amended  | 20:20 VA.R. 2161      | 7/16/04        |
| 1 VAC 55-20-210                                    | Amended  | 20:20 VA.R. 2161      | 7/16/04        |
| 1 VAC 55-20-230 through 1 VAC 55-20-260            | Amended  | 20:20 VA.R. 2161-2162 | 7/16/04        |
| 1 VAC 55-20-280                                    | Amended  | 20:20 VA.R. 2162      | 7/16/04        |
| 1 VAC 55-20-290                                    | Amended  | 20:20 VA.R. 2162      | 7/16/04        |
| 1 VAC 55-20-300                                    | Amended  | 20:20 VA.R. 2162      | 7/16/04        |
| 1 VAC 55-20-320 through 1 VAC 55-20-410            | Amended  | 20:20 VA.R. 2162-2164 | 7/16/04        |
| 1 VAC 55-20-420                                    | Repealed | 20:20 VA.R. 2164      | 7/16/04        |
| 1 VAC 55-20-430                                    | Amended  | 20:20 VA.R. 2164      | 7/16/04        |
| 1 VAC 55-20-450                                    | Amended  | 20:20 VA.R. 2164      | 7/16/04        |
| 1 VAC 55-20-460                                    | Amended  | 20:20 VA.R. 2164      | 7/16/04        |
| 1 VAC 55-20 (Forms)                                | Amended  | 20:20 VA.R. 2164      | --             |
| 1 VAC 75-40-10 through 1 VAC 75-40-60              | Added    | 20:25 VA.R. 3082      | 9/22/04        |
| <b>Title 2. Agriculture</b>                        |          |                       |                |
| 2 VAC 5-440-10 through 2 VAC 5-440-60              | Amended  | 20:12 VA.R. 1471-1474 | 3/25/04        |
| 2 VAC 5-440-80                                     | Repealed | 20:12 VA.R. 1474      | 3/25/04        |
| 2 VAC 5-440-90                                     | Repealed | 20:12 VA.R. 1474      | 3/25/04        |
| 2 VAC 5-440 (Forms)                                | Amended  | 20:12 VA.R. 1474      | --             |
| 2 VAC 20-30  | Erratum  | 20:25 VA.R. 3111      | --             |
| 2 VAC 20-30-20                                     | Amended  | 20:23 VA.R. 2541      | 8/26/04        |
| 2 VAC 20-30-30                                     | Amended  | 20:23 VA.R. 2541      | 8/26/04        |
| 2 VAC 20-30-40                                     | Amended  | 20:23 VA.R. 2541      | 8/26/04        |
| <b>Title 3. Alcoholic Beverages</b>                |          |                       |                |
| 3 VAC 5-30   | Erratum  | 21:1 VA.R. 44         | --             |
| 3 VAC 5-30   | Erratum  | 21:3 VA.R. 345        | --             |
| 3 VAC 5-40   | Erratum  | 21:1 VA.R. 44         | --             |
| 3 VAC 5-40   | Erratum  | 21:3 VA.R. 345        | --             |
| 3 VAC 5-70   | Erratum  | 21:1 VA.R. 44         | --             |
| 3 VAC 5-70   | Erratum  | 21:3 VA.R. 345        | --             |
| <b>Title 4. Conservation and Natural Resources</b> |          |                       |                |
| 4 VAC 3-20   | Repealed | 21:3 VA.R. 317        | *              |

\* January 1, 2005, or 30 days after U.S. EPA approval, whichever is the latter.

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| SECTION NUMBER                               | ACTION   | CITE                  | EFFECTIVE DATE   |
|--|----------|-----------------------|------------------|
| 4 VAC 5-36-20                                | Amended  | 20:13 VA.R. 1604      | 4/7/04           |
| 4 VAC 5-36-50 through 4 VAC 5-36-150         | Amended  | 20:13 VA.R. 1604-1621 | 4/7/04           |
| 4 VAC 5-36-170 through 4 VAC 5-36-210        | Amended  | 20:13 VA.R. 1621-1632 | 4/7/04           |
| 4 VAC 5-36-220                               | Added    | 20:13 VA.R. 1632      | 4/7/04           |
| 4 VAC 15-20-100                              | Amended  | 21:3 VA.R. 318        | 10/1/04          |
| 4 VAC 15-40-280                              | Amended  | 21:1 VA.R. 24         | 10/20/04         |
| 4 VAC 15-50-81                               | Amended  | 20:23 VA.R. 2542      | 8/25/04          |
| 4 VAC 15-50-91                               | Amended  | 20:23 VA.R. 2543      | 8/25/04          |
| 4 VAC 15-90-231                              | Amended  | 20:23 VA.R. 2543      | 8/25/04          |
| 4 VAC 15-90-241                              | Amended  | 20:23 VA.R. 2544      | 8/25/04          |
| 4 VAC 15-240-81                              | Amended  | 20:23 VA.R. 2544      | 8/25/04          |
| 4 VAC 15-240-91                              | Amended  | 20:23 VA.R. 2545      | 8/25/04          |
| 4 VAC 15-260-10                              | Amended  | 20:25 VA.R. 3082      | 7/28/04          |
| 4 VAC 15-320-100                             | Amended  | 21:1 VA.R. 24         | 9/20/04          |
| 4 VAC 20-20-50                               | Amended  | 20:14 VA.R. 1709      | 3/1/04           |
| 4 VAC 20-270-20                              | Amended  | 20:19 VA.R. 2058      | 5/1/04           |
| 4 VAC 20-270-30                              | Amended  | 20:19 VA.R. 2058      | 5/1/04           |
| 4 VAC 20-270-30                              | Amended  | 20:26 VA.R. 3191      | 8/6/04           |
| 4 VAC 20-320-10                              | Amended  | 20:26 VA.R. 3191      | 8/6/04           |
| 4 VAC 20-320-70                              | Amended  | 20:26 VA.R. 3192      | 8/6/04           |
| 4 VAC 20-320-80                              | Amended  | 20:26 VA.R. 3192      | 8/6/04           |
| 4 VAC 20-490-10 emer                         | Amended  | 20:18 VA.R. 2024      | 5/1/04-5/30/04   |
| 4 VAC 20-490-20 emer                         | Amended  | 20:18 VA.R. 2024      | 5/1/04-5/30/04   |
| 4 VAC 20-490-35 emer                         | Repealed | 20:18 VA.R. 2024      | 5/1/04-5/30/04   |
| 4 VAC 20-490-35                              | Repealed | 20:21 VA.R. 2230      | 6/1/04           |
| 4 VAC 20-490-40 emer                         | Amended  | 20:18 VA.R. 2024      | 5/1/04-5/30/04   |
| 4 VAC 20-490-40                              | Amended  | 20:21 VA.R. 2230      | 6/1/04           |
| 4 VAC 20-490-45 emer                         | Repealed | 20:18 VA.R. 2025      | 5/1/04-5/30/04   |
| 4 VAC 20-490-45                              | Repealed | 20:21 VA.R. 2230      | 6/1/04           |
| 4 VAC 20-564-10 through 4 VAC 20-564-50 emer | Added    | 20:25 VA.R. 3096      | 8/16/04-9/3/04   |
| 4 VAC 20-620-50                              | Amended  | 20:16 VA.R. 1863      | 3/26/04          |
| 4 VAC 20-620-60                              | Amended  | 20:16 VA.R. 1863      | 3/26/04          |
| 4 VAC 20-720-20                              | Amended  | 20:14 VA.R. 1710      | 3/1/04           |
| 4 VAC 20-720-20                              | Amended  | 21:4 VA.R. 408        | 10/1/04          |
| 4 VAC 20-720-40                              | Amended  | 20:14 VA.R. 1710      | 3/1/04           |
| 4 VAC 20-720-40 through 4 VAC 20-720-100     | Amended  | 21:4 VA.R. 409-411    | 10/1/04          |
| 4 VAC 20-720-48 emer                         | Added    | 20:14 VA.R. 1714      | 3/1/04-3/31/04   |
| 4 VAC 20-720-50                              | Amended  | 20:14 VA.R. 1711      | 3/1/04           |
| 4 VAC 20-720-60                              | Amended  | 20:14 VA.R. 1711      | 3/1/04           |
| 4 VAC 20-720-80                              | Amended  | 20:14 VA.R. 1712      | 3/1/04           |
| 4 VAC 20-750-10                              | Amended  | 20:19 VA.R. 2058      | 5/1/04           |
| 4 VAC 20-750-20                              | Repealed | 20:19 VA.R. 2059      | 5/1/04           |
| 4 VAC 20-750-30                              | Amended  | 20:19 VA.R. 2059      | 5/1/04           |
| 4 VAC 20-750-40                              | Amended  | 20:19 VA.R. 2059      | 5/1/04           |
| 4 VAC 20-910-45                              | Amended  | 20:16 VA.R. 1864      | 4/1/04           |
| 4 VAC 20-910-45 emer                         | Amended  | 21:5 VA.R. 499        | 11/1/04-11/30/04 |
| 4 VAC 20-920-20                              | Amended  | 20:15 VA.R. 1778      | 3/5/04           |
| 4 VAC 20-920-40                              | Amended  | 20:15 VA.R. 1778      | 3/5/04           |
| 4 VAC 20-950-45                              | Amended  | 20:16 VA.R. 1864      | 4/1/04           |
| 4 VAC 20-950-47                              | Amended  | 21:5 VA.R. 497        | 10/29/04         |
| 4 VAC 20-950-48 emer                         | Amended  | 21:3 VA.R. 334        | 9/29/04-10/30/04 |
| 4 VAC 20-950-48                              | Amended  | 21:5 VA.R. 497        | 10/29/04         |
| 4 VAC 20-950-48.1                            | Added    | 21:5 VA.R. 497        | 10/29/04         |
| 4 VAC 20-1040-20                             | Amended  | 20:19 VA.R. 2060      | 5/1/04           |
| 4 VAC 20-1045-10                             | Added    | 21:4 VA.R. 412        | 10/1/04          |
| 4 VAC 20-1045-20                             | Added    | 21:4 VA.R. 412        | 10/1/04          |

# Cumulative Table of VAC Sections Adopted, Amended, or Repealed

| SECTION NUMBER                                   | ACTION   | CITE                  | EFFECTIVE DATE  |
|--|----------|-----------------------|-----------------|
| 4 VAC 20-1045-30                                 | Added    | 21:4 VA.R. 412        | 10/1/04         |
| 4 VAC 25-20-20                                   | Amended  | 20:23 VA.R. 2547      | 8/25/04         |
| 4 VAC 25-20-30                                   | Amended  | 20:23 VA.R. 2547      | 8/25/04         |
| 4 VAC 25-20-40                                   | Amended  | 20:23 VA.R. 2547      | 8/25/04         |
| 4 VAC 25-20-50                                   | Amended  | 20:23 VA.R. 2547      | 8/25/04         |
| 4 VAC 25-20-70                                   | Amended  | 20:23 VA.R. 2547      | 8/25/04         |
| 4 VAC 25-20-90                                   | Amended  | 20:23 VA.R. 2547      | 8/25/04         |
| 4 VAC 25-20-100                                  | Amended  | 20:23 VA.R. 2547      | 8/25/04         |
| 4 VAC 25-20-110                                  | Amended  | 20:23 VA.R. 2548      | 8/25/04         |
| 4 VAC 25-20-140                                  | Amended  | 20:23 VA.R. 2548      | 8/25/04         |
| 4 VAC 25-20-190                                  | Amended  | 20:23 VA.R. 2548      | 8/25/04         |
| 4 VAC 25-20-200                                  | Amended  | 20:23 VA.R. 2548      | 8/25/04         |
| 4 VAC 25-20-210                                  | Amended  | 20:23 VA.R. 2548      | 8/25/04         |
| 4 VAC 25-20-220                                  | Amended  | 20:23 VA.R. 2549      | 8/25/04         |
| 4 VAC 25-20-250                                  | Amended  | 20:23 VA.R. 2549      | 8/25/04         |
| 4 VAC 25-20-255                                  | Amended  | 20:23 VA.R. 2549      | 8/25/04         |
| 4 VAC 25-20-259                                  | Amended  | 20:23 VA.R. 2549      | 8/25/04         |
| 4 VAC 25-20-390                                  | Amended  | 20:23 VA.R. 2549      | 8/25/04         |
| 4 VAC 25-20-410                                  | Amended  | 20:23 VA.R. 2549      | 8/25/04         |
| 4 VAC 25-20-430                                  | Amended  | 20:23 VA.R. 2549      | 8/25/04         |
| 4 VAC 25-31 (Forms)                              | Amended  | 20:15 VA.R. 1784-1792 | --              |
| 4 VAC 25-31 (Forms)                              | Amended  | 21:1 VA.R. 28         | --              |
| 4 VAC 25-35-10 through 4 VAC 25-35-40            | Amended  | 20:23 VA.R. 2549-2550 | 8/25/04         |
| 4 VAC 25-35-75                                   | Added    | 20:23 VA.R. 2550      | 8/25/04         |
| 4 VAC 25-35-80                                   | Amended  | 20:23 VA.R. 2550      | 8/25/04         |
| 4 VAC 25-35-100                                  | Amended  | 20:23 VA.R. 2551      | 8/25/04         |
| 4 VAC 25-35-110                                  | Amended  | 20:23 VA.R. 2551      | 8/25/04         |
| 4 VAC 25-35-120                                  | Amended  | 20:23 VA.R. 2551      | 8/25/04         |
| 4 VAC 25-125-10 through 4 VAC 25-125-40          | Added    | 20:23 VA.R. 2552-2553 | 8/25/04         |
| 4 VAC 25-130-801.17                              | Amended  | 20:23 VA.R. 2625      | 10/12/04        |
| 4 VAC 25-130-801.18                              | Amended  | 20:23 VA.R. 2626      | 10/12/04        |
| 4 VAC 25-130 (Forms)                             | Amended  | 20:19 VA.R. 2081-2083 | --              |
| 4 VAC 25-130 (Forms)                             | Amended  | 21:2 VA.R. 225        | --              |
| 4 VAC 50-60-10 through 4 VAC 50-60-1240          | Added    | 21:3 VA.R. 317        | *               |
| <b>Title 6. Criminal Justice and Corrections</b> |          |                       |                 |
| 6 VAC 20-190-10                                  | Amended  | 21:2 VA.R. 127        | 11/3/04         |
| 6 VAC 20-190-50                                  | Amended  | 21:2 VA.R. 127        | 11/3/04         |
| 6 VAC 20-190-150                                 | Amended  | 21:2 VA.R. 127        | 11/3/04         |
| 6 VAC 20-190-160                                 | Amended  | 21:2 VA.R. 128        | 11/3/04         |
| 6 VAC 20-210-10 through 6 VAC 20-210-110         | Added    | 20:23 VA.R. 2554-2555 | 8/26/04         |
| 6 VAC 20-240-10 through 6 VAC 20-240-140 emer    | Added    | 20:25 VA.R. 3097-3102 | 8/23/04-8/22/05 |
| 6 VAC 35-160-10 through 6 VAC 35-160-390         | Added    | 20:23 VA.R. 2555-2562 | 8/25/04         |
| <b>Title 8. Education</b>                        |          |                       |                 |
| 8 VAC 20-140-10                                  | Repealed | 21:3 VA.R. 332        | 1/1/05          |
| 8 VAC 20-210-10                                  | Amended  | 21:4 VA.R. 413        | 1/1/05          |
| 8 VAC 20-340-10                                  | Amended  | 20:23 VA.R. 2562      | 8/25/04         |
| 8 VAC 20-340-20                                  | Added    | 20:23 VA.R. 2562      | 8/25/04         |
| 8 VAC 20-340-30                                  | Added    | 20:23 VA.R. 2562      | 8/25/04         |
| 8 VAC 20-470-10                                  | Repealed | 21:4 VA.R. 423        | 3/1/05          |
| 8 VAC 20-670-10 through 8 VAC 20-670-440         | Added    | 20:24 VA.R. 2892-2898 | 9/10/04         |
| 8 VAC 40-130-10                                  | Amended  | 20:23 VA.R. 2562      | 7/26/04         |
| 8 VAC 40-130-25                                  | Amended  | 20:23 VA.R. 2563      | 7/26/04         |
| <b>Title 9. Environment</b>                      |          |                       |                 |
| 9 VAC 5-20-21                                    | Amended  | 20:12 VA.R. 1476      | 3/24/04         |
| 9 VAC 5-20-204                                   | Amended  | 20:23 VA.R. 2564      | 8/25/04         |

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| 9 VAC 5-20-204                          | Erratum | 20:26 VA.R. 3210-3211 | --              |
| 9 VAC 5-20-205                          | Amended | 20:23 VA.R. 2564      | 8/25/04         |
| 9 VAC 5-20-205                          | Erratum | 20:26 VA.R. 3210-3211 | --              |
| 9 VAC 5-20-206 (Rev. G02)               | Amended | 20:12 VA.R. 1498      | 3/24/04         |
| 9 VAC 5-20-206 (Rev. C03)               | Amended | 20:12 VA.R. 1498      | 3/24/04         |
| 9 VAC 5-30-10                           | Amended | 20:24 VA.R. 2898      | 9/8/04          |
| 9 VAC 5-30-30 through 9 VAC 5-30-50     | Amended | 20:24 VA.R. 2898-2900 | 9/8/04          |
| 9 VAC 5-30-55                           | Added   | 20:24 VA.R. 2899      | 9/8/04          |
| 9 VAC 5-30-60                           | Amended | 20:24 VA.R. 2899      | 9/8/04          |
| 9 VAC 5-30-65                           | Added   | 20:24 VA.R. 2899      | 9/8/04          |
| 9 VAC 5-30-70                           | Amended | 20:24 VA.R. 2900      | 9/8/04          |
| 9 VAC 5-30-80                           | Amended | 20:24 VA.R. 2900      | 9/8/04          |
| 9 VAC 5-40-240                          | Amended | 20:12 VA.R. 1499      | 3/24/04         |
| 9 VAC 5-40-310                          | Erratum | 20:15 VA.R. 1809      | --              |
| 9 VAC 5-40-310                          | Amended | 20:12 VA.R. 1499      | 3/24/04         |
| 9 VAC 5-40-3260                         | Amended | 20:12 VA.R. 1479      | 3/24/04         |
| 9 VAC 5-40-5200                         | Amended | 20:12 VA.R. 1500      | 3/24/04         |
| 9 VAC 5-40-5220                         | Amended | 20:12 VA.R. 1501      | 3/24/04         |
| 9 VAC 5-40-5700 through 9 VAC 5-40-5770 | Added   | 20:12 VA.R. 1480      | 3/24/04         |
| 9 VAC 5-40-6820 through 9 VAC 5-40-7230 | Added   | 20:12 VA.R. 1480-1497 | 3/24/04         |
| 9 VAC 5-40-6840                         | Erratum | 20:18 VA.R. 2027      | --              |
| 9 VAC 5-50-400                          | Amended | 20:16 VA.R. 1865      | 6/1/04          |
| 9 VAC 5-50-405                          | Added   | 20:16 VA.R. 1865      | 6/1/04          |
| 9 VAC 5-50-410                          | Amended | 20:16 VA.R. 1865      | 6/1/04          |
| 9 VAC 5-60-60                           | Amended | 20:16 VA.R. 1871      | 6/1/04          |
| 9 VAC 5-60-65                           | Added   | 20:16 VA.R. 1871      | 6/1/04          |
| 9 VAC 5-60-90                           | Amended | 20:16 VA.R. 1871      | 6/1/04          |
| 9 VAC 5-60-91                           | Added   | 20:24 VA.R. 2900      | 9/8/04          |
| 9 VAC 5-60-95                           | Added   | 20:16 VA.R. 1871      | 6/1/04          |
| 9 VAC 5-60-100                          | Amended | 20:16 VA.R. 1872      | 6/1/04          |
| 9 VAC 5-60-120 through 9 VAC 5-60-180   | Amended | 20:16 VA.R. 1877-1889 | 7/1/04          |
| 9 VAC 5-80-2000                         | Amended | 21:4 VA.R. 413        | 12/1/04         |
| 9 VAC 5-80-2010                         | Amended | 21:4 VA.R. 414        | 12/1/04         |
| 9 VAC 5-80-2250 through 9 VAC 5-80-2300 | Added   | 20:23 VA.R. 2566-2567 | 7/1/04          |
| 9 VAC 5-80-2250                         | Amended | 21:4 VA.R. 419        | 12/1/04         |
| 9 VAC 5-91-20 emer                      | Amended | 20:12 VA.R. 1507      | 1/28/04-1/27/05 |
| 9 VAC 5-91-160 emer                     | Amended | 20:12 VA.R. 1513      | 1/28/04-1/27/05 |
| 9 VAC 5-91-180 emer                     | Amended | 20:12 VA.R. 1513      | 1/28/04-1/27/05 |
| 9 VAC 5-91-750 emer                     | Amended | 20:12 VA.R. 1515      | 1/28/04-1/27/05 |
| 9 VAC 5-91-760 emer                     | Amended | 20:12 VA.R. 1515      | 1/28/04-1/27/05 |
| 9 VAC 5-140-550                         | Amended | 20:12 VA.R. 1504      | 3/24/04         |
| 9 VAC 20-60-18                          | Amended | 20:23 VA.R. 2568      | 7/1/04          |
| 9 VAC 20-60-18                          | Amended | 20:24 VA.R. 2901      | 9/8/04          |
| 9 VAC 20-60-262                         | Amended | 20:23 VA.R. 2568      | 7/1/04          |
| 9 VAC 20-60-270                         | Amended | 20:23 VA.R. 2568      | 7/1/04          |
| 9 VAC 20-60-315                         | Amended | 20:23 VA.R. 2570      | 7/1/04          |
| 9 VAC 20-60-1260                        | Amended | 20:23 VA.R. 2571      | 7/1/04          |
| 9 VAC 20-60-1270                        | Amended | 20:23 VA.R. 2571      | 7/1/04          |
| 9 VAC 20-60-1280                        | Amended | 20:23 VA.R. 2573      | 7/1/04          |
| 9 VAC 20-60-1283                        | Added   | 20:23 VA.R. 2573      | 7/1/04          |
| 9 VAC 20-60-1284                        | Added   | 20:23 VA.R. 2573      | 7/1/04          |
| 9 VAC 20-60-1285                        | Amended | 20:23 VA.R. 2574      | 7/1/04          |
| 9 VAC 20-60-1286                        | Added   | 20:23 VA.R. 2575      | 7/1/04          |
| 9 VAC 20-90-10                          | Amended | 20:23 VA.R. 2576      | 7/1/04          |
| 9 VAC 20-90-30                          | Amended | 20:23 VA.R. 2576      | 7/1/04          |
| 9 VAC 20-90-50                          | Amended | 20:23 VA.R. 2576      | 7/1/04          |

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| 9 VAC 20-90-60                           | Amended  | 20:23 VA.R. 2577      | 7/1/04         |
| 9 VAC 20-90-65                           | Added    | 20:23 VA.R. 2577      | 7/1/04         |
| 9 VAC 20-90-70                           | Amended  | 20:23 VA.R. 2578      | 7/1/04         |
| 9 VAC 20-90-90                           | Amended  | 20:23 VA.R. 2579      | 7/1/04         |
| 9 VAC 20-90-100                          | Amended  | 20:23 VA.R. 2579      | 7/1/04         |
| 9 VAC 20-90-110                          | Amended  | 20:23 VA.R. 2580      | 7/1/04         |
| 9 VAC 20-90-115                          | Added    | 20:23 VA.R. 2580      | 7/1/04         |
| 9 VAC 20-90-117                          | Added    | 20:23 VA.R. 2581      | 7/1/04         |
| 9 VAC 20-90-120                          | Amended  | 20:23 VA.R. 2581      | 7/1/04         |
| 9 VAC 20-90-130                          | Added    | 20:23 VA.R. 2583      | 7/1/04         |
| 9 VAC 20-110-90                          | Amended  | 20:24 VA.R. 2901      | 9/8/04         |
| 9 VAC 20-110-110                         | Amended  | 20:24 VA.R. 2901      | 9/8/04         |
| 9 VAC 25-20-10 through 9 VAC 25-20-80    | Amended  | 20:23 VA.R. 2584-2586 | 7/1/04         |
| 9 VAC 25-20-100 through 9 VAC 25-20-130  | Amended  | 20:23 VA.R. 2586-2591 | 7/1/04         |
| 9 VAC 25-20-140                          | Repealed | 20:23 VA.R. 2591      | 7/1/04         |
| 9 VAC 25-20-142                          | Added    | 20:23 VA.R. 2591      | 7/1/04         |
| 9 VAC 25-20-145                          | Added    | 20:23 VA.R. 2592      | 7/1/04         |
| 9 VAC 25-31-10                           | Amended  | 21:2 VA.R. 128        | 11/3/04        |
| 9 VAC 25-31-30                           | Amended  | 21:2 VA.R. 139        | 11/3/04        |
| 9 VAC 25-31-100                          | Amended  | 21:2 VA.R. 140        | 11/3/04        |
| 9 VAC 25-31-130                          | Amended  | 21:2 VA.R. 158        | 11/3/04        |
| 9 VAC 25-31-170                          | Amended  | 21:2 VA.R. 160        | 11/3/04        |
| 9 VAC 25-31-200                          | Amended  | 21:2 VA.R. 162        | 11/3/04        |
| 9 VAC 25-71-10                           | Amended  | 21:2 VA.R. 165        | 11/3/04        |
| 9 VAC 25-71-60                           | Amended  | 21:2 VA.R. 166        | 11/3/04        |
| 9 VAC 25-101-30                          | Amended  | 21:2 VA.R. 166        | 11/3/04        |
| 9 VAC 25-101-35                          | Added    | 21:2 VA.R. 167        | 11/3/04        |
| 9 VAC 25-101-40                          | Amended  | 21:2 VA.R. 167        | 11/3/04        |
| 9 VAC 25-101-45                          | Added    | 21:2 VA.R. 170        | 11/3/04        |
| 9 VAC 25-101-50                          | Amended  | 21:2 VA.R. 170        | 11/3/04        |
| 9 VAC 25-101-60                          | Amended  | 21:2 VA.R. 172        | 11/3/04        |
| 9 VAC 25-101-70                          | Amended  | 21:2 VA.R. 172        | 11/3/04        |
| 9 VAC 25-151-10                          | Amended  | 20:16 VA.R. 1889      | 7/1/04         |
| 9 VAC 25-151-40 through 9 VAC 25-151-370 | Amended  | 20:16 VA.R. 1889-1890 | 7/1/04         |
| 9 VAC 25-151-65                          | Added    | 20:16 VA.R. 1889      | 7/1/04         |
| 9 VAC 25-151-140                         | Amended  | 21:2 VA.R. 173        | 11/3/04        |
| 9 VAC 25-151-150                         | Amended  | 21:2 VA.R. 175        | 11/3/04        |
| 9 VAC 25-151-160                         | Amended  | 21:2 VA.R. 179        | 11/3/04        |
| 9 VAC 25-151-180                         | Amended  | 21:2 VA.R. 179        | 11/3/04        |
| 9 VAC 25-151-230                         | Amended  | 21:2 VA.R. 181        | 11/3/04        |
| 9 VAC 25-151-280                         | Amended  | 21:2 VA.R. 182        | 11/3/04        |
| 9 VAC 25-180-10                          | Amended  | 20:16 VA.R. 1891      | 7/1/04         |
| 9 VAC 25-180-20                          | Amended  | 20:16 VA.R. 1891      | 7/1/04         |
| 9 VAC 25-180-40                          | Amended  | 20:16 VA.R. 1891      | 7/1/04         |
| 9 VAC 25-180-50                          | Amended  | 20:16 VA.R. 1891      | 7/1/04         |
| 9 VAC 25-180-55                          | Amended  | 20:16 VA.R. 1892      | 7/1/04         |
| 9 VAC 25-180-60                          | Amended  | 20:16 VA.R. 1892      | 7/1/04         |
| 9 VAC 25-180-65                          | Added    | 20:16 VA.R. 1893      | 7/1/04         |
| 9 VAC 25-180-70                          | Amended  | 20:16 VA.R. 1894      | 7/1/04         |
| 9 VAC 25-180 (Forms)                     | Amended  | 20:16 VA.R. 1906      | --             |
| 9 VAC 25-190-10                          | Amended  | 20:16 VA.R. 1906      | 7/1/04         |
| 9 VAC 25-190-20                          | Amended  | 20:16 VA.R. 1906      | 7/1/04         |
| 9 VAC 25-190-50                          | Amended  | 20:16 VA.R. 1906      | 7/1/04         |
| 9 VAC 25-190-60                          | Amended  | 20:16 VA.R. 1906      | 7/1/04         |
| 9 VAC 25-190-70                          | Amended  | 20:16 VA.R. 1906      | 7/1/04         |
| 9 VAC 25-191-10 through 9 VAC 25-191-50  | Added    | 21:2 VA.R. 183-198    | 11/3/04        |

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| 9 VAC 25-192-10                                     | Amended  | 21:2 VA.R. 199        | 11/3/04         |
| 9 VAC 25-192-20                                     | Amended  | 21:2 VA.R. 200        | 11/3/04         |
| 9 VAC 25-192-30                                     | Repealed | 21:2 VA.R. 200        | 11/3/04         |
| 9 VAC 25-192-40                                     | Repealed | 21:2 VA.R. 200        | 11/3/04         |
| 9 VAC 25-192-50                                     | Amended  | 21:2 VA.R. 200        | 11/3/04         |
| 9 VAC 25-192-60                                     | Amended  | 21:2 VA.R. 201        | 11/3/04         |
| 9 VAC 25-192-70                                     | Amended  | 21:2 VA.R. 202        | 11/3/04         |
| 9 VAC 25-400-10                                     | Repealed | 20:25 VA.R. 3083      | 9/22/04         |
| 9 VAC 25-401-10 through 9 VAC 25-401-50             | Added    | 20:25 VA.R. 3083      | 9/22/04         |
| 9 VAC 25-580-10                                     | Amended  | 20:12 VA.R. 1505      | 3/24/04         |
| 9 VAC 25-580-50                                     | Amended  | 20:12 VA.R. 1505      | 3/24/04         |
| 9 VAC 25-580-130                                    | Amended  | 20:12 VA.R. 1505      | 3/24/04         |
| 9 VAC 25-580-270                                    | Amended  | 20:12 VA.R. 1505      | 3/24/04         |
| 9 VAC 25-580-290                                    | Repealed | 20:12 VA.R. 1505      | 3/24/04         |
| 9 VAC 25-580-320                                    | Amended  | 20:12 VA.R. 1505      | 3/24/04         |
| 9 VAC 25-590-60                                     | Erratum  | 20:17 VA.R. 1984      | --              |
| 9 VAC 25-630-10                                     | Amended  | 21:2 VA.R. 211        | 11/3/04         |
| 9 VAC 25-630-20                                     | Amended  | 21:2 VA.R. 212        | 11/3/04         |
| 9 VAC 25-630-30                                     | Amended  | 21:2 VA.R. 212        | 11/3/04         |
| 9 VAC 25-630-50                                     | Amended  | 21:2 VA.R. 212        | 11/3/04         |
| 9 VAC 25-720-50                                     | Amended  | 20:24 VA.R. 2903      | 9/8/04          |
| 9 VAC 25-720-60                                     | Amended  | 20:24 VA.R. 2910      | 9/8/04          |
| 9 VAC 25-720-90                                     | Amended  | 20:24 VA.R. 2918      | 9/8/04          |
| 9 VAC 25-720-130                                    | Amended  | 20:24 VA.R. 2920      | 9/8/04          |
| 9 VAC 25-770  | Erratum  | 20:24 VA.R. 2981      | --              |
| 9 VAC 25-770-10 through 9 VAC 25-770-180            | Added    | 20:23 VA.R. 2593-2596 | 8/25/04         |
| 9 VAC 25-790  | Erratum  | 20:12 VA.R. 1526      | --              |
| <b>Title 10. Finance and Financial Institutions</b> |          |                       |                 |
| 10 VAC 5-40-40                                      | Added    | 20:14 VA.R. 1713      | 3/1/04          |
| 10 VAC 5-200-100                                    | Added    | 20:22 VA.R. 2403      | 6/15/04         |
| <b>Title 11. Gaming</b>                             |          |                       |                 |
| 11 VAC 10-20-190                                    | Amended  | 20:23 VA.R. 2598      | 8/25/04         |
| 11 VAC 10-20-200                                    | Amended  | 20:25 VA.R. 3083      | 9/23/04         |
| 11 VAC 10-20-220                                    | Amended  | 20:23 VA.R. 2596      | 8/25/04         |
| 11 VAC 10-20-240 emer                               | Amended  | 20:25 VA.R. 3102      | 7/28/04-7/27/05 |
| 11 VAC 10-45  | Erratum  | 20:25 VA.R. 3112      | --              |
| 11 VAC 10-45-10 through 11 VAC 10-45-70             | Added    | 20:22 VA.R. 2413-2417 | 9/27/04         |
| <b>Title 12. Health</b>                             |          |                       |                 |
| 12 VAC 5-90-10                                      | Amended  | 20:21 VA.R. 2231      | 7/28/04         |
| 12 VAC 5-90-40                                      | Amended  | 20:21 VA.R. 2231      | 7/28/04         |
| 12 VAC 5-90-80                                      | Amended  | 20:21 VA.R. 2231      | 7/28/04         |
| 12 VAC 5-90-90                                      | Amended  | 20:21 VA.R. 2234      | 7/28/04         |
| 12 VAC 5-90-100                                     | Amended  | 20:21 VA.R. 2237      | 7/28/04         |
| 12 VAC 5-90-110                                     | Amended  | 20:21 VA.R. 2237      | 7/28/04         |
| 12 VAC 5-90-160                                     | Amended  | 20:21 VA.R. 2237      | 7/28/04         |
| 12 VAC 5-90-180                                     | Amended  | 20:21 VA.R. 2237      | 7/28/04         |
| 12 VAC 5-90-225                                     | Added    | 20:21 VA.R. 2237      | 7/28/04         |
| 12 VAC 5-90-280 through 12 VAC 5-90-360             | Added    | 20:21 VA.R. 2238      | 7/28/04         |
| 12 VAC 5-125-10 through 12 VAC 5-125-120 emer       | Added    | 20:21 VA.R. 2252-2264 | 6/1/04-5/31/05  |
| 12 VAC 5-200-10 through 12 VAC 5-200-50             | Amended  | 20:22 VA.R. 2403      | 8/11/04         |
| 12 VAC 5-200-70                                     | Repealed | 20:22 VA.R. 2403      | 8/11/04         |
| 12 VAC 5-200-80 through 12 VAC 5-200-190            | Amended  | 20:22 VA.R. 2403      | 8/11/04         |
| 12 VAC 5-200-105                                    | Added    | 20:22 VA.R. 2403      | 8/11/04         |
| 12 VAC 5-200-210                                    | Repealed | 20:22 VA.R. 2403      | 8/11/04         |
| 12 VAC 5-200-220                                    | Amended  | 20:22 VA.R. 2403      | 8/11/04         |

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| 12 VAC 5-200-230                                 | Amended  | 20:22 VA.R. 2403      | 8/11/04        |
| 12 VAC 5-200-270                                 | Amended  | 20:22 VA.R. 2403      | 8/11/04        |
| 12 VAC 5-200-280                                 | Amended  | 20:22 VA.R. 2403      | 8/11/04        |
| 12 VAC 5-200-290                                 | Added    | 20:22 VA.R. 2403      | 8/11/04        |
| 12 VAC 5-210-10                                  | Repealed | 20:22 VA.R. 2403      | 8/11/04        |
| 12 VAC 5-210-20                                  | Repealed | 20:22 VA.R. 2403      | 8/11/04        |
| 12 VAC 5-220-10                                  | Amended  | 20:26 VA.R. 3193      | 9/27/04        |
| 12 VAC 5-220-160                                 | Amended  | 20:26 VA.R. 3196      | 9/27/04        |
| 12 VAC 5-220-230                                 | Amended  | 20:26 VA.R. 3197      | 9/27/04        |
| 12 VAC 5-220-385                                 | Amended  | 20:26 VA.R. 3198      | 9/27/04        |
| 12 VAC 5-371-110                                 | Amended  | 20:26 VA.R. 3200      | 9/27/04        |
| 12 VAC 30-40-235                                 | Added    | 20:19 VA.R. 2060      | 8/1/04         |
| 12 VAC 30-40-280                                 | Amended  | 20:22 VA.R. 2420      | 9/25/04        |
| 12 VAC 30-40-290                                 | Amended  | 20:22 VA.R. 2420      | 9/25/04        |
| 12 VAC 30-40-345                                 | Amended  | 20:22 VA.R. 2422      | 9/25/04        |
| 12 VAC 30-50-130 emer                            | Amended  | 20:23 VA.R. 2630      | 7/1/04-6/30/05 |
| 12 VAC 30-50-140                                 | Amended  | 20:19 VA.R. 2062      | 7/1/04         |
| 12 VAC 30-50-150                                 | Amended  | 20:19 VA.R. 2063      | 7/1/04         |
| 12 VAC 30-50-180                                 | Amended  | 20:19 VA.R. 2064      | 7/1/04         |
| 12 VAC 30-50-210 emer                            | Amended  | 20:19 VA.R. 2075      | 5/11/04-1/3/05 |
| 12 VAC 30-60-40                                  | Amended  | 20:19 VA.R. 2067      | 7/1/04         |
| 12 VAC 30-60-61 emer                             | Amended  | 20:23 VA.R. 2632      | 7/1/04-6/30/05 |
| 12 VAC 30-60-320                                 | Amended  | 20:19 VA.R. 2067      | 7/1/04         |
| 12 VAC 30-70-271                                 | Amended  | 20:19 VA.R. 2068      | 7/1/04         |
| 12 VAC 30-70-291                                 | Amended  | 20:22 VA.R. 2403      | 8/11/04        |
| 12 VAC 30-70-291 emer                            | Amended  | 20:24 VA.R. 2968      | 9/1/04-8/31/05 |
| 12 VAC 30-70-301                                 | Amended  | 20:22 VA.R. 2403      | 8/11/04        |
| 12 VAC 30-70-301 emer                            | Amended  | 20:24 VA.R. 2968      | 9/1/04-8/31/05 |
| 12 VAC 30-70-331                                 | Amended  | 20:22 VA.R. 2403      | 8/11/04        |
| 12 VAC 30-70-391 emer                            | Amended  | 20:24 VA.R. 2969      | 9/1/04-8/31/05 |
| 12 VAC 30-80-20                                  | Amended  | 20:19 VA.R. 2068      | 7/1/04         |
| 12 VAC 30-80-30                                  | Amended  | 20:19 VA.R. 2064      | 7/1/04         |
| 12 VAC 30-80-190 emer                            | Amended  | 20:26 VA.R. 3203      | 9/1/04-8/31/05 |
| 12 VAC 30-80-190 emer                            | Amended  | 20:26 VA.R. 3204      | 9/1/04-8/31/05 |
| 12 VAC 30-80-200                                 | Added    | 20:19 VA.R. 2071      | 7/1/04         |
| 12 VAC 30-90-29                                  | Amended  | 21:2 VA.R. 223        | 11/3/04        |
| 12 VAC 30-90-264                                 | Amended  | 20:19 VA.R. 2067      | 7/1/04         |
| 12 VAC 30-90-271                                 | Amended  | 20:19 VA.R. 2067      | 7/1/04         |
| 12 VAC 30-130-620                                | Amended  | 20:19 VA.R. 2061      | 8/1/04         |
| 12 VAC 30-130-860 through 12 VAC 30-130-890 emer | Amended  | 20:23 VA.R. 2633-2638 | 7/1/04-6/30/05 |
| 12 VAC 30-130-1000 emer                          | Amended  | 20:19 VA.R. 2077      | 5/11/04-1/3/05 |
| 12 VAC 30-141-500 emer                           | Amended  | 20:17 VA.R. 1974      | 6/1/04-5/31/05 |
| <b>Title 13. Housing</b>                         |          |                       |                |
| 13 VAC 5-51-134 emer                             | Added    | 20:24 VA.R. 2970      | 7/8/04-7/7/05  |
| 13 VAC 5-62-260                                  | Amended  | 20:25 VA.R. 3084      | 9/8/04         |
| <b>Title 14. Insurance</b>                       |          |                       |                |
| 14 VAC 5-90-10 through 14 VAC 5-90-50            | Amended  | 20:25 VA.R. 3090-3091 | 8/4/04         |
| 14 VAC 5-90-30                                   | Erratum  | 20:17 VA.R. 1984      | --             |
| 14 VAC 5-90-55                                   | Added    | 20:25 VA.R. 3091      | 8/4/04         |
| 14 VAC 5-90-60 through 14 VAC 5-90-180           | Amended  | 20:25 VA.R. 3092      | 8/4/04         |
| 14 VAC 5-90-60                                   | Erratum  | 20:17 VA.R. 1984      | --             |
| 14 VAC 5-90-70                                   | Erratum  | 20:17 VA.R. 1984      | --             |
| 14 VAC 5-90-130                                  | Erratum  | 20:17 VA.R. 1984      | --             |
| 14 VAC 5-90-170                                  | Erratum  | 20:17 VA.R. 1984      | --             |
| 14 VAC 5-90 (Forms)                              | Amended  | 20:25 VA.R. 3092      | 8/4/04         |
| 14 VAC 5-321-10 through 14 VAC 5-321-60          | Added    | 20:16 VA.R. 1906-1909 | 7/1/04         |

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| 14 VAC 5-335-10 through 14 VAC 5-335-60                  | Added    | 20:21 VA.R. 2240-2242 | 1/1/05          |
| <b>Title 16. Labor and Employment</b>                    |          |                       |                 |
| 16 VAC 25-40-10  | Amended  | 20:26 VA.R. 3201      | 10/15/04        |
| 16 VAC 25-40-20  | Amended  | 20:26 VA.R. 3201      | 10/15/04        |
| 16 VAC 25-40-50  | Amended  | 20:26 VA.R. 3202      | 10/15/04        |
| 16 VAC 25-90-1910  | Erratum  | 21:1 VA.R. 44         | --              |
| 16 VAC 25-90-1910, Appendix C of Subpart T of Part 1910  | Added    | 20:19 VA.R. 2073      | 7/1/04          |
| 16 VAC 25-90-1910.103                                    | Amended  | 20:26 VA.R. 3202      | 10/15/04        |
| 16 VAC 25-90-1910.217                                    | Amended  | 20:26 VA.R. 3202      | 10/15/04        |
| 16 VAC 25-90-1910.219                                    | Amended  | 20:26 VA.R. 3202      | 10/15/04        |
| 16 VAC 25-90-1910.268                                    | Amended  | 20:26 VA.R. 3202      | 10/15/04        |
| 16 VAC 25-90-1910.401                                    | Amended  | 20:19 VA.R. 2073      | 7/1/04          |
| 16 VAC 25-90-1910.402                                    | Amended  | 20:19 VA.R. 2073      | 7/1/04          |
| 16 VAC 25-90-1926.307                                    | Amended  | 20:26 VA.R. 3202      | 10/15/04        |
| 16 VAC 25-145-10 through 16 VAC 25-145-50                | Added    | 20:12 VA.R. 1505-1506 | 4/1/04          |
| 16 VAC 25-175-1926                                       | Erratum  | 21:1 VA.R. 44         | --              |
| <b>Title 18. Professional and Occupational Licensing</b> |          |                       |                 |
| 18 VAC 5-30  | Repealed | 21:3 VA.R. 318        | 11/3/04         |
| 18 VAC 10-20-60  | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 10-20-90  | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 10-20-170   | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 10-20-280   | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 10-20-400   | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 10-20-520   | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 10-20-565   | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 10-20-580   | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 10-20-625   | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 10-20-630   | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 10-20-665   | Amended  | 21:3 VA.R. 318        | 12/1/04         |
| 18 VAC 15-30-420   | Amended  | 20:24 VA.R. 2924      | 9/8/04          |
| 18 VAC 15-30-820   | Amended  | 20:24 VA.R. 2925      | 9/8/04          |
| 18 VAC 15-30 (Forms)                                     | Amended  | 20:24 VA.R. 2925      | 9/8/04          |
| 18 VAC 30-20-80  | Amended  | 20:23 VA.R. 2598      | 8/25/04         |
| 18 VAC 30-20-150   | Amended  | 20:23 VA.R. 2598      | 8/25/04         |
| 18 VAC 30-20-160   | Amended  | 20:23 VA.R. 2598      | 8/25/04         |
| 18 VAC 30-20-290 emer                                    | Added    | 20:23 VA.R. 2638      | 8/25/04-8/24/05 |
| 18 VAC 30-20-320   | Amended  | 20:23 VA.R. 2598      | 8/25/04         |
| 18 VAC 41-30-10 through 18 VAC 41-30-250 emer            | Added    | 20:23 VA.R. 2639-2650 | 7/1/04-6/30/05  |
| 18 VAC 41-40-10 through 18 VAC 41-40-260                 | Added    | 20:19 VA.R. 2074      | 7/1/04          |
| 18 VAC 41-50-10 through 18 VAC 41-50-220 emer            | Added    | 20:23 VA.R. 2651-2662 | 7/1/04-6/30/05  |
| 18 VAC 45-10-10 through 18 VAC 45-10-40                  | Amended  | 20:25 VA.R. 3093-3094 | 11/8/04         |
| 18 VAC 45-10-60 through 18 VAC 45-10-90                  | Amended  | 20:25 VA.R. 3094-3095 | 11/8/04         |
| 18 VAC 60-20-17 emer                                     | Added    | 20:23 VA.R. 2663      | 8/25/04-8/24/05 |
| 18 VAC 60-20-20 emer                                     | Amended  | 20:24 VA.R. 2971      | 7/15/04-7/14/05 |
| 18 VAC 60-20-91 emer                                     | Added    | 20:24 VA.R. 2971      | 7/15/04-7/14/05 |
| 18 VAC 60-20 (Forms) emer                                | Amended  | 20:24 VA.R. 2972      | 7/15/04-7/14/05 |
| 18 VAC 62-20   | Erratum  | 21:1 VA.R. 44         | --              |
| 18 VAC 62-20-10 through 18 VAC 62-20-180                 | Added    | 20:12 VA.R. 1515-1518 | 2/2/04-2/1/05   |
| 18 VAC 62-20-40 emer                                     | Added    | 20:25 VA.R. 3104      | 7/23/04-2/1/05  |
| 18 VAC 62-20-90 emer                                     | Added    | 20:25 VA.R. 3104      | 7/23/04-2/1/05  |
| 18 VAC 65-20-15 emer                                     | Added    | 20:24 VA.R. 2973      | 7/15/04-7/14/05 |
| 18 VAC 65-30-50  | Amended  | 20:21 VA.R. 2242      | 7/28/04         |
| 18 VAC 76-40-10  | Added    | 20:21 VA.R. 2243      | 7/28/04         |
| 18 VAC 76-40-20  | Added    | 20:21 VA.R. 2243      | 7/28/04         |
| 18 VAC 76-40-30  | Added    | 20:21 VA.R. 2243      | 7/28/04         |
| 18 VAC 76-40 (Forms)                                     | Amended  | 20:21 VA.R. 2243      | 7/28/04         |

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| 18 VAC 80-10-10 through 18 VAC 80-10-90    | Amended  | 20:23 VA.R. 2628-2629 | 10/9/04         |
| 18 VAC 85-15-10                            | Added    | 21:1 VA.R. 26         | 9/1/04-8/31/05  |
| 18 VAC 85-15-20                            | Added    | 21:1 VA.R. 26         | 9/1/04-8/31/05  |
| 18 VAC 85-15-30                            | Added    | 21:1 VA.R. 26         | 9/1/04-8/31/05  |
| 18 VAC 85-20-22                            | Amended  | 20:20 VA.R. 2165      | 7/14/04         |
| 18 VAC 85-20 (Forms)                       | Amended  | 20:20 VA.R. 2165      | --              |
| 18 VAC 85-80-61 emer                       | Added    | 20:25 VA.R. 3105      | 7/27/04-7/26/05 |
| 18 VAC 85-120-10 through 18 VAC 85-120-150 | Amended  | 20:23 VA.R. 2599-2601 | 8/25/04         |
| 18 VAC 85-120-75                           | Added    | 20:24 VA.R. 2928      | 9/8/04          |
| 18 VAC 85-120 (Forms)                      | Amended  | 20:24 VA.R. 2928      | 9/8/04          |
| 18 VAC 90-15-10                            | Added    | 21:1 VA.R. 27         | 9/1/04-8/31/05  |
| 18 VAC 90-15-20                            | Added    | 21:1 VA.R. 27         | 9/1/04-8/31/05  |
| 18 VAC 90-15-30                            | Added    | 21:1 VA.R. 27         | 9/1/04-8/31/05  |
| 18 VAC 90-20-10 emer                       | Amended  | 20:22 VA.R. 2424      | 6/24/04-6/23/05 |
| 18 VAC 90-20-10                            | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-30                            | Amended  | 20:20 VA.R. 2166      | 7/14/04         |
| 18 VAC 90-20-35                            | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-40                            | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-50                            | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-60                            | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-65                            | Added    | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-95                            | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-120                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-140                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-160                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-170                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-181 emer                      | Added    | 20:22 VA.R. 2425      | 6/24/04-6/23/05 |
| 18 VAC 90-20-182 emer                      | Added    | 20:22 VA.R. 2425      | 6/24/04-6/23/05 |
| 18 VAC 90-20-183 emer                      | Added    | 20:22 VA.R. 2425      | 6/24/04-6/23/05 |
| 18 VAC 90-20-190                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-200                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-220                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-230                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-270                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-280                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-300 emer                      | Amended  | 20:22 VA.R. 2425      | 6/24/04-6/23/05 |
| 18 VAC 90-20-300                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-310 through 18 VAC 90-20-360  | Repealed | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-390                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-410                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20-460                           | Amended  | 20:24 VA.R. 2929      | 9/8/04          |
| 18 VAC 90-20 (Forms)                       | Amended  | 20:24 VA.R. 2930      | 9/8/04          |
| 18 VAC 90-25-10 through 18 VAC 90-25-100   | Added    | 20:24 VA.R. 2931-2934 | 9/8/04          |
| 18 VAC 90-25 (Forms)                       | Amended  | 20:24 VA.R. 2934      | 9/8/04          |
| 18 VAC 90-30-80 emer                       | Amended  | 20:24 VA.R. 2974      | 7/15/04-7/14/05 |
| 18 VAC 90-30-100 emer                      | Amended  | 20:24 VA.R. 2974      | 7/15/04-7/14/05 |
| 18 VAC 90-30-110 emer                      | Amended  | 20:24 VA.R. 2974      | 7/15/04-7/14/05 |
| 18 VAC 90-30-120 emer                      | Amended  | 20:24 VA.R. 2975      | 7/15/04-7/14/05 |
| 18 VAC 95-20-471 emer                      | Added    | 20:25 VA.R. 3105      | 7/28/04-7/27/05 |
| 18 VAC 105-20-41 emer                      | Added    | 20:24 VA.R. 2975      | 8/25/04-8/24/05 |
| 18 VAC 110-20-10 through 18 VAC 110-20-40  | Amended  | 20:23 VA.R. 2602-2604 | 8/25/04         |
| 18 VAC 110-20-15 emer                      | Added    | 20:24 VA.R. 2976      | 7/15/04-7/14/05 |
| 18 VAC 110-20-60                           | Amended  | 20:23 VA.R. 2604      | 8/25/04         |
| 18 VAC 110-20-70                           | Amended  | 20:23 VA.R. 2604      | 8/25/04         |
| 18 VAC 110-20-80                           | Amended  | 20:23 VA.R. 2604      | 8/25/04         |
| 18 VAC 110-20-90                           | Amended  | 20:23 VA.R. 2604      | 8/25/04         |

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| 18 VAC 110-20-105                           | Amended  | 20:23 VA.R. 2605 | 8/25/04         |
| 18 VAC 110-20-110                           | Amended  | 20:23 VA.R. 2605 | 8/25/04         |
| 18 VAC 110-20-120                           | Amended  | 20:23 VA.R. 2605 | 8/25/04         |
| 18 VAC 110-20-121                           | Added    | 20:23 VA.R. 2605 | 8/25/04         |
| 18 VAC 110-20-130 through 18 VAC 110-20-220 | Amended  | 20:23 VA.R. 2605 | 8/25/04         |
| 18 VAC 110-20-240                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-250                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-280                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-285                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-330                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-350                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-355                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-360                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-370                           | Repealed | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-380                           | Repealed | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-410                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-412                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-415                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-420                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-440                           | Amended  | 20:23 VA.R. 2606 | 8/25/04         |
| 18 VAC 110-20-450                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-460                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-470                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-480                           | Repealed | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-490                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-500                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-510                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-530                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-540                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-550                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-555                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-590                           | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-680 through 18 VAC 110-20-710 | Amended  | 20:23 VA.R. 2607 | 8/25/04         |
| 18 VAC 110-20-720                           | Amended  | 20:18 VA.R. 2021 | 7/1/04          |
| 18 VAC 112-20-10                            | Amended  | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-20                            | Repealed | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-26 emer                       | Added    | 20:23 VA.R. 2664 | 8/25/04-8/24/05 |
| 18 VAC 112-20-40                            | Amended  | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-50                            | Amended  | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-60                            | Amended  | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-65                            | Amended  | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-70                            | Amended  | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-80                            | Repealed | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-90                            | Amended  | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-100                           | Amended  | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-110                           | Repealed | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-120                           | Amended  | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20-130                           | Amended  | 20:24 VA.R. 2935 | 9/8/04          |
| 18 VAC 112-20 (Forms)                       | Amended  | 20:24 VA.R. 2936 | 9/8/04          |
| 18 VAC 115-15-10 emer                       | Added    | 20:23 VA.R. 2665 | 8/25/04-8/24/05 |
| 18 VAC 115-15-20 emer                       | Added    | 20:23 VA.R. 2665 | 8/25/04-8/24/05 |
| 18 VAC 115-15-30 emer                       | Added    | 20:23 VA.R. 2665 | 8/25/04-8/24/05 |
| 18 VAC 115-20-20                            | Amended  | 20:24 VA.R. 2936 | 9/8/04          |
| 18 VAC 115-20-100                           | Amended  | 20:24 VA.R. 2936 | 9/8/04          |
| 18 VAC 115-20-105                           | Added    | 20:24 VA.R. 2936 | 9/8/04          |
| 18 VAC 115-20-106                           | Added    | 20:24 VA.R. 2936 | 9/8/04          |

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| 18 VAC 115-20-107                          | Added   | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-20-110                          | Amended | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-20-140                          | Amended | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-20 (Forms)                      | Amended | 20:24 VA.R. 2937      | 9/8/04          |
| 18 VAC 115-50-20                           | Amended | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-50-90                           | Amended | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-50-95                           | Added   | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-50-96                           | Added   | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-50-97                           | Added   | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-50-100                          | Amended | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-50-120                          | Amended | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-50 (Forms)                      | Amended | 20:24 VA.R. 2937      | 9/8/04          |
| 18 VAC 115-60-20                           | Amended | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-60-110                          | Amended | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-60-115                          | Added   | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-60-116                          | Added   | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-60-117                          | Added   | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-60-120                          | Amended | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-60-140                          | Amended | 20:24 VA.R. 2936      | 9/8/04          |
| 18 VAC 115-60 (Forms)                      | Amended | 20:24 VA.R. 2937      | 9/8/04          |
| 18 VAC 120-10-100                          | Erratum | 20:13 VA.R. 1644      | --              |
| 18 VAC 125-15-10 emer                      | Added   | 20:25 VA.R. 3106      | 7/28/04-7/27/05 |
| 18 VAC 125-15-20 emer                      | Added   | 20:25 VA.R. 3106      | 7/28/04-7/27/05 |
| 18 VAC 125-15-30 emer                      | Added   | 20:25 VA.R. 3106      | 7/28/04-7/27/05 |
| 18 VAC 135-20-80                           | Amended | 20:23 VA.R. 2608      | 9/1/04          |
| 18 VAC 135-20-120                          | Amended | 20:23 VA.R. 2608      | 9/1/04          |
| 18 VAC 135-20-140                          | Amended | 20:23 VA.R. 2608      | 9/1/04          |
| 18 VAC 135-20-370                          | Amended | 20:23 VA.R. 2608      | 9/1/04          |
| 18 VAC 140-20-171 emer                     | Added   | 20:23 VA.R. 2665      | 8/25/04-8/24/05 |
| 18 VAC 145-20-151                          | Amended | 21:3 VA.R. 319        | 12/1/04         |
| 18 VAC 145-30-10 through 18 VAC 145-30-160 | Added   | 20:20 VA.R. 2167-2170 | 7/14/04         |
| 18 VAC 145-30 (Forms)                      | Amended | 20:20 VA.R. 2170      | --              |
| 18 VAC 150-20-10                           | Amended | 20:24 VA.R. 2966      | 10/23/04        |
| 18 VAC 150-20-15 emer                      | Added   | 20:23 VA.R. 2666      | 8/25/04-8/24/05 |
| 18 VAC 150-20 (Forms)                      | Amended | 20:24 VA.R. 2967      | 10/23/04        |
| 18 VAC 160-20-102                          | Amended | 21:3 VA.R. 319        | 12/1/04         |
| <b>Title 19. Public Safety</b>             |         |                       |                 |
| 19 VAC 30-70-1                             | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-2                             | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-6                             | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-7                             | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-8                             | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-9                             | Added   | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-10                            | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-30 through 19 VAC 30-70-110   | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-130 through 19 VAC 30-70-170  | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-190 through 19 VAC 30-70-230  | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-250 through 19 VAC 30-70-300  | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-340                           | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-350                           | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-360                           | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-400                           | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-430 through 19 VAC 30-70-560  | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-580                           | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-600                           | Amended | 21:4 VA.R. 420        | 9/22/04         |
| 19 VAC 30-70-650                           | Amended | 21:4 VA.R. 420        | 9/22/04         |

## Cumulative Table of VAC Sections Adopted, Amended, or Repealed

| SECTION NUMBER   | ACTION   | CITE                  | EFFECTIVE DATE |
|--|----------|-----------------------|----------------|
| <b>Title 20. Public Utilities and Telecommunications</b> |          |                       |                |
| 20 VAC 5-309-15  | Amended  | 20:15 VA.R. 1781      | 3/12/04        |
| 20 VAC 5-309-20  | Amended  | 20:15 VA.R. 1781      | 3/12/04        |
| 20 VAC 5-309-40  | Amended  | 20:15 VA.R. 1781      | 3/12/04        |
| 20 VAC 5-309-70  | Amended  | 20:15 VA.R. 1782      | 3/12/04        |
| 20 VAC 5-309-110   | Amended  | 20:15 VA.R. 1782      | 3/12/04        |
| 20 VAC 5-309-140   | Amended  | 20:15 VA.R. 1783      | 3/12/04        |
| 20 VAC 5-419-10 through 20 VAC 5-419-40                  | Amended  | 20:24 VA.R. 2939-2942 | 7/21/04        |
| 20 VAC 5-425-10 through 20 VAC 5-425-50                  | Added    | 20:23 VA.R. 2611-2613 | 7/1/04         |
| <b>Title 22. Social Services</b>                         |          |                       |                |
| 22 VAC 15-20-10 through 22 VAC 15-20-380                 | Repealed | 20:24 VA.R. 2942-2943 | 11/1/04        |
| 22 VAC 15-50-10 through 22 VAC 15-50-70                  | Repealed | 20:24 VA.R. 2943      | 10/1/04        |
| 22 VAC 15-51-10 through 22 VAC 15-51-80                  | Added    | 20:24 VA.R. 2943-2948 | 10/1/04        |
| 22 VAC 30-50-30  | Amended  | 20:18 VA.R. 2022      | 6/18/04        |
| 22 VAC 40-32   | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-80-10  | Amended  | 20:24 VA.R. 2948      | 11/1/04        |
| 22 VAC 40-80-30 through 22 VAC 40-80-60                  | Amended  | 20:24 VA.R. 2950-2951 | 11/1/04        |
| 22 VAC 40-80-80 through 22 VAC 40-80-210                 | Amended  | 20:24 VA.R. 2951-2955 | 11/1/04        |
| 22 VAC 40-80-220   | Repealed | 20:24 VA.R. 2955      | 11/1/04        |
| 22 VAC 40-80-230   | Amended  | 20:24 VA.R. 2955      | 11/1/04        |
| 22 VAC 40-80-240   | Amended  | 20:24 VA.R. 2955      | 11/1/04        |
| 22 VAC 40-80-260   | Amended  | 20:24 VA.R. 2956      | 11/1/04        |
| 22 VAC 40-80-270   | Amended  | 20:24 VA.R. 2956      | 11/1/04        |
| 22 VAC 40-80-290   | Amended  | 20:24 VA.R. 2956      | 11/1/04        |
| 22 VAC 40-80-300   | Amended  | 20:24 VA.R. 2957      | 11/1/04        |
| 22 VAC 40-80-310   | Amended  | 20:24 VA.R. 2957      | 11/1/04        |
| 22 VAC 40-80-330   | Amended  | 20:24 VA.R. 2957      | 11/1/04        |
| 22 VAC 40-80-340   | Amended  | 20:24 VA.R. 2957      | 11/1/04        |
| 22 VAC 40-80-350   | Repealed | 20:24 VA.R. 2958      | 11/1/04        |
| 22 VAC 40-80-360   | Repealed | 20:24 VA.R. 2958      | 11/1/04        |
| 22 VAC 40-80-370   | Amended  | 20:24 VA.R. 2958      | 11/1/04        |
| 22 VAC 40-80-375   | Added    | 20:24 VA.R. 2959      | 11/1/04        |
| 22 VAC 40-80-380   | Repealed | 20:24 VA.R. 2959      | 11/1/04        |
| 22 VAC 40-80-390 through 22 VAC 40-80-520                | Added    | 20:24 VA.R. 2959-2964 | 11/1/04        |
| 22 VAC 40-180 (Forms)                                    | Amended  | 20:21 VA.R. 2265-2268 | --             |
| 22 VAC 40-190  | Erratum  | 20:12 VA.R. 1526      | --             |
| 22 VAC 40-191  | Erratum  | 20:12 VA.R. 1526      | --             |
| 22 VAC 40-191-40   | Amended  | 20:22 VA.R. 2404      | 9/1/04         |
| 22 VAC 40-191-50   | Amended  | 20:22 VA.R. 2407      | 9/1/04         |
| 22 VAC 40-290-10   | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-293-10   | Added    | 20:21 VA.R. 2245      | 7/28/04        |
| 22 VAC 40-293-20   | Added    | 20:21 VA.R. 2245      | 7/28/04        |
| 22 VAC 40-295-10 through 22 VAC 40-295-170               | Added    | 20:23 VA.R. 2614-2620 | 9/1/04         |
| 22 VAC 40-300  | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-310  | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-320  | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-330-10   | Amended  | 20:23 VA.R. 2620      | 9/1/04         |
| 22 VAC 40-330-20   | Amended  | 20:23 VA.R. 2620      | 9/1/04         |
| 22 VAC 40-340-10   | Amended  | 20:23 VA.R. 2621      | 9/1/04         |
| 22 VAC 40-350  | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-360  | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-370  | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-380  | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-390  | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-420  | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-430  | Repealed | 20:23 VA.R. 2613      | 9/1/04         |

## Cumulative Table of VAC Sections Adopted, Amended, or Repealed

| SECTION NUMBER                                     | ACTION   | CITE                  | EFFECTIVE DATE |
|--|----------|-----------------------|----------------|
| 22 VAC 40-440                                      | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-450                                      | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-460                                      | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-490                                      | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-500                                      | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-510                                      | Repealed | 20:23 VA.R. 2613      | 9/1/04         |
| 22 VAC 40-520                                      | Repealed | 20:23 VA.R. 2614      | 9/1/04         |
| 22 VAC 40-530                                      | Repealed | 20:23 VA.R. 2614      | 9/1/04         |
| 22 VAC 40-550                                      | Repealed | 20:23 VA.R. 2614      | 9/1/04         |
| 22 VAC 40-580                                      | Repealed | 20:23 VA.R. 2614      | 9/1/04         |
| 22 VAC 40-590                                      | Repealed | 20:23 VA.R. 2614      | 9/1/04         |
| 22 VAC 40-610                                      | Repealed | 20:23 VA.R. 2614      | 9/1/04         |
| 22 VAC 40-620                                      | Repealed | 20:23 VA.R. 2614      | 9/1/04         |
| 22 VAC 40-650                                      | Repealed | 20:23 VA.R. 2614      | 9/1/04         |
| 22 VAC 40-705-30                                   | Amended  | 21:4 VA.R. 421        | 12/1/04        |
| 22 VAC 40-740-10 through 22 VAC 40-740-60          | Amended  | 20:20 VA.R. 2175-2178 | 8/1/04         |
| 22 VAC 40-740 (Forms)                              | Amended  | 20:20 VA.R. 2178      | --             |
| 22 VAC 40-750                                      | Repealed | 20:23 VA.R. 2614      | 9/1/04         |
| 22 VAC 40-760                                      | Repealed | 20:23 VA.R. 2614      | 9/1/04         |
| <b>Title 24. Transportation and Motor Vehicles</b> |          |                       |                |
| 24 VAC 20-70                                       | Repealed | 20:25 VA.R. 3092      | 9/22/04        |
| 24 VAC 20-100-10                                   | Amended  | 20:21 VA.R. 2246      | 7/1/04         |
| 24 VAC 20-100-130                                  | Amended  | 20:21 VA.R. 2247      | 7/1/04         |
| 24 VAC 20-100-160                                  | Amended  | 20:21 VA.R. 2247      | 7/1/04         |
| 24 VAC 20-100-190 through 24 VAC 20-100-220        | Amended  | 20:21 VA.R. 2247-2248 | 7/1/04         |
| 24 VAC 20-100-290 through 24 VAC 20-100-330        | Amended  | 20:21 VA.R. 2248-2249 | 7/1/04         |
| 24 VAC 20-100-350                                  | Amended  | 20:21 VA.R. 2249      | 7/1/04         |
| 24 VAC 20-100-370 through 24 VAC 20-100-460        | Amended  | 20:21 VA.R. 2249-2250 | 7/1/04         |
| 24 VAC 20-100-490 through 24 VAC 20-100-540        | Amended  | 20:21 VA.R. 2250-2251 | 7/1/04         |
| 24 VAC 20-100-550                                  | Added    | 20:21 VA.R. 2251      | 7/1/04         |
| 24 VAC 20-100 (Forms)                              | Amended  | 20:21 VA.R. 2251      | 7/1/04         |
| 24 VAC 30-120-170                                  | Amended  | 21:3 VA.R. 330        | 11/17/04       |
| 24 VAC 30-380-10                                   | Amended  | 20:13 VA.R. 1633      | 2/12/04        |

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# NOTICES OF INTENDED REGULATORY ACTION

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## Symbol Key

† Indicates entries since last publication of the *Virginia Register*

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## TITLE 9. ENVIRONMENT

### STATE AIR POLLUTION CONTROL BOARD

#### † Notice Of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Air Pollution Control Board intends to consider amending regulations entitled **9 VAC 5-20, General Provisions (Rev. D04)**. The purpose of the proposed action is to enlarge the scope of volatile organic compound and nitrogen oxides emissions control areas in order to include new ozone nonattainment areas.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 10.1-1308 of the Code of Virginia and §§ 110 and 182 of the Clean Air Act (40 CFR Part 51).

Public comments may be submitted until 5 p.m. on January 12, 2005.

**Contact:** Gary Graham, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4103, FAX (804) 698-4510 or e-mail [gegraham@deq.virginia.gov](mailto:gegraham@deq.virginia.gov).

VA.R. Doc. No. R05-66; Filed November 10, 2004, 10:56 a.m.

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## TITLE 12. HEALTH

### STATE BOARD OF HEALTH

#### Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Health intends to consider amending regulations entitled **12 VAC 5-90, Regulations for Disease Reporting and Control**. The purpose of the proposed action is to update reporting requirements; update lab, TB and HIV requirements; update vaccine-preventable and toxic substances provisions; and establish new isolation and quarantine requirements.

The agency does not intend to hold a public hearing on the proposed regulation after publication in the Virginia Register.

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

Public comments may be submitted until 5 p.m. on December 1, 2004.

**Contact:** Diane Woolard, Ph.D., Department of Health, 109 Governor St., Richmond, VA 23219, telephone (804) 864-8142 or e-mail [diane.woolard@vdh.virginia.gov](mailto:diane.woolard@vdh.virginia.gov).

VA.R. Doc. No. R05-47; Filed October 13, 2004, 2:42 p.m.

## DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

#### † Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending regulations entitled **12 VAC 30-80, Methods and Standards for Establishing Payment Rates--Other Types of Care**. The purpose of the proposed action is to promulgate a new methodology for the reimbursement of generic drugs.

The agency does not intend to hold a public hearing on the proposed regulation after publication in the Virginia Register.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public comments may be submitted until December 29, 2004, to Javier Menendez, R.Ph., Manager, Pharmacy Services, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

**Contact:** Victoria P. Simmons or Brian M. McCormick, Regulatory Coordinators, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7959, FAX (804) 786-1680 or e-mail [vicki.simmons@dmas.virginia.gov](mailto:vicki.simmons@dmas.virginia.gov) or [brian.mccormick@dmas.virginia.gov](mailto:brian.mccormick@dmas.virginia.gov).

VA.R. Doc. No. R05-57; Filed November 3, 2004, 2:48 p.m.

#### † Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending regulations entitled **12 VAC 30-120, Waiver Services**. The purpose of the proposed action is to conform the agency's regulations to the federally approved CBC mental retardation waiver. This program provides supportive services in home and communities of persons with diagnoses of mental retardation and children younger than the age of six years who are at risk of developmental delay.

The agency does not intend to hold a public hearing on the proposed regulation after publication in the Virginia Register.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

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# Notices of Intended Regulatory Action

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Public comments may be submitted until December 29, 2004, to Suzanne Klaas, Analyst, Division of Long Term Care and Quality Assurance, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

**Contact:** Victoria P. Simmons or Brian M. McCormick, Regulatory Coordinators, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7959, FAX (804) 786-1680 or e-mail [vicki.simmons@dmas.virginia.gov](mailto:vicki.simmons@dmas.virginia.gov) or [brian.mccormick@dmas.virginia.gov](mailto:brian.mccormick@dmas.virginia.gov).

VA.R. Doc. No. R05-55; Filed November 3, 2004, 2:50 p.m.

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## TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

### BOARD OF COUNSELING

#### † Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Counseling intends to consider amending regulations entitled **18 VAC 115-20, Regulations Governing the Practice of Professional Counseling**. The purpose of the proposed action is to amend prerequisites for licensure by endorsement to allow for greater portability of licensure from state to state.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

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

Public comments may be submitted until 5 p.m. on December 29, 2004.

**Contact:** Evelyn B. Brown, Executive Director, Board of Counseling, 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9133, FAX (804) 662-9943 or e-mail [evelyn.brown@dhp.virginia.gov](mailto:evelyn.brown@dhp.virginia.gov).

VA.R. Doc. No. R05-59; Filed November 4, 2004, 11:04 a.m.

### BOARD OF OPTOMETRY

#### † Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Optometry intends to consider amending regulations entitled **18 VAC 105-20, Regulations for the Virginia Board of Optometry**, and repealing regulations entitled **18 VAC 105-30, Regulations on Certification of Optometrists to Use Therapeutic Pharmaceutical Agents**. The purpose of the proposed action is to incorporate the requirements for initial licensure with therapeutic education agents (TPA) certification, fees for applications and renewals, and the continuing education requirement for TPA-certified optometrists.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

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

Public comments may be submitted until 5 p.m. on December 29, 2004.

**Contact:** Elizabeth A. Carter, Ph.D., Executive Director, Board for Optometry, 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9910, FAX (804) 662-7097 or e-mail [elizabeth.carter@dhp.virginia.gov](mailto:elizabeth.carter@dhp.virginia.gov).

VA.R. Doc. No. R05-60; Filed November 4, 2004, 11:04 a.m.

### BOARD OF PHARMACY

#### Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Pharmacy intends to consider amending regulations entitled **18 VAC 110-30, Regulations for Practitioners of the Healing Arts to Sell Controlled Substances**. The purpose of the proposed action is to conform and update requirements for physicians selling drugs in their practice consistent with regulations for the practice of pharmacy.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: Chapters 33 (§ 54.1-3300 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia.

Public comments may be submitted until 5 p.m. on December 1, 2004.

**Contact:** Elizabeth Scott Russell, R.Ph., Executive Director, Board of Pharmacy, 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9911, FAX (804) 662-9313 or e-mail [elizabeth.russell@dhp.virginia.gov](mailto:elizabeth.russell@dhp.virginia.gov).

VA.R. Doc. No. R05-45; Filed October 13, 2004, 9:55 a.m.

### BOARD OF PHYSICAL THERAPY

#### Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Pharmacy intends to consider amending regulations entitled **18 VAC 112-20, Regulations Governing the Practice of Physical Therapy**. The purpose of the proposed action is to consider acceptance of organizations other than the Foreign Credentialing Commission on Physical Therapy (FCCPT) for credentialing applicants for physical therapy licensure who are graduates of schools that are not approved or accredited.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: § 54.1-2400 and Chapter 34.1 (54.1-3473 et seq.) of Title 54.1 of the Code of Virginia.

Public comments may be submitted until 5 p.m. on December 1, 2004.

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## Notices of Intended Regulatory Action

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**Contact:** Elizabeth Young, Executive Director, Board of Physical Therapy, 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9924, FAX (804) 662-9523 or e-mail [elizabeth.young@dhp.virginia.gov](mailto:elizabeth.young@dhp.virginia.gov).

VA.R. Doc. No. R05-46; Filed October 13, 2004, 9:55 a.m.



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# PROPOSED REGULATIONS

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For information concerning Proposed Regulations, see Information Page.

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## 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.

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## TITLE 9. ENVIRONMENT

### VIRGINIA WASTE MANAGEMENT BOARD

Title of Regulation: **9 VAC 20-80. Solid Waste Management Regulations (amending 9 VAC 20-80-60, 9 VAC 20-80-400, 9 VAC 20-80-480, 9 VAC 20-80-485).**

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

Public Hearing Date: January 11, 2005 - 1:30 p.m.

Public comments may be submitted until 5 p.m. on January 28, 2005.

(See Calendar of Events section for additional information)

Agency Contact: Michael Dieter, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4146, FAX (804) 698-4327, or e-mail [mjdieter@deq.virginia.gov](mailto:mjdieter@deq.virginia.gov).

Basis: 40 CFR Part 258 provides the federal authority for the criteria for municipal solid waste landfills.

The presently proposed amendment deals with the portions of the regulations that are not affected by the federal requirements and that are not subject to the federal program approval. Therefore, the state regulations are no more restrictive than the federal regulations.

The Virginia Waste Management Act authorizes the Waste Management Board to supervise and control waste management activities in the Commonwealth and to promulgate regulations necessary to carry out its powers and duties. Article 2 of the Act prohibits the ownership or operation of an open dump, which is defined in § 10.1-1400 to be any "...site on which solid waste is placed, discharged, deposited, injected, dumped, or spilled so as to create a nuisance or present a threat of a release of harmful substances into environment or present a hazard to human health."

The Act further prohibits any person from operating a facility for the disposal, treatment, or storage of nonhazardous solid waste without a permit from the director of the Department of Environmental Quality (§ 10.1-1408.1 A). The Act requires the permit to contain such conditions or requirements that would prevent a substantial present or potential danger to human health and the environment (§ 10.1-1408.1 E). Section 10.1-1402 states that the board is authorized to promulgate and enforce regulations, and provide for reasonable variances and exemptions necessary to carry out its powers and duties and the intent of this chapter and the federal acts, except that a description of provisions of any proposed regulation which are more restrictive than applicable federal requirements, together with the reason why the more restrictive provisions are needed, shall be provided to the standing committee of each house of the General Assembly to

which matters relating to the content of the regulation are most properly referable.

Purpose: Currently, applicants wishing to store waste in piles must obtain a full permit from the department. Processing a full permit can be time consuming and costly. The requirements for storing waste in piles are not technically challenging. Expedited permitting procedures would benefit the regulated community. 9 VAC 20-80-480, 9 VAC 20-80-485, and 9 VAC 20-80-400 were modified to provide a permit by rule for waste piles. Permit by rule will provide an expedited process for permitting waste piles to place the least possible burden on the regulated community while still protecting human health and the environment. Exclusions have been provided for storage of waste materials in a prescribed manner.

The regulation is needed in order to regulate the storage of waste materials in order to minimize the threat from fires, leachate and contaminated storm water discharge, and abandonment of the waste materials. Modifications have been provided to make the regulation of waste piles less burdensome.

The goal of the amended regulation is to modify the regulation to: accommodate a permit by rule for waste piles; review the applicable sections of the regulation to assure provisions to protect human health and the environment and eliminate any unnecessary provisions that do not accomplish this goal.

Substance: Conditional exemptions under 9 VAC 20-80-60 E were provided allowing the storage of waste material in piles as long as they meet the provisions of the exclusion and they do not create an open dump hazard or public nuisance.

9 VAC 20-80-400 was modified to recognize the provisions for permit by rule in 9 VAC 20-80-485, and will provide reasonable provisions to protect human health and the environment, including provisions to protect surface water and ground water, and minimize the potential for fire.

9 VAC 20-80-480 and 9 VAC 20-80-485 were modified to provide for a permit by rule for waste piles. The permit by rule provisions are similar to those used for transfer stations, materials recovery facilities, incinerators, and composting facilities.

9 VAC 20-80-485 provides a list of documentation including plans, certifications and financial assurance that must be submitted by the applicant to the department in order to fulfill the requirements for permit by rule for a waste pile.

Issues: Advantages to the public include eliminating requirements for mandatory full permits by providing exempt waste storage activities under certain circumstances as well as expedited permit procedures for the storage of waste materials in piles. The requirements for the conditional exemption and the permit by rule (PBR) maintain the protection of human health and the environment. PBR is a

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## Proposed Regulations

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less burdensome process than that required under the current regulations.

The advantages to the Commonwealth include quicker permit processing procedures quicker turn around of permits and less staff time spent on processing permit applications.

No foreseeable disadvantages exist. The regulations are easier and cheaper to comply with than the current regulations while still maintaining protection of human health and the environment.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The Virginia Waste Management Act (Chapter 14, Sections 10.1-1400 through 10.1-1457 of the Code of Virginia) authorizes the Virginia Waste Management Board to supervise and control waste management activities in the state and to promulgate regulations necessary to carry out its powers and duties. Specifically, § 10.1-1408.1 of the Code of Virginia prohibits the operation of a sanitary landfill or any other facility for the disposal, treatment or storage of non-hazardous solid waste without a permit. Section 10.1-1402 authorizes the Virginia Waste Management Board to provide for reasonable variances and exemptions necessary to carry out its powers and duties as well as the intent of the Virginia Waste Management Act and relevant federal acts.

The proposed regulation (1) provides an additional exemption from the permit requirements for land clearing debris stored in piles as long as the debris is stored in a manner prescribed in the regulation, (2) allows owners and operators of waste piles to apply for a permit-by-rule rather than a full permit, and (3) modifies the waste pile management requirements themselves to (i) allow for the storage in piles of organic material that is not readily putrescible as long as it is stored in lined or covered waste storage areas, (ii) require that the operation plan for a waste management facility cover the issue of dust suppression and include descriptions of the management and disposition of waste materials and of waste management procedures that ensure that oldest waste materials are sent off-site for reuse or disposal before newer materials, and (iii) require the owner or operator of a waste pile to put up a closure sign within 15 days of the last receipt of waste and keep the sign in place until all closure activities have been completed.

The proposed regulation adds clarifying language and removes unnecessary language. The regulation also includes

a number of changes that clarify the intent of the regulation and make the regulation consistent with current practice.

Estimated economic impact. (1) The existing regulation provides certain solid waste management practices conditional exemption from the permit requirements as long as they do not create an open dump, a hazard, or a public nuisance. The proposed regulation provides an additional exemption for land clearing debris. Land clearing debris (including stumps and brush, clean wood wastes, log yard scrapings consisting of a mixture of soil and wood, cotton gin trash, peanut hulls, and similar organic wastes that do not readily decompose) may be stored in piles without a permit as long as the pile meets certain minimum requirements, including how the waste is managed, the location and size of the waste pile, and disposal of the waste once industrial activities at the site have ceased.

The waste management provisions require the prevention of leachate discharges, dispersal of the waste by wind or rain, waste pile combustion or fire, and waste pile putrescence. The regulation also specifies the location and size of the waste pile for it to qualify for an exemption. Waste piles seeking an exemption from the permit requirement are required to store waste materials at the site of the industrial activity, maintain a 50 foot fire break between the waste pile and any structure or tree line (based on National Fire Protection Association guidelines), ensure that the slope of the ground within the area of the pile and within 50 feet of the pile does not exceed 4:1 (based on gradient on which construction and cleanup equipment are able to operate with ease), and make sure that waste materials are stored no closer than 50 feet from any property line or regularly flowing water body, floodplain, or wetland (based on similar requirements in other solid waste management regulations). The size of a waste pile is restricted to covering no more than one-third of an acre and rising no more than 15 feet from the base. Finally, waste stored at a site must be disposed off at a permitted solid waste management facility within 90 days of cessation of industrial activity at the site.

The proposed exemption will provide economic benefits to owners and operators of waste piles consisting of land clearing debris. For waste piles meeting the above requirements, owners and operators will not be required to get a permit. According to estimates provided by the Department of Environmental Quality (DEQ), the price charged by consultants to prepare the required documents range between \$80,000 and \$85,000 for a full permit and between \$10,000 and \$15,000 for a permit-by-rule. In addition to these costs, owners and operators are required to pay a permit fee (a minimum of \$1,040 for a full permit and \$390 for a permit-by-rule) and all costs associated with meeting the public participation and notification requirements.

However, the proposed change may also impose economic costs. The intent of the permit requirement is to reduce the risk to the public and the environment from waste piles. The risks arise from the potential for fire, leachate discharges, and abandonment of the site. Thus, the improper storage of waste and the improper management of waste piles could create serious public health and environmental hazards. The aim of the permitting mechanism is to ensure that these activities are

conducted in a manner that is protective of the public and the environment. The costs associated with obtaining a permit can be viewed as the cost of ensuring the safe use of an environmental resource. In this case, the costs associated with getting a permit are the cost of ensuring that the storage and management of waste piles is done in a manner that is protective of the public and of the air, water, and soil quality in Virginia. By providing an exemption for land clearing debris, it is possible that the proposed regulation will result in owners and operators storing land clearing debris in piles in a manner that poses a significant risk to the public and the environment. However, DEQ does not believe that the exemption is likely to significantly increase the risk to the public and to the environment. According to the agency, the requirements necessary to be eligible for the exemption are designed such that the risk to the public and to the environment from fires, leachate discharges, and abandonment are not significantly higher than under the full permit.

The net impact of the proposed change will depend on whether the benefits of providing the exemption are greater than or less than the costs associated with doing so. Requirements for the storage and management of the waste in piles should be commensurate with the risk posed by these piles to public health and the environment. If the existing full permit requirements for the storage and management of land clearing debris in piles are excessive given the risk posed by them, the proposed change is likely to produce a net positive economic impact. By ensuring that owners and operators of waste piles do not have to meet any unnecessary or excessive requirements, the proposed change is likely to produce efficiency gains. If, on the other hand, the exemption requirements are not stringent enough given the risk, the proposed change is likely to produce a net negative economic impact. By increasing risk to the public and the environment from fire, leachate discharges, and abandonment, the proposed change will shift some of the costs associated with storing land clearing debris in piles from the businesses engaged in these activities to the taxpayer, resulting in an inefficient allocation of resources.

While most of the exemption requirements are based on standard practice, the rationale for setting the maximum dimensions of the waste pile to less than 15 feet in height and to less than one-third of an acre in area is unclear.

The National Fire Protection Association guidelines state that narrow, low piles facilitate fire extinguishing and recommend piles of wood chips and hogged material not exceeding 60 feet in height, 300 feet in width, and 500 feet in length (or 3.44 acres in area). However, a 1986 Virginia Tech study<sup>1</sup> on storing bark mulch in piles found that, to prevent the occurrence of fires, the piling height for mulch should not exceed 12-15 feet. While the National Fire Protection Association guidelines establish waste pile dimensions based on the ease of putting out a fire, the Virginia Tech study establishes waste pile dimensions based on the potential of the waste pile to catch fire. Moreover, the piling height recommended by the Virginia Tech study applies specifically

to mulch. The potential for fire in a waste pile varies depending on the type of material being stored. For example, sawdust has a higher potential for fire than mulch, indicating that a pile height of less than the 12-15 feet recommended by the Virginia Tech study would be appropriate in order to prevent fires in a waste pile consisting of sawdust.

Another factor that played a role in restricting pile size to a maximum of 15 feet in height and one-third of an acre in area was the potential for abandonment. According to DEQ, it not always economically feasible to clean up very large sites that have been abandoned. Thus, in order to keep the cleanup burden in the event of a site being abandoned at manageable proportions, the maximum size of the waste pile was restricted to the abovementioned dimensions.

According to DEQ, the maximum dimension of a waste pile eligible for exemption was determined as a compromise between members of the Technical Advisory Committee (seeking a maximum waste pile dimension of 20 feet in height and between one-third and one-half acre in area) and the agency (seeking a maximum waste pile dimension of 12 feet in height and one-third acre in area). Thus, the determination was made based on considerations not solely to do with the public health and environmental risk posed by these waste piles. In order to produce the most efficient outcome, the maximum dimensions of a waste pile eligible for an exemption should be based solely on reducing the public health and environmental risk from fire or abandonment to an acceptable level.

In order to address the risks to public health and the environment from waste pile fires and from abandonment of these sites, it may be advisable to establish separate requirements for each.

The maximum size of a waste pile eligible for exemption could be determined based on the public health and environmental consequences of a waste pile fire. However, the maximum dimension of the waste pile should be not determined based on eliminating all risk of a waste pile fire. Instead it should be determined based on reducing those risks that have significant public health and environmental consequences. The public health and environmental consequences of a fire in a pile of land clearing debris include the potential for the fire spreading to surrounding areas and the potential for public health and environmental damage from smoke generated by the fire. Small fires in a waste pile are not likely to produce a very large adverse impact on public health or the environment. Based on the National Fire Protection Association guidelines, a fire in a waste pile of land clearing debris is not likely to be as hard to put out as, say, a fire in a tire pile. Moreover, the firebreak requirement of a minimum 50 feet distance between a waste pile and any structure or tree line is likely to prevent small fires spreading from the waste pile to surrounding areas before they can be put out. Finally, as these waste piles consist solely of non-hazardous organic material and tend to be located in less populated areas, the smoke generated by a small fire is likely to have little to no impact on public health or the environment. In the case of such fires, the public health and environmental benefits associated with reducing the risk of fire are very small. Thus, determining the maximum pile size with the intent of eliminating all risk of fires, even small

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<sup>1</sup> White, M. S., 1986. Spontaneous Heating and Combustion in Piled Bark Mulch. Presentation to the 15th Annual Meeting of the National Bark Producers Association.

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fires that are likely to have little public health or environmental impact, is likely to be unnecessarily restrictive. The benefits of such a restriction are likely to be small and will most likely be outweighed by the costs of placing such a restriction. The maximum pile size should be determined based on reducing or eliminating those risks that are likely to have significant consequences for public health and the environment. In addition, varying the maximum pile size requirement based on the type of material being stored would provide greater flexibility without significantly affecting the risk to the public and the environment, thus, further enhancing the efficiency of the regulation.

Concerns regarding abandonment of the site can be addressed by factors other than waste pile size. For example, financial assurance requirements can be incorporated into the proposed regulation that would ensure adequate resources to cover the cost of cleanup in the event of the site being abandoned. Rather than restricting the size of the waste pile to 15 feet in height and one-third acre in area, including a separate requirement for financial assurance for any waste piles exceeding these dimensions would address the potential for site abandonment.

Designing the exemption requirements in the above manner is likely to increase the efficiency of the regulation by making the requirements of the regulation commensurate with the risk of fire and abandonment posed by these waste piles.

(2) The proposed regulation allows owners and operators of waste piles to apply for a permit-by-rule rather than a full permit. Under the existing regulation, owners and operators of waste piles are required to apply for a solid waste management permit prior to storing waste in piles. Under the proposed regulation, owners and operators of waste piles will be deemed to have a permit as long as they meet the permit-by-rule requirements. The enforcement aspect of the regulation remains unchanged. DEQ intends to conduct as many inspections as under a full permit (currently, twice a year).

The permit-by-rule provision for waste piles is likely to produce economic benefits. By requiring owners and operators of waste piles to meet the less burdensome permit-by-rule provisions, the proposed regulation is likely to lower the costs of obtaining a permit for storing waste in piles. Some of the less burdensome requirements include requiring the construction and design of the facility to be certified rather than prepared by a professional engineer, requiring the siting of the facility to be certified by the owner rather than a professional engineer, and less detailed operation and closure plans. Based on estimates provided by DEQ, the price charged by consultants to prepare the required documents range between \$80,000 and \$85,000 for a full permit and between \$10,000 and \$15,000 for a permit-by-rule. Thus, the proposed change will result in saving in the range of between \$65,000 and \$75,000. In addition to these costs, owners and operators are also required to pay a permit fee. The fee for a full permit is a minimum of \$1,040 and is based on the cost incurred by DEQ in reviewing materials and issuing the permit.

The fee for a permit-by-rule is \$390<sup>2</sup>. Thus, owners and operators of waste piles are likely to save upwards of \$650 in permit fees. In addition to lowering the cost associated with getting a permit, the proposed change is also likely to reduce the time between application for and issuance of the permit. DEQ estimates that a permit-by-rule will be granted approximately ten days from the date of application.

However, the proposed change may also impose economic costs. As mentioned previously, the aim of the permitting mechanism is to ensure that the storage and management of waste in piles is conducted in a manner that is protective of public health and the environment. Thus, the costs associated with obtaining a permit can be viewed as the cost of ensuring the safe use of an environmental resource. By reducing the requirements for waste stored in piles, the proposed regulation may be increasing the risk to public health and the environment through an increased risk of fire, leachate discharge, and abandonment at sites where waste is stored in piles.

DEQ believes that the permit-by-rule requirements are adequate to protect public health and the environment and the proposed change is not likely to have a significantly impact on the risk to the public and the environment from waste piles. According to the agency, the differences between the full permit and the permit-by-rule requirements are not sufficient to lead to a substantial increase in risk to the public and the environment. The construction and design of the waste pile, while they do not have to be prepared by a professional engineer, are required to be certified by one as meeting the design and construction standards specified in the existing regulation for the issuance of a full permit. Moreover, even though the siting of the waste pile has to be certified by the owner, and not a professional engineer, it still has to meet the full permit requirements in the existing regulation. Finally, operation and closure plans, while less detailed than what is required for a full permit, are still required to address the issues of fire, leachate discharge, and abandonment. The enforcement aspect of the proposed regulation remains unchanged. DEQ intends to continue to conduct inspections of these sites on a bi-annual basis. The absence of significant differences between the permit-by-rule and full permit requirements coupled with the intended enforcement action indicate that the economic costs associated with the proposed change are not likely to be very significant. Moreover, under the existing regulation, transfer stations, materials recovery facilities, energy recovery, thermal treatment, and incineration facilities, and composting facilities are all allowed to seek a permit-by-rule. Allowing these facilities the option of applying for a permit-by-rule rather than a full permit does not appear to have led to any significant adverse consequences to the public or the environment.

The net economic impact of the proposed change will depend on whether the permit-by-rule requirements are consistent with the risk posed to the public and the environment from waste being stored in piles. If the permit-by-rule requirements are appropriate, the proposed change is likely to have a net positive economic impact. By ensuring that owners and

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<sup>2</sup> According to DEQ, the fee amount for the permit-by-rule was based on an estimate of resources used by the agency in reviewing the submitted material.

operators of waste piles do not have to meet any unnecessary or excessive requirements under a full permit, the proposed change is likely to produce efficiency gains. If, on the other hand, the exemption requirements are not stringent enough given the risk, the proposed change is likely to produce a net negative economic impact. By increasing risk to the public and the environment from fire, leachate discharges, and abandonment, the proposed change will shift some of the costs associated with storing waste in piles from the businesses engaged in these activities to the tax payer, resulting in an inefficient allocation of resources. It is not possible to precisely estimate at this time the cost to the public of proposed change. Such an estimate would require being able to calculate the risk of fire, leachate discharges, or abandonment of waste pile and the cost to the taxpayer in the event of each of these occurrences. However, based on the above discussion, it does not appear that the economic costs associated with allowing permit-by-rule are likely to be very large and are likely to be outweighed by the benefits to owners and operators of applying for a permit-by-rule rather than a full permit.

(3) The proposed regulation also modifies the waste pile requirements themselves to (i) allow for the storage in piles of organic material that is not readily putrescible, as long as it is stored lined or covered waste storage areas, (ii) require that the operation plan for a waste management facility cover the issue of dust suppression and include descriptions of the management and disposition of waste materials and of waste management procedures that ensure that oldest waste materials are sent off-site for reuse or disposal before newer materials, and (iii) require the owner or operator of a waste pile to put up a closure sign within 15 days of the last receipt of waste and keep the sign in place until all closure activities have been completed.

Under the existing regulation, putrescible waste cannot be stored in a pile for more than one day. The proposed regulation relaxes this requirement to allow some wastes that are not readily putrescible to be stored in piles for more than a day. This change is intended to allow facilities additional operational flexibility to store materials for which they may not have an immediate market. However, the benefit of providing the additional flexibility has been balanced against the cost of any increase in risk to the public and to the environment resulting from allowing the storage of moderately putrescible waste in piles. It is not possible to precisely estimate the benefit of the additional flexibility to facilities storing these types of materials and the cost to the public and the environment of doing so. However, DEQ believes that the costs associated with the proposed change are not likely to be significant. According to the agency, the storage and waste management requirements for these types of waste established in the regulation are adequate to protect public health and the environment.

The new operational requirements specified in the proposed regulation are likely to impose additional costs on facilities storing waste in piles. According to DEQ<sup>3</sup>, depending on

weather conditions, landfills spend between \$100 and \$150 a day in dust suppression (the estimate includes equipment and labor costs). However, dust suppression costs for facilities storing waste in piles is likely to be lower than that for landfills as they are likely to have fewer customers and trips per day to the waste pile. In addition to the costs of dust suppression, facilities will also be required to describe their waste management practices and ensure that the oldest waste is reused or disposed first. These additional costs have to be balanced by the additional benefits to the public and the environment of these requirements. The net economic impact of the proposed change is likely to depend on whether the additional costs are greater than or less than the benefits. It is not possible at this time to precisely estimate the all the costs and benefits of the proposed change.

The additional sign-posting requirement is not likely to have a significant economic impact. Any waste dumped on a waste pile following closure of a facility is the responsibility of the owner and/or operator of the waste pile. Thus, it is in their interest to do adequately signpost the area following closure. According to DEQ, most facilities are likely to be meeting the signposting requirement even though it is not required in the existing regulation. Thus, requiring it under the proposed regulation is not likely to have a significant effect on current practice.

DEQ has not issued any permits to date allowing for the storage of waste in piles. Thus, facilities that are currently storing waste in piles are doing so illegally. Some of these facilities are or have been under enforcement action. According to DEQ, two violations have already been issued, one violation is currently in enforcement, and one violation is pending. DEQ further estimates that there are nine more candidates for enforcement action. No fines have been collected to date following an enforcement action. The intent of the proposed regulation is to reduce the requirements of the regulation as they relate to waste piles to the minimum necessary to protect public health and the environment and, thus, encourage facilities storing waste in piles to be permitted. In addition, the proposed regulation is also intended to improve enforcement activities and make them more effective.

Businesses and entities affected. The proposed regulation is likely to affect all businesses and entities storing waste in piles. These individuals and entities will now be able to seek an exemption from the permit requirements for storing land clearing debris in piles. They will also be allowed to apply for a permit-by-rule for storing other types of waste in piles instead of a full permit. The permit-by-rule requirements are less burdensome and take a shorter amount of time to review than a full permit. Finally, requirements relating to the management of waste piles are modified to allow moderately putrescible wastes to be stored in piles for more than one day. In addition, operational plan requirements have been expanded and a signposting requirement included in the proposed regulation.

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<sup>3</sup> The estimate is based on DEQ conversations with personnel at two landfills, one with approximately 50 customers per day and the other with between 100

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and 150 customers per day. Depending on weather conditions, both spent a maximum of one or two hours a day in dust suppression.

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According to the Virginia Tech Department of Wood Science, there are approximately 800 primary and secondary wood product manufacturers operating in the state that would be affected by the proposed change. Moreover, the primary manufacturers (approximately 300) produce over 80% of the residue that would be managed under this regulation. In addition, some agricultural industries could also be affected by the proposed regulation. In all, DEQ estimates that there are approximately 300 businesses and entities likely to be affected by the proposed regulation.

Localities particularly affected. The proposed regulation applies to all localities in the Commonwealth. However, the proposed regulation will have the most impact in areas where waste is likely to be stored in piles, i.e., areas where there is not a ready market for products such as sawdust and wood chips. Most of these areas are located in Southwest Virginia, with a few located in the Tidewater area (relating to the storage of peanut hulls).

Projected impact on employment. The proposed regulation is not likely to have a significant impact on employment.

Effects on the use and value of private property. The proposed regulation affects businesses and entities storing waste in piles. These businesses will have the option of seeking an exemption for storing land clearing debris in piles or a permit-by-rule instead of a full permit for storing other waste in piles. The exemption and permit-by-rule requirements are less burdensome and less time consuming than the full permit requirements. By reducing the costs associated with being in compliance with the regulation, the proposed changes are likely to lower operation costs and increase the asset value of these businesses. However, as none of these facilities have to date applied for a permit, the magnitude of the positive impact is unclear. In addition to the exemption and permit-by-rule provisions, the proposed regulation also modifies the waste management requirements for waste piles. These modifications are likely to increase the costs of compliance for a business, thus having a negative impact on their asset value. The net impact of the all the proposed changes is likely to be positive. Any increase in cost due to modifications to the waste management requirements are likely to be outweighed by the lower cost associated with the exemption and permit-by-rule requirements.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The department has reviewed the economic impact analysis prepared by the Department of Planning and Budget and has no comment.

Summary:

*The proposed amendments (i) provide an additional exemption from the permit requirements for land clearing debris stored in piles as long as the debris is stored in a manner prescribed in the regulation; (ii) allow owners and operators of waste piles to apply for a permit-by-rule rather than a full permit; and (iii) modify the waste pile management requirements themselves to (a) allow for the storage in piles of organic material that is not readily putrescible as long as it is stored in lined or covered waste storage areas, (b) require that the operation plan for a*

*waste management facility cover the issue of dust suppression and include descriptions of the management and disposition of waste materials and of waste management procedures that ensure that oldest waste materials are sent off site for reuse or disposal before newer materials, and (c) require the owner or operator of a waste pile to put up a closure sign within 15 days of the last receipt of waste and keep the sign in place until all closure activities have been completed.*

**9 VAC 20-80-60. Applicability of chapter.**

A. This chapter applies to all persons who manage or dispose of solid wastes as defined in Part III (9 VAC 20-80-140 et seq.) of this chapter.

B. All facilities that were permitted prior to March 15, 1993, and upon which solid waste has been disposed of prior to October 9, 1993, may continue to receive solid waste until they have reached their vertical design capacity or until the closure date established pursuant to § 10.1-1413.2 of the Code of Virginia, provided:

Note: Municipal solid waste landfills (sanitary landfills) are subject to prioritization and a schedule for closure pursuant to § 10.1-1413.2 of the Code of Virginia.

1. The facility is in compliance with the requirements for liners and leachate control in effect at the time of permit issuance.

2. On or before October 9, 1993, the owner or operator of the solid waste management facility has submitted to the director:

a. An acknowledgment that the owner or operator is familiar with state and federal law and regulations pertaining to solid waste management facilities operating after October 9, 1993, including post-closure care, corrective action and financial responsibility requirements;

b. A statement signed by a registered professional engineer that he has reviewed the regulations established by the department for solid waste management facilities, including the open dump criteria contained therein, that he has inspected the facility and examined the monitoring data compiled for the facility in accordance with applicable regulations and that, on the basis of his inspection and review, he has concluded:

(1) That the facility is not an open dump;

(2) That the facility does not pose a substantial present or potential hazard to human health and the environment; and

(3) That the leachate or residues from the facility do not pose a threat of contamination or pollution of the air, surface water or ground water in a manner constituting an open dump or resulting in a substantial present or potential hazard to human health or the environment; and

c. A statement signed by the owner or operator:

(1) That the facility complies with applicable financial assurance regulations; and

(2) Estimating when the facility will reach its vertical design capacity.

3. The facility may not be enlarged prematurely to avoid compliance with this chapter when such enlargement is not consistent with past operating practices, the permit or modified operating practices to ensure good management.

C. Facilities are authorized to expand laterally beyond the waste boundaries existing on October 9, 1993, as follows:

1. Existing captive industrial landfills.

a. Existing nonhazardous industrial waste facilities that are located on property owned or controlled by the generator of the waste disposed of in the facility shall comply with all the provisions of this chapter except as shown in subdivision 1 of this subsection.

b. Facility owners or operators shall not be required to amend their facility permit in order to expand a captive industrial landfill beyond the waste boundaries existing on October 9, 1993. Liners and leachate collection systems constructed beyond the waste boundaries existing on October 9, 1993 shall be constructed in accordance with the requirements in effect at the time of permit issuance.

c. Owners or operators of facilities which are authorized under subdivision 1 of this subsection to accept waste for disposal beyond the waste boundaries existing on October 9, 1993, shall ensure that such expanded disposal areas maintain setback distances applicable to such facilities in 9 VAC 20-80-270 A.

d. Facilities authorized for expansion in accordance with subdivision 1 of this subsection are limited to expansion to the limits of the permitted disposal area existing on October 9, 1993, or the facility boundary existing on October 9, 1993, if no discrete disposal area is defined in the facility permit.

2. Other existing industrial waste landfills.

a. Existing nonhazardous industrial waste facilities that are not located on property owned or controlled by the generator of the waste disposed of in the facility shall comply with all the provisions of this chapter except as shown in subdivision 2 of this subsection.

b. Facility owners or operators shall not be required to amend their facility permit in order to expand an industrial landfill beyond the waste boundaries existing on October 9, 1993. Liners and leachate collection systems constructed beyond the waste boundaries existing on October 9, 1993, shall be constructed in accordance with the requirements of 9 VAC 20-80-270 B.

c. Prior to the expansion of any such facility, the owner or operator submits to the department a written notice of the proposed expansion at least 60 days prior to commencement of construction. The notice shall include recent ground water monitoring data sufficient to determine that the facility does not pose a threat of contamination of ground water in a manner constituting an open dump or creating a substantial present or potential hazard to human health or the environment (see

9 VAC 20-80-180 B 4). The director shall evaluate the data included with the notification and may advise the owner or operator of any additional requirements that may be necessary to ensure compliance with applicable laws and prevent a substantial present or potential hazard to health or the environment.

d. Owners or operators of facilities which are authorized under subdivision 2 of this subsection to accept waste for disposal beyond the waste boundaries existing on October 9, 1993, shall ensure that such expanded disposal areas maintain setback distances applicable to such facilities in 9 VAC 20-80-270 A.

e. Facilities authorized for expansion in accordance with this subsection are limited to expansion to the limits of the permitted disposal area existing on October 9, 1993, or the facility boundary existing on October 9, 1993, if no discrete disposal area is defined in the facility permit.

3. Existing construction/demolition/debris landfills.

a. Existing facilities that accept only construction/demolition/debris waste shall comply with all the provisions of this chapter except as shown in subdivision 3 of this subsection.

b. Facility owners or operators shall not be required to amend their facility permit in order to expand a construction/demolition/debris landfill beyond the waste boundaries existing on October 9, 1993. Liners and leachate collection systems constructed beyond the waste boundaries existing on October 9, 1993, shall be constructed in accordance with the requirements of 9 VAC 20-80-260 B.

c. Prior to the expansion of any such facility, the owner or operator submits to the department a written notice of the proposed expansion at least sixty days prior to commencement of construction. The notice shall include recent ground water monitoring data sufficient to determine that the facility does not pose a threat of contamination of ground water in a manner constituting an open dump or creating a substantial present or potential hazard to human health or the environment (see 9 VAC 20-80-180 B 4). The director shall evaluate the data included with the notification and may advise the owner or operator of any additional requirements that may be necessary to ensure compliance with applicable laws and prevent a substantial present or potential hazard to health or the environment.

d. Owners or operators of facilities which are authorized under this subdivision 3 to accept waste for disposal beyond the active portion of the landfill existing on October 9, 1993, shall ensure that such expanded disposal areas maintain setback distances applicable to such facilities in 9 VAC 20-80-260 A and B.

e. Facilities, or portions thereof, which have reached their vertical design capacity shall be closed in compliance with 9 VAC 20-80-260 E.

f. Facilities authorized for expansion in accordance with subdivision 2 c of this subsection are limited to expansion to the permitted disposal area existing on October 9,

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1993, or the facility boundary existing on October 9, 1993, if no discrete disposal area is defined in the facility permit.

4. Facilities or units undergoing expansion in accordance with the partial exemptions created by subdivision 1 b, 2 b, or 3 b of this subsection may not receive hazardous wastes generated by the exempt small quantity generators as defined by the Virginia Hazardous Waste Management Regulations (9 VAC 20-60), wastes containing free liquids for disposal on the expanded portions of the facility. Other wastes that require special handling in accordance with the requirements of Part VIII (9 VAC 20-80-630 et seq.) of this chapter or which contain hazardous constituents which would pose a risk to health or environment, may only be accepted with specific approval by the director.

5. Nothing in subdivisions 1 b, 2 b, and 3 b of this subsection shall alter any requirement for ground water monitoring, financial responsibility, operator certification, closure, post-closure care, operation, maintenance or corrective action imposed under this chapter, or impair the powers of the director to revoke or amend a permit pursuant to § 10.1-1409 of the Virginia Waste Management Act or Part VII (9 VAC 20-80-480 et seq.) of this chapter.

D. An owner or operator of a previously unpermitted facility that managed materials previously exempt from this chapter shall submit a complete application for a solid waste management facility permit or a permit amendment in accordance with Part VII of this chapter within six months after these materials have been defined or identified as solid wastes. If the director finds that the application is complete, the owner or operator may continue to manage the newly defined or identified waste until a permit or permit amendment decision has been rendered or until a date two years after the change in definition whichever occurs sooner, provided however, that in so doing he shall not operate or maintain an open dump, a hazard, or a nuisance.

The owner or operator of an existing solid waste management facility shall comply with this regulation beginning September 24, 2003. Where necessary conflicts exist between the existing facility permit and the new requirements of the regulations, the regulations shall supercede the permit except where the standards in the permit are more stringent than the regulation. Language in an existing permit shall not act as a shield to compliance with the regulation, unless a variance to the regulations has been approved by the director in accordance with the provisions of Part IX (9 VAC 20-80-730 et seq.) of this chapter. Existing facility permits will not be required to be updated to eliminate requirements conflicting with the regulation, except at the request of the director or if a permit is amended for another reason. However, all sanitary landfills and incinerators that accept waste from jurisdictions outside of Virginia must submit the materials required under 9 VAC 20-80-113 D by March 22, 2004.

E. Conditional exemptions. The following solid waste management practices are exempt from this chapter provided no open dump, hazard, or public nuisance is created:

1. Composting of sewage sludge at the sewage treatment plant of generation without addition of other types of solid wastes.

2. Composting of household waste generated at a single-family residence at the site of generation.

3. Composting activities performed for educational purposes as long as no more than five tons of materials are on site at any time. Greater quantities will be allowed with suitable justification presented to the department. For quantities greater than five tons approval from the director will be required prior to composting.

4. Management of wastes regulated by the State Board of Health, the State Water Control Board, or any other state agency with such authority.

5. On-site management of soil contaminated with petroleum products required as part of an ongoing corrective action by the department under Article 9 (§ 62.1-44.34:8 et seq.) or Article 11 (§ 62.1-44.34:14 et seq.) of Chapter 3.1 of Title 62.1 of the Code of Virginia. Management of the contaminated soils away from the site of generation is subject to this chapter unless specifically provided for in the approved corrective action plan.

6. Management of solid waste in appropriate containers at the site of its generation, provided that:

a. Putrescible waste is not stored more than seven days between time of collection and time of removal for disposal; and

b. All nonputrescible wastes that are on a system of regularly scheduled collection for disposal with collections occurring at intervals of less than 90 days.

7. Landfilling of solid waste which includes only rocks, brick, block, dirt, broken concrete and road pavement and which contains no paper, yard, or wood wastes.

8. On-site management of solid wastes generated by the wastewater treatment facilities provided such management is subject to a regulation promulgated by the State Water Control Board.

9. Placing of stumps and other land clearing debris from agricultural or forestal activities on site of the clearing where no debris is accepted from off-site. This does not include the burial of these materials.

10. Placing of solid wastes including large tires from mining equipment from mineral mining activities on a mineral mining site in compliance with a permit issued by the Department of Mines, Minerals and Energy where no such waste is accepted from off-site and does not contain any municipal solid wastes or other special wastes. Placement of such solid wastes shall be accomplished in an environmentally sound manner.

11. Storage of less than 100 waste tires at the site of generation provided that no waste tires are accepted from off-site and that the storage will not present a hazard or a nuisance.

12. *The storage of landclearing debris including stumps and brush, unadulterated wood wastes, log yard scrapings consisting of a mixture of soil and wood, cotton gin trash, peanut hulls and similar organic wastes that do not readily*

decompose, in piles are exempt from this chapter if they are stored as prescribed below:

a. The wastes are managed in the following manner:

- (1) They do not cause discharges of leachate, or attract vectors.
- (2) They are managed to prevent dispersal by wind and rain.
- (3) They are managed to reduce the potential for combustion and fire.
- (4) The wastes are managed so that they do not become putrescent.

b. Any facility storing waste materials under the provisions of this section obtains a storm water discharge permit if they are considered a significant source under the provisions of 9 VAC 25-31-120 A 1 e.

c. No more than an total of 1/3 acre of waste material is stored on-site and the waste pile does not exceed 15 feet in height above base grade.

d. Siting provisions.

- (1) All waste materials are stored at the site of the industrial activity that produces them.
- (2) A 50-foot fire break is maintained between the wastepile and any structure or treeline.
- (3) The slope of the ground within the area of the pile and within 50 feet of the pile does not exceed 4:1.
- (4) No waste material may be stored closer than 50 feet to any regularly flowing surface water body or river, floodplain, or wetland.
- (5) No stored waste materials shall extend closer than 50 feet to any property line.

e. If the industrial activities at the site cease, any waste stored at the site must be properly disposed in a permitted solid waste management facility within 90 days.

f. Waste piles that do not meet these provisions are required to obtain a permit in accordance with the provisions in 9 VAC 20-80-480 and meet all of the requirements in 9 VAC 20-80-400. Facilities that do not comply with the provisions of this subdivision and fail to obtain a permit are subject to the provisions of 9 VAC 20-80-90 for unpermitted facilities.

F. This chapter is not applicable to units or facilities closed in accordance with regulations or permits in effect prior to December 21, 1988, unless releases, as defined in Part I (9 VAC 20-80-10 et seq.) of this chapter, from such closed facilities cause the site to be classified as an open dump, a hazard or a nuisance under § 10.1-1402(21) of the Code of Virginia, or a site where improper waste management has occurred under § 10.1-1402(19) of the Code of Virginia.

**9 VAC 20-80-400. Waste piles.**

A. Applicability.

1. The regulations in this section apply to owners and operators of facilities that store or treat non-putrescible solid waste in piles.

2. The regulations in this section do not apply to owners or operators of waste piles that will be closed with wastes left in place. Such waste piles are subject to regulations contained in Part V (9 VAC 20-80-240 et seq.) of this chapter.

3. This section applies to units that manage ~~uncontainerized putrescible wastes~~ inert waste and organic wastes that are not readily putrescible in piles that do not remain in the unit at the end of the working day. ~~If such wastes remain in waste piles at the end of the day, this section does not apply and the management of such wastes shall be in accordance with the requirements shown in 9 VAC 20-80-330 or 9 VAC 20-80-470, as applicable. This section does not apply if materials will be actively composted according to the provisions of 9 VAC 20-80-330.~~

4. Any material from a state other than Virginia that is classified as a hazardous waste in that state shall be managed in accordance with the Virginia Hazardous Waste Management Regulations (9 VAC 20-60). Such wastes are not acceptable for treatment or storage in a solid waste management facility in the Commonwealth.

5. The regulations in this section do not apply to the management of industrial co-products in piles. A material shall be considered an industrial co-product if a demonstration can be made consistent with 9 VAC 20-80-140 D that the material is not a solid waste.

6. The regulations in this section do not apply to active logging operations subject to regulation under the provisions of §§ 10.1-1181 through 10.1-1181.2 of the Code of Virginia.

B. Siting.

1. Solid waste management facilities storing or treating waste in piles shall be adjacent to or have direct access to paved or gravel roads ~~which are paved or surfaced and that are capable of withstanding anticipated load limits.~~

2. Waste piles shall not be sited or constructed in areas subject to base floods.

3. Facility treating or storing solid waste in piles shall not be closer than 50 feet to any surface ~~stream~~ water body or wetland.

4. No facility treating or storing wastes in piles shall extend closer than 50 feet to any property line nor closer than 200 feet to any residential area, health care facility, school or recreational park area, or similar type public institution.

5. Unless the waste pile is located inside or under a structure that provides protection from precipitation so that neither run-off nor leachate is generated, such units shall ~~be~~ provided with an adequate area to allow for proper management of leachate and runoff; *in accordance with subdivision C 2 and D 4 of this section.*

~~b. Not be located in areas which are geologically unstable or where site topography is heavily dissected; and~~

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~~c. Not be located in any area where a seasonal high water table lies within two feet of the ground surface.~~

## C. Design/construction.

1. The owner or operator of any waste pile that is inside or under a structure that provides protection from precipitation so that neither run-off nor leachate is generated is not subject to regulation under subdivision 2 of this subsection, provided that:

- a. Liquids or materials containing free liquids are not placed in the pile;
- b. The pile is protected from surface water run-on by the structure or in some other manner;
- c. The pile is designed and operated to control dispersal of the waste by wind, where necessary, by means other than wetting;
- d. The pile will not generate leachate through decomposition or other reactions; and
- e. The structures, buildings, and ramps shall be of concrete, brick, or other material that can be easily cleaned.

## 2. Exposed waste piles.

a. Liners. A waste pile (except for an existing portion of a waste pile) shall have:

(1) A liner that is designed, constructed, and installed to prevent any migration of wastes out of the pile into the adjacent soil or ground water or surface water at any time during the active life (including the closure period) of the waste pile. The liner shall be:

- (a) Constructed of materials that have appropriate chemical properties and sufficient strength and thickness to prevent failure due to pressure gradients (including static head and external hydrogeologic forces), physical contact with the waste or leachate to which they are exposed, climatic conditions, the stress of installation, and the stress of daily operation;
- (b) Placed upon a foundation or base capable of providing support to the liner and resistance to pressure gradients above and below the liner to prevent failure of the liner due to settlement, compression, or uplift; and
- (c) Installed to cover all surrounding earth likely to be in contact with the waste or leachate; and

(2) A leachate collection and removal system immediately above the liner that is designed, constructed, maintained, and operated to collect and remove leachate from the pile. The design and operating conditions shall ensure that the leachate depth over the liner does not exceed one foot at its lowest point. The leachate collection and removal system shall be:

- (a) Constructed of materials that are:

(i) Chemically resistant to the waste managed in the pile and the leachate expected to be generated; and

(ii) Of sufficient strength and thickness to prevent collapse under the pressures exerted by overlaying wastes, waste cover materials, and by any equipment used at the pile; and

(b) Designed and operated to function without clogging through the scheduled closure of the waste pile.

*(c) Leachate generated by the unit must be stored in lined impoundments or tanks sized using good engineering practice.*

b. The owner or operator will be exempted from the requirements of subdivision 2 a of this subsection if the director finds, based on a demonstration by the owner or operator, that alternate design and operating practices, together with location characteristics, will prevent the migration of any waste constituents into the ground water or surface water at any future time. In deciding whether to grant an exemption, the director will consider:

(1) The nature and quantity of the wastes;

(2) The proposed alternate design and operation;

(3) The hydrogeologic setting of the facility, including attenuating capacity and thickness of the liners and soils present between the pile and ground water or surface water; and

(4) All other factors which would influence the quality and mobility of the leachate produced and the potential for it to migrate to ground water or surface water;

c. During construction or installation, liners shall be inspected by the owner's or operator's construction quality assurance personnel for uniformity, damage, and imperfections (e.g., holes, cracks, thin spots, or foreign materials).

d. Immediately after construction or installation.

(1) Synthetic liners shall be inspected to ensure tight seams and joints and the absence of tears, punctures, or blisters; and

(2) Soil-based liners shall be inspected for imperfections including lenses, cracks, channels, root holes, or other structural non-uniformities that may cause an increase in the hydraulic conductivity of the liner.

*(3) Any imperfections in the alternate liner design approved by the director will be repaired.*

e. The owner or operator shall design, construct, operate, and maintain a run-on control system capable of preventing flow onto the active portion of the pile during peak discharge from at least a 25-year storm.

f. The owner or operator shall design, construct, operate, and maintain a run-off management system to collect and

control at least the water volume resulting from a 24-hour, 25-year storm.

3. Area, facilities and appropriate equipment shall be provided to segregate undesirable components from the incoming solid waste to be processed.

~~4. Roads serving the unloading, treatment, and storage areas shall be of all-weather construction.~~

~~5.~~ 4. The storage or treatment units shall be designed to reduce the potential for fires and migration of vectors, and to prevent escape of wastes, washwaters, waste decomposition odors, dust, and litter from the facility. *The storage and treatment units will be designed to withstand the physical, chemical, and biological characteristics of the waste managed.*

~~6.~~ 5. Materials and energy recovery, incineration, or thermal treatment facilities that treat or store materials in piles shall be provided with:

a. Sufficient internal storage areas for unprocessed incoming solid waste to ensure an environmentally sound operation and afford sufficient space to allow for proper processing of maximum anticipated daily incoming solid waste.

b. Areas and appropriate equipment to segregate nonrecoverable or otherwise undesirable components from the solid waste being processed.

c. Fire alarm and protection systems capable of detecting, controlling and extinguishing any and all fires shall be provided.

d. Facilities shall be designed with perimeter security fencing and gate controls to prevent unauthorized access to the site.

#### D. Operation.

1. No ~~uncontainerized~~ putrescible solid waste shall remain at the storage and/or treatment facility at the end of the working day unless it is stored in *lined or covered waste storage areas or*, interim transportation vehicles (trailers, roll-off containers) designed specifically for storage.

2. A written operating plan *for the waste management facility* shall be prepared covering at the minimum:

a. Facility housekeeping, on-site traffic control, schedules for waste delivery vehicle flow, wastewater/*leachate* collection, storm water collection, vector control, odor control, *dust suppression*, noise control, and methods of enforcement of traffic flow plans for the waste delivery vehicles;

b. A description of types of wastes that will be managed at the facility, of the storage or treatment activity, of any required testing including test methods and frequencies, and sampling techniques.

c. *A description of the management and disposition of waste materials will be provided that addresses waste materials that are undesirable and will not be received at the facility.*

*d. Descriptions of first-in, first-out waste management procedures to ensure that the oldest waste materials being stored are sent off-site for re-use or disposal prior to newer materials.*

3. A written contingency plan shall be prepared covering operating procedures to be employed during periods of non-operation. This plan shall set forth procedures to be employed in the event of equipment breakdown which will require standby equipment, extension of operating hours, or diversion of solid waste to other facilities.

4. Leachate and run-off that have been in contact with the contents of the waste pile shall not be permitted to drain or discharge into surface waters except when authorized under a VPDES permit issued pursuant to 9 VAC 25-31.

5. No regulated hazardous wastes shall be accepted for processing unless they are specifically exempted by the provisions of the Virginia Hazardous Waste Management Regulations (9 VAC 20-60).

6. Collection and holding facilities associated with run-on and run-off control systems shall be emptied or otherwise managed expeditiously after storms to maintain design capacity of the system.

7. If the pile contains any particulate matter which may be subject to wind dispersal, the owner or operator shall cover or otherwise manage the pile to control wind dispersal.

8. While a waste pile is in operation, it shall be inspected weekly and after storms to detect evidence of any of the following:

a. Deterioration, malfunctions, or improper operation of run-on and run-off control systems;

b. Proper functioning of wind dispersal control systems, where present; and

c. The presence of leachate in and proper functioning of leachate collection and removal systems, where present.

9. Incompatible wastes, or incompatible wastes and materials shall not be placed in the same pile.

*10. Roads serving the unloading, treatment, and storage areas shall be maintained to be passable in all weather by ordinary vehicles when the facility is operating. All operation areas and units shall be accessible.*

#### E. Closure.

1. Closure standards. The owner or operator shall close his facility in a manner that minimizes the need for further maintenance, and controls, minimizes or eliminates, to the extent necessary to protect human health and the environment, the post-closure escape of uncontrolled leachate, surface runoff, or waste decomposition products to the ground water, surface water, or to the atmosphere.

a. At closure, the owner or operator shall remove or decontaminate all waste residues, contaminated containment system components (liners, etc.), contaminated subsoils, and structures and equipment contaminated with waste and leachate.

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b. If, after removing or decontaminating all residues and making all reasonable efforts to effect removal or decontamination of contaminated components, subsoils, structures, and equipment as required in subdivision 1 a of this subsection, the owner or operator finds that not all contaminated subsoils can be practicably removed or decontaminated, he shall close the facility and perform post-closure care in accordance with the closure and post-closure care requirements of Part V of this chapter.

## 2. Closure plan and amendment of plan.

a. The owner or operator of a waste pile shall have a written closure plan. This plan shall identify the steps necessary to completely close the unit at its full operation under the permit conditions. The closure plan shall include at least a schedule for final closure including, as a minimum, the anticipated date when wastes will no longer be received, the date when completion of final closure is anticipated, and intervening milestone dates which will allow tracking of the progress of closure.

b. The owner or operator may amend his closure plan at any time during the active life of the facility. The owner or operator shall so amend his plan any time changes in operating plans or facility design affects the closure plan.

c. The owner or operator shall notify the department whenever an amended closure plan has been prepared and placed in the operating record. *A copy of the closure plan will be maintained at the facility and provided to the department upon request.*

d. Prior to beginning closure of each solid waste disposal unit, the owner or operator shall notify the department of the intent to close.

e. The owner or operator shall provide to the department a certification from a registered professional engineer that the facility has been closed in accordance with the closure plan.

3. Time allowed for closure. The owner or operator shall complete closure activities in accordance with the closure plan and within six months after receiving the final volume of wastes. The director may approve a longer closure period if the owner or operator can demonstrate that the required or planned closure activities will, of necessity, take longer than six months to complete; and that he has taken all steps to eliminate any significant threat to human health and the environment from the unclosed but inactive facility.

4. *Within 15 days of the last receipt of waste*, the owner or operator shall post one sign notifying all persons of the closing, and providing a notice prohibiting further receipt of waste materials. *The sign will remain in place until closure activities are complete.* Further, suitable barriers shall be installed at former accesses to prevent new waste from being deposited.

5. Inspection. The department shall inspect all solid waste management facilities at the time of closure to confirm that the closing is complete and adequate. It shall notify the owner of a closed facility, in writing, if the closure is satisfactory, and shall require any necessary construction or

such other steps as may be necessary to bring unsatisfactory sites into compliance with this chapter.

## 9 VAC 20-80-480. Applicability.

A. No person shall construct, operate or modify a solid waste management facility in this Commonwealth without a permit issued by the director unless otherwise specified in subsection D of this section *or 9 VAC 20-80-485.*

B. Each solid waste management facility permit shall be limited to one site and shall be non-transferable between sites.

C. Issuance of a new permit is required when there is:

1. Any new solid waste management facility; *or*

2. Any change in design or process of a solid waste management facility that will, in the opinion of the director, result in a substantially different type of facility; *or*

3. Any expansion beyond the facility boundary, expansion of the waste management unit boundary or increase in the capacity of the facility specified in the existing permit. Expansions beyond the facility boundary solely for remedial purposes that do not provide for additional waste disposal area will be considered permit amendments for the purpose of establishing permit fees under the provisions of 9 VAC 20-90-40 *et seq.* For all other considerations, expansions for remedial purposes will be considered a new permit.

D. Exemptions from permit requirements. Notwithstanding the above, the following shall not require a permit:

1. The management of materials excluded under 9 VAC 20-80-150 or conditionally exempt under 9 VAC 20-80-160;

2. The solid waste management practices conditionally exempt under 9 VAC 20-80-60 D;

3. Use or reuse or temporary storage incidental to use or reuse whereby material which would otherwise be solid waste is used or reused, or prepared for use or reuse, as an ingredient in an industrial process to make a product, or as an effective substitute for a commercial product;

NOTE: This exemption does not include reclamation processes, storage prior to reclamation, and storage of speculatively accumulated materials.

4. The management of wastes regulated under other regulations of the department as specified in 9 VAC 20-80-120; *or*

5. The management of wastes in remediation waste management units regulated under 9 VAC 20-80-450.

E. Variances. The director may grant a variance from any regulation contained in this part to a permittee provided the requirements of Part IX (9 VAC 20-80-730 *et seq.*) of this chapter are met.

## 9 VAC 20-80-485. Permits-by-rule and other special permits.

A. Permits by rule. Unless the owner or operator of the following facilities chooses to apply for and receive a full permit, he shall be deemed to have a solid waste

management facility permit notwithstanding any other provisions of Part VII (9 VAC 20-80-480 et seq.) of this chapter, except 9 VAC 20-80-500 B 2 and B 3, if the conditions listed are met:

1. Transfer stations. The owner or operator of a transfer station, if he:

- a. Notifies the director of his intent to operate such a facility and provides to the department documentation required under 9 VAC 20-80-500 B;
- b. Provides the director with a certification that the facility meets the siting standards of 9 VAC 20-80-340 B;
- c. Furnishes to the director a certificate signed by a registered professional engineer that the facility has been designed and constructed in accordance with the standards of 9 VAC 20-80-340 C;
- d. Submits to the director an operational plan describing how the standards of 9 VAC 20-80-340 D will be met;
- e. Submits to the director a closure plan describing how the standards of 9 VAC 20-80-340 E will be met; and
- f. Submits to the director the proof of financial responsibility if required by the Financial Assurance Regulations for Solid Waste Disposal, Transfer, and Treatment Facilities (9 VAC 20-70); and
- g. Submits to the director the results of the public participation effort conducted in accordance with the requirements contained in subdivision 5 of this subsection.

2. Materials recovery facilities. The owner or operator of a materials recovery facility, if the owner or operator:

- a. Notifies the director of his intent to operate such a facility and provides the department with documentation required under 9 VAC 20-80-500 B;
- b. Provides the director with a certification that the facility meets the siting standards of 9 VAC 20-80-360 B, as applicable;
- c. Furnishes to the director a certificate signed by a registered professional engineer that the facility has been designed and constructed in accordance with the standards of 9 VAC 20-80-360 C, as applicable;
- d. Submits to the director an operational plan describing how the standards of 9 VAC 20-80-360 D, as applicable, will be met;
- e. Submits to the director a closure plan describing how the standards of 9 VAC 20-80-360 E, as applicable, will be met;
- f. Submits to the director the proof of financial responsibility if required by the Financial Assurance Regulations for Solid Waste Disposal, Transfer, and Treatment Facilities (9 VAC 20-70); and
- g. Submits to the director the results of the public participation effort conducted in accordance with the

requirements contained in subdivision 5 of this subsection; and

h. In addition to the above, in the case of facilities engaged in reclamation of petroleum-contaminated materials, submits to the director:

- (1) A copy of the facility permit issued in accordance with the regulations promulgated by the of Air Pollution Control Board when applicable; and
- (2) A description how the requirements of 9 VAC 20-80-700 will be met.

i. Existing soil reclamation facilities which became operational prior to March 15, 1993, on the basis of written approval from the director, are considered to be operating under a permit-by-rule.

3. Energy recovery, thermal treatment, or incineration facility. The owner or operator of an energy recovery, thermal treatment, or incineration facility, if he:

- a. Notifies the director of his intent to operate such a facility and provides to the department documentation required under 9 VAC 20-80-500 B;
- b. Provides the director with a certification that the facility meets the siting standards of 9 VAC 20-80-370 B, as applicable;
- c. Furnishes to the director a certificate signed by a registered professional engineer that the facility has been designed and constructed in accordance with the standards of 9 VAC 20-80-370 C, as applicable; and
- d. Submits to the director an operational plan describing how the standards of 9 VAC 20-80-370 D, as applicable, will be met.
- e. Submits to the director a closure plan describing how the standards of 9 VAC 20-80-370 E, as applicable, will be met;
- f. Submits to the director the proof of financial responsibility if required by the Financial Assurance Regulations for Solid Waste Disposal, Transfer, and Treatment Facilities (9 VAC 20-70); and
- g. Furnishes to the director a copy of the facility permit issued in accordance with the regulations promulgated by the Air Pollution Control Board.
- h. In addition to the above, in the case of thermal treatment facilities engaged in reclamation of petroleum-contaminated materials, submits to the director a description of how the requirements of 9 VAC 20-80-700 will be met.

4. Composting facilities. The owner or operator of all Type A or Type B facilities that receive no more than 700 tons per quarter of compostable materials, if he:

- a. Notifies the director of his intent to operate such a facility and provides to the department documentation required under 9 VAC 20-80-500 B;

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- b. Provides the director with the description of the type of facility and the classification of materials that will be composted as classified under 9 VAC 20-80-330 A 4;
- c. Provides the director with a certification that the facility meets the siting standards of 9 VAC 20-80-330 B;
- d. Furnishes to the director a certificate signed by a registered professional engineer that the facility has been designed and constructed in accordance with the standards of 9 VAC 20-80-330 C;
- e. Submits to the director an operational plan describing how the standards of 9 VAC 20-80-330 D will be met;
- f. Submits to the director a closure plan describing how the standards of 9 VAC 20-80-330 E will be met;
- g. Submits to the director the proof of financial responsibility if required by the Financial Assurance Regulations for Solid Waste Disposal, Transfer, and Treatment Facilities (9 VAC 20-70); and
- h. Submits to the director the results of the public participation effort conducted in accordance with the requirements contained in subdivision 5 of this subsection.

**5. Waste piles. The owner or operator of a waste pile, if the owner or operator:**

- a. *Notifies the director of his intent to operate such a facility and provides the department with documentation required under 9 VAC 20-80-500 B;*
- b. *Provides the director with a certification that the facility meets the siting standards of 9 VAC 20-80-400 B, as applicable;*
- c. *Furnishes to the director a certificate signed by a registered professional engineer that the facility has been designed and constructed in accordance with the standards of 9 VAC 20-80-400 C, as applicable;*
- d. *Submits to the director an operational plan, including a contingency plan, describing how the standards of 9 VAC 20-80-400 D, as applicable, will be met;*
- e. *Submits to the director a closure plan describing how the standards of 9 VAC 20-80-400 E, as applicable, will be met;*
- f. *Submits to the director the proof of financial responsibility if required by the Financial Assurance Regulations for Solid Waste Facilities (9 VAC 20-70);*
- g. *Submits to the director the results of the public participation effort conducted in accordance with the requirements contained in subdivision 6 of this subsection; and*
- h. *Submits to the director a copy of the facility's VPDES permit if applicable.*

**5- 6. Public participation.**

- a. Before the initiation of any construction at the facility under subdivision 1, 2, 3, or 4 of this subsection, the owner or operator shall publish a notice once a week for

two consecutive weeks in a major local newspaper of general circulation informing the public that he intends to construct and operate a facility eligible for a permit-by-rule. The notice shall include:

- (1) A brief description of the proposed facility and its location;
- (2) A statement that the purpose of the public participation is to acquaint the public with the technical aspects of the facility and how the standards and the requirements of this chapter will be met, to identify issues of concern, to facilitate communication and to establish a dialogue between the permittee and persons who may be affected by the facility;
- (3) Announcement of a 30-day comment period, in accordance with subdivision 5 6 d of this subsection, and the name, telephone number, and address of the owner's or operator's representative who can be contacted by the interested persons to answer questions or where comments shall be sent;
- (4) Announcement of the date, time, and place for a public meeting held in accordance with subdivision 5 6 c of this subsection; and
- (5) Location where copies of the documentation to be submitted to the department in support of the permit-by-rule notification and any supporting documents can be viewed and copied.

b. The owner or operator shall place a copy of the documentation and support documents in a location accessible to the public in the vicinity of the proposed facility.

c. The owner or operator shall hold a public meeting not earlier than 15 days after the publication of the notice required in subdivision 5 6 a of this subsection and no later than seven days before the close of the 30-day comment period. The meeting shall be held to the extent practicable in the vicinity of the proposed facility.

d. The public shall be provided 30 days to comment on the technical and the regulatory aspects of the proposal. The comment period will begin on the date the owner or operator publishes the notice in the local newspaper.

e. The requirements of this section do not apply to the owners or operators of a material or energy recovery facility, an incinerator or a thermal treatment unit that has received a permit from the department based on the regulations promulgated by the State Air Pollution Control Board or State Water Control Board that required facility-specific public participation procedures.

6. Upon receiving the certifications and other required documents, including the results of the public meeting and the applicant's response to the comments received, the director will acknowledge their receipt within 10 working days. If the applicant's submission is administratively incomplete, the letter will state that the facility will not be considered to have a permit-by-rule until the missing certifications or other required documentation is submitted. At the time of the initial receipt or at a later date, the director

may require changes in the documents designed to assure compliance with the standards of Part VI (9 VAC 20-80-320 et seq.) and Part VIII (9 VAC 20-80-630 et seq.), if applicable. Should such changes not be accomplished by the facility owner or operator, the director may require the operator to submit the full permit application and to obtain a regular solid waste management facility permit.

7. Change of ownership. A permit by rule may not be transferred by the permittee to a new owner or operator. However, when the property transfer takes place without proper closure, the new owner shall notify the department of the sale and fulfill all the requirements contained in subdivisions 1 through 4 of this subsection with the exception of those dealing with the financial assurance. Upon presentation of the financial assurance proof required by 9 VAC 20-70 by the new owner, the department will release the old owner from his closure and financial responsibilities and acknowledge existence of the new permit by rule in the name of the new owner.

8. Facility modifications. The owner or operator of a facility operating under a permit by rule may modify its design and operation by furnishing the department a new certificate prepared by the professional engineer and new documentation required under subdivision 1, 2, 3, ~~or 4~~, or 5 as applicable, and ~~§ 6~~ of this subsection. Whenever modifications in the design or operation of the facility affect the provisions of the approved closure plan, the owner or operator shall also submit an amended closure plan. Should there be an increase in the closure costs, the owner or operator shall submit a new proof of financial responsibility as required by the Financial Assurance Regulations for Solid Waste Disposal, Transfer, and Treatment Facilities (9 VAC 20-70).

9. Loss of permit by rule status. In the event that a facility operating under a permit by rule violates any applicable siting, design and construction, or closure provisions of Part VI of this chapter, the owner or operator of the facility will be considered to be operating an unpermitted facility as provided for in 9 VAC 20-80-80 and shall be required to either obtain a new permit as required by Part VII or close under Part V or VI of this chapter, as applicable.

10. Termination. The director shall terminate permit by rule and shall require closure of the facility whenever he finds that:

- a. As a result of changes in key personnel, the requirements necessary for a permit by rule are no longer satisfied;
- b. The applicant has knowingly or willfully misrepresented or failed to disclose a material fact in his disclosure statement, or any other report or certification required under this chapter, or has knowingly or willfully failed to notify the director of any material change to the information in the disclosure statement;
- c. Any key personnel have been convicted of any of the crimes listed in § 10.1-1409 of the Code of Virginia, punishable as felonies under the laws of the Commonwealth, or the equivalent of them under the laws of any other jurisdiction; or has been adjudged by an

administrative agency or a court of competent jurisdiction to have violated the environmental protection laws of the United States, the Commonwealth or any other state and the director determines that such conviction or adjudication is sufficiently probative of the permittee's inability or unwillingness to operate the facility in a lawful manner; or

d. The operation of the facility is inconsistent with the facility's operations manual and the operational requirements of the regulations.

B. Emergency permits. Notwithstanding any other provision of Part VII of this chapter, in the event the director finds an imminent and substantial endangerment to human health or the environment, the director may issue a temporary emergency permit to a facility to allow treatment, storage, or disposal of solid waste for a nonpermitted facility or solid waste not covered by the permit for a facility with an effective permit. Such permits:

1. May be oral or written. If oral, it shall be followed within five days by a written emergency permit;
2. Shall not exceed 90 days in duration;
3. Shall clearly specify the solid wastes to be received, and the manner and location of their treatment, storage, or disposal;
4. Shall be accompanied by a public notice including:
  - a. Name and address of the office granting the emergency authorization;
  - b. Name and location of the facility so permitted;
  - c. A brief description of the wastes involved;
  - d. A brief description of the action authorized and reasons for authorizing it;
  - e. Duration of the emergency permit; and
5. Shall incorporate, to the extent possible and not inconsistent with the emergency situation, all applicable requirements of this chapter.

C. Experimental facility permits.

1. The director may issue an experimental facility permit for any solid waste treatment facility which proposes to utilize an innovative and experimental solid waste treatment technology or process for which permit standards for such experimental activity have not been promulgated under Part VI of this chapter. Any such permit shall include such terms and conditions as will assure protection of human health and the environment. Such permits:
  - a. Shall provide for the construction of such facilities based on the standards shown in 9 VAC 20-80-470, as necessary;
  - b. Shall provide for operation of the facility for no longer than one calendar year unless renewed as provided in subdivision 3 of this subsection;
  - c. Shall provide for the receipt and treatment by the facility of only those types and quantities of solid waste

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# Proposed Regulations

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which the director deems necessary for purposes of determining the efficiency and performance capabilities of the technology or process and the effects of such technology or process on human health and the environment; and

d. Shall include such requirements as the director deems necessary to protect human health and the environment (including, but not limited to, requirements regarding monitoring, operation, closure and remedial action), and such requirements as the director deems necessary regarding testing and providing of information to the director with respect to the operation of the facility.

2. For the purpose of expediting review and issuance of permits under this subsection, the director may, consistent with the protection of human health and the environment, modify or waive permit application and permit issuance requirements in Part VII of this chapter except that there may be no modification or waiver of regulations regarding local certification, disclosure statement requirements, financial responsibility (including insurance) or of procedures regarding public participation.

3. Any permit issued under this subsection may be renewed not more than three times. Each such renewal shall be for a period of not more than one calendar year.

V.A.R. Doc. No. R04-17; Filed November 10, 2004, 10:57 a.m.

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## TITLE 12. HEALTH

### DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

**Title of Regulation:** 12 VAC 30-141. Family Access to Medical Insurance Security Plan (amending 12 VAC 30-141-500).

**Statutory Authority:** § 32.1-351 of the Code of Virginia; Item 324 H of Chapter 1042 of the 2003 Acts of Assembly.

**Public Hearing Date:** N/A -- Public comments may be submitted until January 28, 2005.

(See Calendar of Events section for additional information)

**Agency Contact:** Linda L. Nablo, Director, Child Health Insurance Programs/FAMIS Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 225-4212, FAX (804) 786-1680, or e-mail Linda.Nablo@dmas.virginia.gov.

**Basis:** Section 32.1-351 of the Code of Virginia authorizes the board or director to "adopt, promulgate and enforce such regulations pursuant to the Administrative Process Act (§ 2.2-400 et. seq.) as may be necessary for the implementation and administration of the Family Access to Medical Insurance Security Plan."

Chapter 1042 of the 2003 Appropriation Act, (Item 324 H) mandated that DMAS promulgate regulations to implement a

program for FAMIS to require "prior authorization of prescription drugs for noninstitutionalized recipients when more than nine unique prescriptions have been prescribed within a 180-day period."

Section 2102(a)(7) of the federal Social Security Act requires states "to assure the quality and appropriateness of care" in Title XXI SCHIP programs.

Finally, 42 CFR 457.495(d) requires prior authorization decisions to be in "accordance with the medical needs of the patient."

**Purpose:** The purpose of this action is to implement a program of retrospective and prospective utilization review of pharmacy services for noninstitutionalized fee-for-service and PCCM FAMIS enrollees who are prescribed more than nine unique prescriptions within a 180-day period.

FAMIS covers children who lack access to health insurance and with income levels at or below 200% of the federal poverty level. High numbers of prescription drugs can pose particular hazards to their health and safety.

**Substance:** The new provisions require retrospective review of drugs for noninstitutionalized FAMIS recipients receiving fee-for-service benefits when they exceed nine unique prescriptions within a 180-day period. In addition, the program will require the dispensing pharmacist to obtain prior authorization before dispensing any prescription that meets the threshold requirements and that may cause a potentially harmful drug-to-drug Level One interaction. Unlike the Prospective Drug Utilization Review process, which allows the dispensing pharmacist to override the drug interaction alert, when an enrollee exceeds the threshold of nine unique prescriptions and the enrollee's drug regimen contains a potentially harmful drug-to-drug Level One interaction, the threshold program does not permit the dispensing pharmacist to override the prior authorization requirement. Rather, the pharmacist is required to obtain a prior authorization before dispensing the prescribed drug. This program does not apply to FAMIS recipients enrolled in managed care organizations.

High drug thresholds for FAMIS enrollees is addressed in both the existing emergency regulation concerning this issue and the FAMIS State Plan amendment, submitted to CMS for approval on June 15, 2004. The amendment describes the limitations and utilization review requirements for noninstitutionalized FAMIS enrollees who receive high numbers of prescriptions for legend drugs. The 2003 General Assembly mandated this modification to the FAMIS regulations for pharmacy services, and directs DMAS to implement this modification.

**Issues:** There are no disadvantages to the public in this change. The greatest advantage to the public is an increase in the health and safety of FAMIS enrollees who receive threshold review. FAMIS enrollees can be expected to benefit the most from this change because the higher level of scrutiny of their drug profiles will better ensure their health and safety.

**Department of Planning and Budget's Economic Impact Analysis:** The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process

Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. Pursuant to Item 324 H of the 2003 Appropriation Act, the proposed changes permanently implement a utilization review program for the use of high numbers of prescription drugs by noninstitutionalized Family Access to Medical Insurance Plan (FAMIS) fee-for-service recipients. The proposed changes have been implemented under emergency regulations since June 2004.

Estimated economic impact. The proposed regulations establish permanent utilization review requirements in cases where FAMIS fee-for-service recipients use high numbers of prescription drugs. Item 324 H of the 2003 Appropriation Act mandates the Department of Medical Assistance Services (DMAS) to require prior authorization of prescription drugs for FAMIS noninstitutionalized recipients when more than nine unique prescriptions have been prescribed within a 180-day period.

Individual dispensing pharmacies do not have access to all the information on drugs that may be dispensed through other pharmacies. Also, utilization review of such cases requires case-by-case analysis of the recipients' drug profiles by a trained pharmacist, as it cannot be computerized. With the proposed changes, when the tenth drug is prescribed, a retrospective drug utilization review is triggered. If the tenth drug contraindicates with the other drugs, the prescribing physician is notified and is requested to respond. Furthermore, if the tenth prescription indicates a level one drug-to-drug interaction, prior authorization is required.

Currently, there are 7,232 FAMIS children affected by the proposed changes. DMAS estimates approximately 2.0% (145) to 5.0% (362) of the recipients to have a tenth prescription within the 180-day period and trigger the retrospective utilization review. Of these cases, approximately 6 to 12 cases are expected to involve a drug contraindication in which case the dispensing pharmacist may have to make a phone call to the prescribing physician and the prescribing physician may have to respond to a written notice, possibly avoiding a prescription error. Finally, very few of these 6 to 12 cases are expected to involve a level one drug-to-drug interaction triggering a prior authorization, as DMAS has not been aware of any such cases within the affected population.

Required retrospective and prospective utilization reviews are conducted through a contractor for an estimated cost of \$27,000 (state and federal) per year. One of the main benefits of the proposed change is the reduced potential for drug overuse, fraud, and abuse. DMAS expects to save \$15,000 to \$150,000 in state and federal shares of drug reimbursements annually by the review of excess utilization

cases. Also, recipients with high utilization of drugs are often very sick children. A review of their complete drug profiles may prevent some drug contraindications, overdoses, and inappropriate dosages and consequently reduce the potential risks to health and safety of these children.

Businesses and entities affected. The proposed regulations apply to 7,232 FAMIS enrollees, 27,000 medical providers, and 1,600 pharmacy providers.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The proposed regulations may increase the demand for labor by the contractor to perform 145-362 expected utilization reviews. Since only 6 to 12 cases may require an action by the pharmacists and the prescribers, no significant employment effect on medical and pharmacy providers is expected.

Effects on the use and value of private property. No significant effect on the use and value of private property is expected.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The agency concurs with the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning the Utilization Review of High Drug Thresholds for FAMIS.

Preamble:

*The proposed amendments provide that FAMIS enrollees who are prescribed more than nine unique prescriptions in a 180-day period shall receive retrospective utilization review of their drug profiles. In addition, for enrollees who meet the threshold requirement and where the utilization reveals their drug regimen could cause a potentially harmful drug-to-drug Level One interaction, the program will require the dispensing pharmacist to obtain prior authorization before dispensing the prescribed drug.*

**12 VAC 30-141-500. Benefits reimbursement.**

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

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

C. Reimbursement to MCHIPs shall be determined on the basis of the estimated cost of providing the MCHIP benefit package and services to an actuarially equivalent population.

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MCHIP rates will be determined annually and published 30 days prior to the effective date.

## D. Exceptions.

1. Prior authorization is required after five visits in a fiscal year for physical therapy, occupational therapy and speech therapy provided by home health providers and outpatient rehabilitation facilities and for home health skilled nursing visits. Prior authorization is required after five visits for outpatient mental health visits in the first year of service and prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging, Computer Axial Tomography scans, or Positron Emission Tomography scans.

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

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

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

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

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

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

8. *Reimbursement for covered prescription drugs for noninstitutionalized FAMIS recipients receiving the fee-for-service or PCCM benefits will be subject to review and prior authorization when their current number of prescriptions exceeds nine unique prescriptions within 180 days, and as may be further defined by the agency's guidance documents for pharmacy utilization review and the prior authorization program. The prior authorization process shall be applied consistent with the process set forth in 12 VAC 30-50-210 A 7.*

VA.R. Doc. No. R04-142; Filed November 4, 2004, 2:14 p.m.

## TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

### BOARD OF DENTISTRY

#### REPROPOSED

**REGISTRAR'S NOTICE:** At its June 18, 2004, meeting, the Board of Dentistry substantially amended the proposed regulations originally proposed in 20:8 VA.R. 718-731 December 29, 2003, and is soliciting comments on these changes. Additional changes to the proposed regulations are bracketed. Public comments will be received until January 28, 2005.

**Title of Regulation:** 18 VAC 60-20. Regulations Governing the Practice of Dentistry and Dental Hygiene (amending 18 VAC 60-20-10, 18 VAC 60-20-16, 18 VAC 60-20-20, 18 VAC 60-20-50 through [ ~~18 VAC 60-20-90~~ 18 VAC 60-20-100 ], 18 VAC 60-20-105, 18 VAC 60-20-110, 18 VAC 60-20-120, [ 18 VAC 60-20-190, ] 18 VAC 60-20-195; adding 18 VAC 60-20-106, 18 VAC 60-20-107, 18 VAC 60-20-135; repealing 18 VAC 60-20-130).

**Statutory Authority:** § 54.1-2400 and Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 of the Code of Virginia.

**Public Hearing Date:** January 21, 2005 - 9 a.m.

Public comments may be submitted until January 28, 2005.  
(See Calendar of Events section for additional information)

**Agency Contact:** Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114, or e-mail elaine.yeatts@dhp.virginia.gov.

**Basis:** Section 54.1-2400 of the Code of Virginia provides the board the authority to promulgate regulations to administer the regulatory system under its authority to license and regulate dentists and dental hygienists as found in Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 of the Code of Virginia.

**Purpose:** As a result of an extensive periodic review of its regulations, the board has proposed amendments to clarify or simplify certain provisions for applicants and licensees and to eliminate unnecessary examinations. Educational criteria, currently applied by the board and required by the Code of Virginia, are spelled out in regulation for a clearer understanding by applicants for licensure. With the intent of protecting the live patients on which the examination is conducted, applicants who fail the clinical examination three times would be required to take additional clinical hours to prepare them for the specific area(s) failed.

The primary intent of amending regulations is to more clearly specify the requirements for administration of sedation or anesthesia. Dentists who administer any form of analgesia, sedation or anesthesia in a dental office must have specific knowledge and training in delivery of those agents and in the monitoring and recovery of a patient. Likewise, it is essential

for the dentist to be appropriately prepared and equipped to respond to emergencies that may arise if a patient's breathing or responses are compromised. Both the dentist and the ancillary personnel should be proficient in handling related complications or emergencies. Therefore, requirements for training, emergency equipment and techniques, and monitoring are necessary to protect the health and safety of patients in dental offices.

Substance: Definitions have been updated to reflect current terminology, particularly that pertaining to revised regulations for anesthesia and sedation and to eliminate terms that were no longer being used. Amendments to the requirements for dental education will reflect the current board interpretation of an accredited or approved dental program, which is either a pre-doctoral dental education program or a one- or two-year post-doctoral dental education program.

Changes in examination requirements offer additional options for persons who took the board-approved examinations five or more years prior to applying for licensure in Virginia. In addition, there are new requirements for remediation for candidates who have failed the licensure examination three times. Rather than requiring passage of a jurisprudence examination, the board will now require that the applicant read and understand the laws and regulations governing the practice of dentistry in Virginia.

Regulations for anesthesia, sedation and analgesia have been rewritten and reorganized to make clear the application of the rules in various settings, the educational and training qualifications of the dentist and dental assistants, the equipment and monitoring needed for each level, and the discharge criteria for ensuring the safety of the patient.

Issues: Advantages and disadvantages to the public: Dentists are increasingly utilizing some form of analgesia, sedation or anesthesia to perform dental procedures with the maximum amount of comfort to their patients. In addition, some oral and maxillofacial surgeons are performing cosmetic surgery in an office-based setting. While the board currently has regulations for anesthesia and sedation, there has been a growing concern that the practitioner qualifications, equipment and monitoring standards were not sufficient to ensure the safety of patients in a dental practice. Most dentists practice with an accepted standard of care, utilizing trained anesthesia providers, equipping their offices with essential rescue and monitoring equipment, and carefully selecting the appropriate anesthesia and informing the patient in advance. These regulations, however, will provide a clearer standard by which dentists are expected to practice and give patients a higher degree of safety when receiving office-based anesthesia. As insurers and practitioners encourage more procedures to be performed in an office-based practice or surgi-center rather than a hospital, these regulations will provide a definite advantage to patients, who typically do not have sufficient knowledge to judge whether the dentist and the facility are appropriately equipped and trained and whether adequate care is being taken to prepare and monitor their recovery. Since the regulations do not apply to the administration of local anesthesia, there should be no effect on the majority of general dentists and no disadvantages to the public in terms of limiting access or increasing cost.

Advantages and disadvantages to the agency: There are no specific advantages or disadvantages to the agency. Regulations that set standards for practice may create an opportunity for complaints for noncompliance, but under current laws and regulations, failure to appropriately provide and monitor anesthesia could be considered substandard care and subject the licensee to disciplinary action. The advantage of these regulations is derived from having more specific, objective standards on which to base such a decision or make findings in a disciplinary case involving sedation or anesthesia. However, with more complete and objective rules to follow, practitioners who are conscientious about their practice and protecting their patients should be able to avoid incidents of unprofessional conduct related to delivery of anesthesia.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The Board of Dentistry (board) proposes to: 1) allow applicants who successfully complete the board-approved examinations five or more years prior to the date of receipt of their applications to avoid retaking the exam if they complete board-approved continuing education, 2) allow applicants who successfully complete the board-approved examinations five or more years prior to the date of receipt of their applications to avoid retaking the exam if they have maintained continuous practice in 48 out of the past 60 months, 3) allow dental hygienists to provide a mailing address with a post office box numbers rather than a street address, 4) add sponsors to the list from which the board will approve continuing education credit, 5) eliminate the board's ongoing function in approving continuing education programs, 6) require that all licensure applicants submit a current report from the Healthcare Integrity and Protection Data Bank, 7) require candidates for dentistry licensure who have failed any section of the board-approved examination three times to complete a minimum of 14 hours of additional clinical training in each section of the examination to be retested, in order to be approved by the board to sit for the examination a fourth time, 8) require candidates for dental hygienist licensure who have failed any section of the board-approved examination three times to complete a minimum of 7 hours of additional clinical training in each section of the examination to be retested, in order to be approved by the board to sit for the examination a fourth time, 9) eliminate the examination on knowledge of Virginia's laws and regulations, 10) require dentists who administer general anesthesia or conscious sedation to hold current certification in advanced resuscitative techniques, such as Advanced Cardiac Life Support or

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Pediatric Advanced Life Support, 11) require that ancillary personnel who assist in the administration and monitoring of conscious or deep sedation have Basic Cardiac Life Support (CPR) certification or hold certification as a certified anesthesia assistant, 12) add one method and rescind another method for receiving radiation certification, 13) require all licensed dentists and dental hygienist to have training in CPR, 14) permit dental hygienists to carry over continuing education credits to the following year if they obtain more than the required minimum number of credits in a given year, 15) limit the number of continuing education hours that an individual applying for license reinstatement or reactivation must complete, 16) require that prior to administration of sedation or general anesthesia, the dentist shall obtain informed, written consent from the patient or other responsible party, and 17) make several clarifications.

Estimated economic impact. Exemptions from retaking the licensure examination. Unlike dental hygienists, dentists cannot obtain licensure by endorsement under these regulations. On the other hand, the dental examinations required by the board are those administered by the Southern Regional Testing Agency (SRTA).<sup>1</sup> In addition to Virginia, Arkansas, Georgia, Kentucky, South Carolina, and Tennessee are members of SRTA.<sup>2</sup> Dentists from these states will likely have passed the SRTA exams in order to have become licensed in their home state. If they passed the SRTA exams within the last five years, they will not need to retake the exams to obtain licensure in Virginia. The current regulations also permit applicants who successfully complete the board-approved examinations five or more years prior to the date of the board's receipt of their applications for licensure to waive retaking the board-approved examinations (SRTA) if they demonstrate that they have maintained continuous clinical, ethical, and legal practice since passing the approved exam. Thus, licensed dentists from Arkansas, Georgia, Kentucky, South Carolina, and Tennessee who obtained licensure by passing the SRTA exams and have maintained continuous clinical, ethical, and legal practice since can obtain a license in Virginia without having to take more examinations.

The board proposes to allow applicants who passed the board-approved (SRTA) examinations five or more years ago to waive retaking the exams if they have maintained clinical, ethical, and legal practice for 48 of the past 60 months, instead of the current continuous practice requirement. The board also proposes to permit applicants who passed the board-approved (SRTA) examinations five or more years ago and have not been in practice for at least 48 of the past 60 months to take board-approved continuing education in lieu of retaking the exams. The required continuing education consists of 15 hours for each year in which the applicant's license has been inactive, not to exceed a total of 45 hours; where at least 15 must be earned in the most recent 12 months and the remainder within the 36 months preceding the application. By relaxing the continuous practice requirement and by allowing continuing education credits to serve in lieu of retaking the SRTA examinations, more dentists currently licensed in Arkansas, Georgia, Kentucky, South

Carolina, and Tennessee may seek to become licensed in Virginia and provide dental services in the Commonwealth. To the extent that the proposed changes effectively increase the number of dentists from these states that obtain Virginia licensure and begin practicing in the Commonwealth, the supply of dental services in Virginia will increase. Increasing the supply of a good or service will tend to reduce its market price. If the cost of dental services is reduced, more people will be able to afford dental care, consequently receiving the benefit of improved health.

Typically, no demonstration of knowledge is required to obtain continuing education credits. Only attendance is mandated. Thus, accepting continuing education credits in lieu of retaking exams is effectively eliminating a requirement to demonstrate knowledge. On the other hand, accepting continuing education credits in lieu of retaking exams for dentists who are applying for licensure in Virginia and are licensed in Arkansas, Georgia, Kentucky, South Carolina, and Tennessee, but have practiced actively for less than four of the previous five years, treats these dentists more in line with Virginia dentists with inactive licensure status. Dentists with an inactive Virginia license must complete up to 45 hours of continuing education in order to reactivate their licenses and resume practice.

Dentists from all other states (non-SRTA states), including the neighboring states of Maryland and North Carolina, must take and pass examinations in order to obtain licensure in Virginia, regardless of their accomplishments and the content of the licensure-qualifying examinations they have passed in their home states. This discourages the potential entry of highly skilled dentists into Virginia. For example, excellent dentists based in the Maryland suburbs of Washington, D.C. may consider opening offices in Northern Virginia, but are discouraged from doing so due to the time and costs associated with taking additional licensure examinations in order to obtain Virginia licensure. Or for another example, say an outstanding dentist who has passed very rigorous licensure examinations in her home non-SRTA state is contemplating a move to the Commonwealth and practicing here because her spouse has received an interesting employment offer in Virginia. The time and costs required for preparation, as well as perhaps annoyance at being required to take unnecessary examinations, may discourage this highly qualified dentist from seeking licensure and providing dental services in Virginia.

Besides SRTA, there are three other regional examining boards: 1) the North East Regional Board (NERB), with member states Connecticut, Illinois, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, West Virginia, and the District of Columbia, 2) the Central Regional Dental Testing Service (CRDTS), with member states Colorado, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Wisconsin, and Wyoming, and 3) the Western Regional Examining Board (WREB), with member states Alaska, Arizona, Idaho, Montana, New Mexico, Oklahoma, Oregon, Texas, Utah, and Washington. The remaining ten states, Alabama, California, Delaware, Hawaii, Florida, Indiana, Louisiana, Mississippi, Nevada, and North Carolina do not belong to a regional board. Unless the NERB, CRDTS, and WREB exams, and the

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<sup>1</sup> Ibid

<sup>2</sup> Source: the Southern Regional Testing Agency Website, [www.sрта.org](http://www.sрта.org)

licensing exams for the unaligned states, are significantly less stringent than the SRTA exams, there is no health and safety justification for mandating that licensed dentists from these states who have passed their state's licensing exams take and pass the SRTA exams for Virginia licensure. By discouraging non-SRTA state dentists from seeking licensure in Virginia, the quantity and perhaps quality of dental services in Virginia are lower than they otherwise would be, while the costs of dental services are higher.

Discouraging highly skilled dentists from practicing in Virginia clearly reduces the supply of dental services in Virginia. If there are fewer suppliers of a good or service and the demand for the good or service has not changed, then it can be expected that the market price will increase.<sup>3</sup> Thus, by discouraging highly skilled dentists who have passed licensure examinations in other states that are at least as rigorous as Virginia's from providing dental services in the Commonwealth, the prices paid for dental services in Virginia are likely higher than they would otherwise be. If the cost of dental services is increased, fewer people are able to afford dental care; consequently fewer people will receive the health benefits of dental care.

The overall average quality of dental services may be reduced as well. This is the case for two reasons. First, discouraging dentists who have passed licensure examinations that are more rigorous than Virginia's from seeking licensure in the Commonwealth results in fewer dentists providing services in Virginia who have met and passed a higher standard indicating knowledge and skills than is required here. Second, when there is greater competition in the supply of a good or service, suppliers are under greater pressure to produce high quality in order to keep and obtain customers.

Dental hygienists' mailing address. Currently, dental hygienists are required to provide the board with their current resident address. The regulations specifically state, "No post office box numbers are accepted." Licensee information is posted on the Department of Health Professions' (department) website. Since no post office box numbers are accepted, the current requirement effectively requires dental hygienists to have their home address, including the street name and number, published on the Internet. Some dental hygienists have expressed serious privacy and safety concerns about having their home address readily available on the Internet. Such available information may increase the likelihood of harassment at home, for example. The board proposes to instead require that dental hygienists provide the board with their current mailing address. The "No post office box numbers are accepted" language is deleted. This proposal creates a net benefit since the hygienists' privacy and safety concerns are alleviated by the removal of the home street address requirement, and the board and department find the proposed required information to be adequate.

Continuing education. As stated above, dental hygienists must have 15 hours of continuing education each year. The board proposes to amend the regulations so that if a dental hygienist takes more than 15 hours of CE in a given year, she

can apply those hours in excess of 15 to the 15-hour requirement in the following year. This proposal is beneficial for dental hygienists in that it introduces flexibility in when they may schedule their continuing education. Since the timing of other responsibilities and opportunities may be less flexible, this potentially allows dental hygienists to use their time more productively.

These regulations contain a list of approved sponsors of continuing education. The board proposes to add The MCV Orthodontic and Research Foundation, The Dental Assisting National Board, the American Safety and Health Institute, accredited dental schools or specialty residency programs, and a regional testing agency when a licensee is serving as an examiner in a clinical exam to the list of sponsors from which the board will approve continuing education credit. These organizations will benefit in that being listed as an approved continuing education sponsor will likely increase demand by Virginia licensees for their courses, or in the case of the regional testing agencies, willingness to participate as an examiner in a clinical exam.

In the current list of approved continuing education sponsors, "any other board approved programs" is included. The board proposes to strike that statement from the list. According to the department, the review and approval process is time-consuming for staff and board members, and several of the existing approved organizations and entities will allow outside providers to offer continuing education courses one they approve them. Some potential continuing education sponsors may wish to become approved independent of the existing approved organizations and entities. These potential continuing education sponsors will incur some cost in that this option will no longer be available. The value of this option to potential continuing education sponsors is not known, thus an accurate comparison to the cost savings to the department and the board cannot be made.

Healthcare integrity and protection data bank report. The board proposes to require that all applicants for either dental or dental hygienist licensure submit a current report from the Healthcare Integrity and Protection Data Bank (HIDB). The HIDP report lists disciplinary actions in other states. The cost for the applicant is \$8.50.<sup>4</sup> By obtaining the report the board will be better able to be kept aware of possible past poor practice by applicants for licensure. The improved information on the applicant's work history will allow the board to better evaluate whether applicants are likely to put the public at risk due to unethical or grossly incompetent service. Since the cost for the applicant is relatively small, and the benefit to the Commonwealth is potentially large, this proposed amendment will likely produce a net benefit.

Remedial training. Under the current regulations, a candidate who repeatedly fails sections of the dental or dental hygienist licensure exams may continue to retake those sections until he passes. In regard to the dental licensure exam, the board proposes that "If the candidate has failed any section of the board-approved examination three times, he shall complete a minimum of 14 hours of additional clinical training in each section of the examination to be retested, in order to be

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<sup>3</sup> The U.S. Department of Justice, Federal Trade Commission report "Improving Health Care: A Dose of Competition," July 2004, points out "that limits on entry increase health care costs."

<sup>4</sup> Source: Department of Health Professions

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approved by the board to sit for the examination a fourth time." The proposed minimum amount of remedial clinical training for candidates who have failed a section of the dental hygienist exam three times is 7 hours. In dental and dental hygienist exams, candidates perform procedures on actual patients. The patients are typically individuals that have volunteered to receive dental work by students in exchange for reduced fees or no payment.<sup>5</sup>

Allowing examinees to repeatedly perform failing-quality dental work on live patients clearly has a negative impact on those patients. Requiring additional clinical training for candidates who repeatedly fail will likely reduce the amount of poor dental work performed on the patients receiving reduced fee dental services during examinations. This is the case for two reasons: 1) additional hours of training may result in improved performance, and 2) the additional time and cost may discourage some repeated exam-failing candidates from retaking the exam. The likely reduction in failing-quality dental and dental hygienist work is particularly beneficial for Virginians of lesser means, since people with fewer resources are more likely to choose dental services from dental students in exchange for reduced fees or no payment.

Additional clinical training costs about \$100 per hour for both dentists and dental hygienists.<sup>6</sup> Thus candidates who choose to pursue a fourth try at a previously failed section will pay about \$1,400 in fees for the proposed required additional 14 hours of clinical training. The \$1,400 figure does not include the value of the candidates' time and travel costs associated with obtaining and taking the additional clinical training. According to the department, it is very unusual for candidates to fail the same section three times. Thus, this proposal will be applicable on only rare occasions.

Jurisprudence examination. All applicants for licensure must currently pass an examination on the content of the applicable Virginia dental or dental hygiene laws and regulations in order to obtain licensure. The board proposes to no longer require that applicants take such an exam. Instead, applicants must attest to having read, understood, and kept current with the applicable Virginia dental or dental hygiene laws and regulations. Eliminating the jurisprudence exam requirement saves applicants the exam fee as well as the time of taking the exam and traveling to and from the test center. The test fee is \$55 and it takes approximately one hour to complete the exam.<sup>7</sup> According to the department testing centers exist throughout the Commonwealth. In addition, applicants will likely spend less time reading the rules and regulations prior to attesting to their understanding, than they currently spend studying for the jurisprudence exam.

Eliminating the jurisprudence exam requirement will also likely result in some dentists and dental hygienists not understanding Virginia's laws and regulations as well as they would with the requirement. Attesting to understanding documents does not provide the same assurance of knowledge as passing a test on its contents. The impact of some dentists and dental hygienists not understanding

Virginia's laws and regulations as well as they would otherwise is unknown. The impact depends on how many dentists and dental hygienists are less well informed once the change takes effect, what topics they are less well informed about, whether being less well-informed affects their actions, and how their actions change if they change. None of these are factors are known.

Anesthesia, advanced cardiac life support and basic cardiac life support. The board proposes to require that dentists who administer either deep sedation/general anesthesia or conscious sedation hold current certification in advanced resuscitative techniques, such as courses in Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) from the American Heart Association. This proposal is based upon the recommendation of a panel assembled by the board that consisted of dental school faculty and practicing oral and maxillofacial surgeons. It was the judgment of the panel that dentists who have not demonstrated the knowledge necessary to obtain certification potentially put their patients health at risk. This certification is already required for physicians who administer sedation. All or nearly all oral and maxillofacial surgeons in Virginia hold certification in ACLS or PALS.<sup>8</sup> This is due to the surgeons' belief in its necessity, as well as its requirement by malpractice insurance companies.<sup>9</sup> Thus, this proposal will most likely not affect oral and maxillofacial surgeons. The panel believes that some general dentistry practitioners who administer conscious sedation may not be certified in ACLS or PALS. The panel does not have a research estimate of the safety risk posed by dentists administering conscious sedation without ACLS or PALS certification, but believes that it is significant.

ACLS certification typically requires 16 hours of class with fees from \$250 to \$300.<sup>10</sup> PALS certification requires additional time and fees.<sup>11</sup> In addition to fees, dentists' time also has value. The mean hourly wage for dentists in Virginia is \$57.73.<sup>12</sup> Assuming that the value of a dentist's time is equal to his mean hourly wage, and not accounting for travel expenses, it would cost a dentist \$923.68<sup>13</sup> on average to comply with the proposed certification requirement. Since estimates of dentists' improved ability to handle adverse reactions to conscious sedation due to ACLS or PALS certification are unavailable, an accurate comparison of the benefit of requiring ACLS or PALS certification to its cost cannot be made.

The board also proposes to require that ancillary personnel who assist in the administration and monitoring of conscious or deep sedation have Basic Cardiac Life Support (CPR) certification or hold certification as a certified anesthesia assistant (CAA). Having more than one person present who can perform CPR may help improve survival chances for someone in cardiac arrest. Additionally, if the dentist administering anesthesia becomes incapacitated, it can be

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<sup>5</sup> Ibid

<sup>6</sup> Ibid

<sup>7</sup> Ibid

<sup>8</sup> Source: Board of Dentistry's anesthesia panel

<sup>9</sup> Ibid

<sup>10</sup> Source: Department of Health Professions

<sup>11</sup> Ibid

<sup>12</sup> Source: U.S. Department of Labor, Bureau of Labor Statistics, 2001 State Occupational Employment and Wage Estimates

<sup>13</sup> 16 x \$57.73 = \$923.68

beneficial to have another individual present who can help in resuscitation. The panel believes that it is common, but not universal, for ancillary personnel to have at least CPR training.

CPR certification typically requires 8 hours of class at a cost of \$150 to \$200.<sup>14</sup> CAA requires more time and higher fees.<sup>15</sup> The mean hourly wage for dental assistants in Virginia is \$12.95<sup>16</sup> Assuming that the value of a dental assistant's time is equal to his mean hourly wage, and not accounting for travel expenses, it would cost a dental assistant \$207.20<sup>17</sup> on average to comply with the proposed certification requirement. Since estimates of improved health outcomes due to the ancillary personnel who assist in the administration and monitoring of conscious or deep sedation having had training in CPR are not available, an accurate comparison of the benefit of requiring this certification to its cost cannot be made.

The board also proposes to require that all licensed dentists and dental hygienists have training in at least CPR. According to the board the performance of a dental or hygiene procedure can trigger a cardiopulmonary event, to which the licensee must be able to respond. Since hygienists are now permitted to practice under general supervision (without the physical presence of a dentist), they may be the only licensees available when such an event occurs. The cost of obtaining CPR certification is described above. The probability of a cardiopulmonary event occurring during a dental or hygiene procedure not involving sedation is not known. Thus, an accurate estimate of the benefit of requiring that all licensed dentists and dental hygienists have training in at least CPR cannot be made.

The board proposes to require that prior to administration of sedation or general anesthesia, that the dentist discuss the risks, benefits and alternatives and obtain informed, written consent from the patient. This proposed requirement is identical to a rule in regulations governing administration of sedation or anesthesia under the Board of Medicine. This proposal will likely produce a net benefit since the patient will be able to make a better-informed decision on whether to proceed with the sedation or anesthesia and the dental procedure, while the cost will consist of essentially just a small amount of time.

Under the current regulations, in order for a dentist to be permitted to administer conscious sedation, she must either complete all the requirements to qualify for administration of deep sedation/general anesthesia, or complete the conscious sedation training set by the American Dental Association's Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry in effect at the time training occurred, while enrolled at an accredited dental program or while enrolled in a post-doctoral university or teaching hospital program. The board proposes to add another option to satisfy the educational credential required to administer conscious sedation. Under this option the dentist would complete an approved continuing education course of 60 hours of didactic

instruction, plus the management of at least 20 patients, in parenteral conscious sedation. The course must be consistent with guidelines of the American Dental Association on teaching the comprehensive control of anxiety and pain in dentistry. Acceptance of such a credential will enable the practicing dentist who wants to expand her ability to administer sedation the opportunity to obtain the necessary training without having to return to school for an advanced dental education program. To the extent that receiving training by this method enables these dentists to offer conscious sedation services without increased risk to the patients versus obtaining training through the currently available option, the proposal will create a net benefit in that additional optional services will be available to patients.

Emergency equipment when sedation is used. The aforementioned panel of oral and maxillofacial surgeons and dentistry professors determined that in order to best ensure the health and safety of patients, dentists who administer deep sedation/general anesthesia should be required to maintain the following additional emergency equipment in their dental facility: 1) pulse oximetry 2) blood pressure monitoring equipment, 3) appropriate emergency drugs for patient resuscitation, 4) EKG monitoring equipment and temperature measuring devices, 5) pharmacologic antagonist agents, 6) external defibrillator (manual or automatic), and 7) for intubated patients, an End-Tidal CO<sup>2</sup> monitor. According to testimony from oral and maxillofacial surgeons who administer general anesthesia, such equipment is standard in offices where outpatient surgery is performed.<sup>18</sup> The department provided the following cost estimates for the proposed additional required emergency equipment: 1) \$50 or less for pulse oximetry 2) \$50 or less for blood pressure monitoring equipment, 3) \$ (figure to be supplied by the department) for appropriate emergency drugs for patient resuscitation, 4) \$ (figure to be supplied by the department) for EKG monitoring equipment and temperature measuring devices, 5) \$50 or less for pharmacologic antagonist agents, 6) \$1,100 for an external defibrillator (manual or automatic), and 7) \$850 for an End-Tidal CO<sup>2</sup> monitor.

The panel also determined that in order to best ensure the health and safety of patients, dentists who administer conscious sedation should be required to maintain the following additional emergency equipment in their dental facility: 1) pulse oximetry, 2) blood pressure monitoring equipment, 3) appropriate emergency drugs for patient resuscitation, and 4) pharmacologic antagonist agents. As mentioned above, the estimated costs for these items are 1) \$50 or less, 2) \$50 or less, 3) \$ (figure to be supplied by the department), and 4) \$50 or less, respectively.

The benefits of requiring the proposed additional emergency equipment for dentists who administer deep sedation/general anesthesia or conscious sedation depend on the probability of each item preventing adverse health outcomes, and the value placed on the prevention of those adverse health outcomes. The probability of each item preventing adverse health outcomes depends on both the probability that it would be needed at any given time, and the probability that the item would be successful in preventing the potential adverse health

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<sup>14</sup> Source: Department of Health Professions

<sup>15</sup> Ibid

<sup>16</sup> Source: U.S. Department of Labor, Bureau of Labor Statistics, 2001 State Occupational Employment and Wage Estimates

<sup>17</sup> 16 x \$12.95 = \$207.20

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<sup>18</sup> Source: Department of Health Professions

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outcome in question. Since accurate estimates of the benefits of each item are not currently available, an accurate comparison of the benefits with the above-described costs cannot be made at this time.

**Radiation certification.** Under the current regulations there are four methods by which an individual may become certified to place or expose dental X-ray film: 1) satisfactorily complete a course or examination recognized by the Commission on Dental Accreditation of the American Dental Association, 2) be certified by the American Registry of Radiologic Technologists, 3) satisfactorily complete a course and pass an examination in compliance with guidelines provided by the board, or 4) pass the board's examination in radiation safety and hygiene followed by on the job training. According to the department, the board's exam is very rarely requested. In order to save on the costs of maintaining the rarely used exam, the board proposes to discontinue it and eliminate the current fourth option for obtaining radiation certification. The board proposes to introduce a new fourth option, satisfactory completion of a radiation course and passage of an exam given by the Dental Assisting National Board. Since the board exam is very rarely used and it is costly to maintain, discontinuing the option to gain radiation certification via a board exam will likely produce a net benefit. Adding the Dental Assisting National Board as an approved source from which to obtain radiation certification can be beneficial to the extent that individuals will find it an attractive option.

**Businesses and entities affected.** The proposed amendments affect the 5,390 licensed dentists, 3,709 licensed dental hygienists, their patients and practices, dental schools, dental hygienist schools, and their students and faculty.

**Localities particularly affected.** The proposed regulations affect all Virginia localities.

**Projected impact on employment.** By relaxing the continuous practice requirement and by allowing continuing education credits to serve in lieu of retaking the SRTA examinations, more dentists currently licensed in Arkansas, Georgia, Kentucky, South Carolina, and Tennessee may seek to become licensed and open practices or join current practices in Virginia. The total number of new individuals who open or join dental practices in the Commonwealth due to this change is likely to be small. The addition of a small number of new dentists practicing in Virginia would likely prompt the hiring of a small number of new support personnel, such as dental hygienists and dental assistants.

The proposals to require dentists who administer either deep sedation/general anesthesia or conscious sedation hold current certification in advanced resuscitative techniques, such as courses in Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) from the American Heart Association and to require that ancillary personnel who assist in the administration and monitoring of conscious or deep sedation have Basic Cardiac Life Support (CPR) certification or hold certification as a certified anesthesia assistant (CAA) will provide additional demand for these services from the organizations that provide them. The proposal that all dentists have CPR training will also create additional demand for this training from the organizations that

provide it. Employment for the providers of these services will likely increase to satisfy the increased demand.

The proposals to require additional emergency equipment for dentists who administer deep sedation/general anesthesia or conscious sedation will increase demand for the producers of pulse oximetry, blood pressure monitoring equipment, appropriate emergency drugs for patient resuscitation, EKG monitoring equipment and temperature measuring devices, pharmacologic antagonist agents, external defibrillators, and End-Tidal CO<sup>2</sup> monitors. Employment for the providers of these products may consequently increase.

**Effects on the use and value of private property.** A small number of new dental practices may be established or expanded due to the proposed relaxation of the continuous practice requirement and the permitting of continuing education credits to serve in lieu of retaking the SRTA examinations.

The value of the MCV Orthodontic and Research Foundation, the Dental Assisting National Board, the American Safety and Health Institute, and accredited dental schools or specialty residency programs may increase somewhat due to increased demand for their continuing education courses stemming from the proposal to list those organizations as approved continuing education sponsors. The value of the Dental Assisting National Board may also increase if their listing as an approved source from which to obtain radiation certification produces new demand for their services.

The proposals to require dentists who administer either deep sedation/general anesthesia or conscious sedation hold current certification in advanced resuscitative techniques, such as courses in ACLS or PALS from the American Heart Association and to require that ancillary personnel who assist in the administration and monitoring of conscious or deep sedation have CPR certification or hold certification as a CAA will provide additional demand for these services from the organizations that provide them. The proposal that all dentists have CPR training will also create additional demand for this training from the organizations that provide it. The value of these organizations will consequently increase.

The proposals to require additional emergency equipment for dentists who administer deep sedation/general anesthesia or conscious sedation will increase demand for the producers of pulse oximetry, blood pressure monitoring equipment, appropriate emergency drugs for patient resuscitation, EKG monitoring equipment and temperature measuring devices, pharmacologic antagonist agents, external defibrillators, and End-Tidal CO<sup>2</sup> monitors. The value of these producers will consequently increase.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Dentistry does not concur with the analysis of the Department of Planning and Budget (DPB) for amendments to 18 VAC 60-20 relative to its requirements for licensure. The board is concerned that the analysis fails to consider provisions in the Code of Virginia.

The department is incorrect in stating the licensure by endorsement is not permitted because regulations of the board do not allow it. Regulations must be based on statute,

and there is a statutory provision that is interpreted as prohibiting licensure by endorsement, so any modification of that policy would require action by the General Assembly. Prior to 1995, regulations of the Board of Dentistry did provide for licensure by endorsement. In the 1995 General Assembly, SB 767 was passed to "prohibit licensure by endorsement for the practice of dentistry in the Commonwealth" (Summary of bill by Legislative Services). The bill provided that "notwithstanding the provisions of § 54.1-103 C, it shall be unlawful for any person to practice dentistry or to receive a licensure from any commissioner of the revenue to practice dentistry, unless he has passed the examination and obtained a license." Any dentist who seeks to be licensed in Virginia is required, by law, to have taken the examination accepted for licensure, and prior to January 1, 2005, the examination accepted for licensure in Virginia was exclusively the examination of the Southern Regional Testing Agency (SRTA). Therefore, anyone who took a licensing examination prior to 1/1/05 would have to provide proof of passage of the SRTA examination.

At its meeting on September 10, 2004, the Board of Dentistry voted to accept the four regional examinations (SRTA, NERB, CRDTS and WREB) as described in the EIA. Beginning in 2005, an applicant who passes any of the regional examinations can submit such evidence to the board for licensure. In addition, the board has submitted draft legislation to repeal the code section that prohibits licensure by endorsement for dentists and to accept dentists who apply for licensure by credentials.

In addition, other comments by DPB in its analysis related to licensure by endorsement do not seem to be factually supported. DPB asserts that discouraging non-SRTA state dentists from seeking licensure in Virginia lowers the quantity and quality of dental services, while the cost of such services are higher. No data has been provided to support the contention that the quality of dental care is lower and the cost higher than in other states. Costs are more related to the general cost of living in an area than to the availability of dentists. For example, costs for dental services are higher in Northern Virginia than they are in Southside Virginia, although the number of dentists in more urban areas is higher for the population they serve.

#### Summary:

*The proposed amendments update definitions to reflect current terminology, particularly that pertaining to revised regulations for anesthesia and sedation and eliminate terms that are no longer being used. Amendments to the requirements for dental education will reflect the current board interpretation of an accredited or approved dental program, which is either a pre-doctoral dental education program or a one- or two-year post-doctoral dental education program.*

*Changes in examination requirements offer additional options for persons who took the board-approved examinations five or more years prior to applying for licensure in Virginia. In addition, there are new requirements for remediation for candidates who have failed the licensure examination three times. Rather than requiring passage of a jurisprudence examination, the board*

*will now require that the applicant read, understand and remain current with the laws and regulations governing the practice of dentistry in Virginia.*

*Regulations for anesthesia, sedation and analgesia have been rewritten and reorganized to make clear the application of the rules in various settings, the educational and training qualifications of the dentist and dental assistants, the equipment and monitoring needed for each level, and the discharge criteria for ensuring the safety of the patient.*

#### **18 VAC 60-20-10. Definitions.**

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"ADA" means the American Dental Association.

"Advertising" means a representation or other notice given to the public or members thereof, directly or indirectly, by a dentist on behalf of himself, his facility, his partner or associate, or any dentist affiliated with the dentist or his facility by any means or method for the purpose of inducing purchase, sale or use of dental methods, services, treatments, operations, procedures or products, or to promote continued or increased use of such dental methods, treatments, operations, procedures or products.

"Analgesia" means the diminution or elimination of pain in the conscious patient.

"Anxiolysis" means the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness.

"Approved schools" means those dental schools, colleges, departments of universities or colleges, or schools of dental hygiene programs currently accredited by the Commission on Dental Accreditation of the American Dental Association.

~~"Competent instructor" means any person appointed to the faculty of a dental school, college or department or a university or a college who holds a license or teacher's license to practice dentistry or dental hygiene in the Commonwealth.~~

"Conscious sedation" means a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal commands, produced by a ~~pharmacologic or nonpharmacologic~~ ~~method~~ pharmacological or nonpharmacological methods, including inhalation, parenteral, transdermal or enteral, or a combination thereof.

"Deep sedation/general anesthesia" means an induced state of depressed consciousness or unconsciousness accompanied by a complete or partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or respond purposefully to physical stimulation or verbal command and is produced by a pharmacological or nonpharmacological method or a combination thereof.

"Dental assistant" means any unlicensed person under the supervision of a dentist who renders assistance for services provided to the patient as authorized under this chapter but

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shall not include an individual serving in purely a secretarial or clerical capacity.

"Direction" means ~~[ the presence of ]~~ the dentist ~~[ evaluates the patient and is present ]~~ for ~~[ the evaluation, ]~~ observation, advice, and control over the performance of dental services.

"Enteral" is any technique of administration in which the agent is absorbed through the gastrointestinal tract or oral mucosa (i.e., oral, rectal, sublingual).

~~"General anesthesia" means a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or nonpharmacologic method, or combination thereof.~~

"General supervision" means that the dentist has evaluated the patient and issued a written order for the specific, authorized services to be provided by a dental hygienist when the dentist is not present in the facility while the services are being provided.

"Inhalation" is a technique of administration in which a gaseous or volatile agent, including nitrous oxide, is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

"Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness.

"Local anesthesia" means the loss of sensation or pain in the oral cavity or ~~its contiguous~~ the maxillofacial or adjacent and associated structures generally produced by a topically applied agent or injected agent without ~~causing the loss depressing the level of~~ consciousness.

~~"Monitoring general anesthesia and conscious sedation" includes the following: recording and reporting of blood pressure, pulse, respiration, and other vital signs to the attending dentist during the conduct of these procedures and after the dentist has induced a patient and established a maintenance level.~~

~~"Monitoring nitrous oxide oxygen inhalation analgesia" means making the proper adjustments of nitrous oxide machines at the request of the dentist during the administration of the sedation, and observing the patient's vital signs.~~

~~"Nitrous oxide oxygen inhalation analgesia" means the utilization of nitrous oxide and oxygen to produce a state of reduced sensibility to pain designating particularly the relief of pain without the loss of consciousness.~~

"Parenteral" means a technique of administration in which the ~~[ agent is injected into tissues, either subcutaneous, sublingual, submucosal, intramuscular or intravenous drug bypasses the gastrointestinal tract (i.e., intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraocular) ]~~.

"Radiographs" means intraoral and extraoral x-rays of the hard and soft ~~oral structures tissues~~ to be used for purposes of diagnosis.

## 18 VAC 60-20-16. Address of record.

At all times, each licensed dentist shall provide the board with a current, primary business address, and each dental hygienist shall provide a current ~~resident mailing address. No post-office box numbers are accepted.~~ All required notices mailed by the board to any such licensee shall be validly given when mailed to the latest address given by the licensee. All changes of address shall be furnished to the board in writing within 30 days of such changes.

## 18 VAC 60-20-20. License renewal and reinstatement.

A. Renewal fees. Every person holding an active or inactive license, a full-time faculty license, or a restricted volunteer license to practice dentistry or dental hygiene shall, on or before March 31, renew his license. Every person holding a teacher's license or a temporary permit to practice dentistry or dental hygiene shall, on or before June 30, renew his license.

1. The fee for renewal of an active license or permit to practice or teach dentistry shall be \$150, and the fee for renewal of an active license or permit to practice or teach dental hygiene shall be \$50.
2. The fee for renewal of an inactive license shall be \$75 for dentists and \$25 for dental hygienists.
3. The fee for renewal of a restricted volunteer license shall be \$15.

B. Late fees. Any person who does not return the completed form and fee by the deadline required in subsection A of this section shall be required to pay an additional late fee of \$50 for dentists and \$20 for dental hygienists. The board shall renew a license if the renewal form, renewal fee, and late fee are received within one year of the deadline required in subsection A of this section.

C. Reinstatement fees and procedures. The license of any person who does not return the completed renewal form and fees by the deadline required in subsection A of this section shall automatically expire and become invalid and his practice of dentistry/dental hygiene shall be illegal.

1. Any person whose license has expired for more than one year and who wishes to reinstate such license shall submit to the board a reinstatement application, the renewal fee and the reinstatement fee of \$225 for dentists and \$135 for dental hygienists.
2. Practicing in Virginia with an expired license may subject the licensee to disciplinary action and additional fines by the board.
3. The executive director may reinstate such expired license provided that the applicant can demonstrate continuing competence, that no grounds exist pursuant to § 54.1-2706 of the Code of Virginia and 18 VAC 60-20-170 to deny said reinstatement, and that the applicant has paid the unpaid renewal fee, the reinstatement fee and any fines or assessments. *Evidence of continuing competence shall include hours of continuing education [ as required by subsection H of 18 VAC 60-20-50 ] and may also include evidence of active practice in another state [ or in federal service ] or current specialty board certification.*

D. Reinstatement of a license previously revoked or indefinitely suspended. Any person whose license has been revoked shall submit to the board for its approval a reinstatement application and fee of \$750 for dentists and \$500 for dental hygienists. Any person whose license has been indefinitely suspended shall submit to the board for its approval a reinstatement application and fee of \$350 for dentists and \$250 for dental hygienists.

**18 VAC 60-20-50. Requirements for continuing education.**

A. After April 1, 1995, a dentist or a dental hygienist shall be required to have completed a minimum of 15 hours of approved continuing education for each annual renewal of licensure.

[ 1. *Effective (one year after the effective date of this regulation), a dentist or a dental hygienist shall be required to maintain evidence of successful completion of training in basic cardiopulmonary resuscitation.*

2. *Effective (one year after the effective date of this regulation), a dentist who administers or a dental hygienist who monitors patients under general anesthesia, deep sedation or conscious sedation shall complete four hours every two years of approved continuing education directly related to administration or monitoring of such anesthesia or sedation as part of the hours required for licensure renewal.*

3. ] Continuing education hours [ ~~for dentists~~ ] in excess of the number required for renewal may be transferred or credited to ~~another~~ *the next renewal* year for a total of not more than 15 hours.

B. An approved continuing dental education program shall be relevant to the treatment and care of patients and shall be:

1. Clinical courses in dentistry and dental hygiene; or
2. Nonclinical subjects that relate to the skills necessary to provide dental or dental hygiene services and are supportive of clinical services (i.e., patient management, legal and ethical responsibilities, stress management). Courses not acceptable for the purpose of this subsection include, but are not limited to, estate planning, financial planning, investments, and personal health.

C. Continuing education credit may be earned for verifiable attendance at or participation in any courses, to include audio and video presentations, which meet the requirements in subdivision B 1 of this section and which are given by one of the following sponsors:

1. American Dental Association and National Dental Association, their constituent and component/branch associations;
2. American Dental Hygienists' Association and National Dental Hygienists Association, their constituent and component/branch associations;
3. American Dental Assisting Association, its constituent and component/branch associations;
4. American Dental Association specialty organizations, their constituent and component/branch associations;

5. American Medical Association and National Medical Association, their specialty organizations, constituent, and component/branch associations;

6. Academy of General Dentistry, its constituent and component/branch associations;

7. Community colleges with an accredited dental hygiene program if offered under the auspices of the dental hygienist program;

8. A college [ , or ] university [ ~~, or hospital service which that~~ ] is accredited by an accrediting agency approved by the U.S. [ ~~Office~~ Department ] of Education [ *or a hospital or health care institution accredited by the Joint Commission on Accreditation of Health Care Organizations* ];

9. The American Heart Association, the American Red Cross [ , the American Safety and Health Institute ] and the American Cancer Society;

10. A medical school which is accredited by the American Medical Association's Liaison Committee for Medical Education [ *or a dental school or dental specialty residency program accredited by the Commission on Dental Accreditation of the American Dental Association* ];

11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);

12. The Commonwealth Dental Hygienists' Society; ~~or~~

13. *The MCV Orthodontic and Research Foundation;*

14. *The Dental Assisting National Board; or*

13. 15. [ ~~Any other board-approved programs~~ *A regional testing agency (i.e., Central Regional Dental Testing Service, Northeast Regional Board of Dental Examiners, Southern Regional Testing Agency, or Western Regional Examining Board) when serving as an examiner* ].

D. A licensee is exempt from completing continuing education requirements and considered in compliance on the first renewal date following [ ~~his~~ *the licensee's* ] initial licensure.

E. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

F. A licensee is required to provide information on compliance with continuing education requirements in his annual license renewal. Following the renewal period, the board may conduct an audit of licensees to verify compliance. Licensees selected for audit must provide original documents certifying that they have fulfilled their continuing education requirements by the deadline date as specified by the board.

G. All licensees are required to maintain original documents verifying the date and subject of the program or activity. Documentation must be maintained for a period of four years following renewal.

H. A licensee who has allowed his license to lapse, or who has had his license suspended or revoked, must submit evidence of completion of continuing education equal to the

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requirements for the number of years in which his license has not been active, *not to exceed a total of 45 hours*. [ *Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months preceding an application for reinstatement.* ]

I. Continuing education hours required by [ ~~disciplinary board~~ ] order shall not be used to satisfy the continuing education requirement for license renewal [ *or reinstatement* ].

J. Failure to comply with continuing education requirements may subject the licensee to disciplinary action by the board.

## 18 VAC 60-20-60. Education.

A. Dental licensure. An applicant for dental licensure shall be a graduate and a holder of a diploma *or a certificate* from [ ~~an accredited~~ ] *or approved* [ *a* ] dental ~~school program~~ [ *recognized accredited* ] by the Commission on Dental Accreditation of the American Dental Association, *which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program in any other specialty.*

B. Dental hygiene licensure. An applicant for dental hygiene licensure shall have graduated from or have been issued a certificate by [ ~~an accredited school or a~~ ] program of dental hygiene [ *recognized accredited* ] by the Commission on Dental Accreditation of the American Dental Association.

## 18 VAC 60-20-70. Licensure examinations.

A. Dental examinations.

1. All applicants shall have successfully completed Part I and Part II of the examinations of the Joint Commission on National Dental Examinations prior to making application to this board.

2. All applicants to practice dentistry shall satisfactorily pass the complete board-approved examinations in dentistry. Applicants who successfully completed the board-approved examinations five or more years prior to the date of receipt of their applications for licensure by this board may be required to retake the examinations *or take board-approved continuing education* unless they demonstrate that they have maintained *continuous* clinical, ethical and legal practice ~~since passing the board-approved examinations for 48 of the past 60 months immediately prior to submission of an application for licensure.~~

3. *If the candidate has failed any section of [ ~~the a~~ ] board-approved examination three times, [ ~~he the candidate~~ ] shall complete a minimum of 14 hours of additional clinical training in each section of the examination to be retested in order to be approved by the board to sit for the examination a fourth time.*

B. Dental hygiene examinations.

1. All applicants are required to successfully complete the dental hygiene examination of the Joint Commission on National Dental Examinations prior to making application to this board for licensure.

2. All applicants to practice dental hygiene shall successfully complete the board-approved examinations in dental hygiene, except those persons eligible for licensure pursuant to 18 VAC 60-20-80.

3. *If the candidate has failed any section of [ ~~the a~~ ] board-approved examination three times, [ ~~he the candidate~~ ] shall complete a minimum of seven hours of additional clinical training in each section of the examination to be retested in order to be approved by the board to sit for the examination a fourth time.*

C. [ *All* ] applicants who successfully complete the board-approved examinations five or more years prior to the date of receipt of their applications for licensure by this board may be required to retake the board-approved examinations *or take board-approved continuing education* unless they demonstrate that they have maintained *continuous* clinical, ethical, and legal practice ~~since passing the board-approved examinations for 48 of the past 60 months immediately prior to submission of an application for licensure.~~

D. All applicants for licensure by examination shall be required to ~~pass an examination on~~ *attest that they have read and understand* [ *and will remain current with* ] the applicable Virginia dental and dental hygiene laws and the regulations of this board.

## 18 VAC 60-20-80. Licensure by endorsement for dental hygienists.

An applicant for dental hygiene endorsement licensure shall:

1. Be a graduate or be issued a certificate from an accredited dental hygiene school/program of dental hygiene recognized by the Commission on Dental Accreditation of the American Dental Association;

2. Be currently licensed to practice dental hygiene in another state, territory, District of Columbia, or possession of the United States, and have *continuous* clinical, ethical, and legal practice for 24 out of the past 48 months immediately preceding application for licensure. ~~Active patient care in armed forces dental corps, state or federal agency, volunteer practice in a public clinic, and intern or residency programs, may substitute for required clinical practice;~~

3. Be certified to be in good standing from each state in which he is currently licensed or has ever held a license;

4. Have successfully completed a clinical licensing examination substantially equivalent to that required by Virginia;

5. Not have failed the clinical examination accepted by the board within the last five years;

6. Be of good moral character;

7. Not have committed any act which would constitute a violation of § 54.1-2706 of the Code of Virginia;

8. Have successfully completed the dental hygiene examination of the Joint Commission on National Dental Examinations prior to making application to this board; [ *and* ]

9. ~~Pass an examination on~~ *Attest to having read and understand [ and to remain current with ]* the laws and the regulations governing the practice of dentistry and dental hygiene in Virginia [ ~~;~~ *and*

~~10. Submit a current report from the Healthcare Integrity and Protection Data Bank (HIPDB) ].~~

**18 VAC 60-20-90. Temporary permit, teacher's license, and full-time faculty license.**

A. A temporary permit shall be issued only for the purpose of allowing dental and dental hygiene practice as limited by §§ 54.1-2715 and 54.1-2726 of the Code of Virginia.

B. A temporary permit will not be renewed unless the permittee shows that extraordinary circumstances prevented the permittee from taking the licensure examination during the term of the temporary permit.

C. A full-time faculty license shall be issued to any dentist who meets the entry requirements of § 54.1-2713 of the Code of Virginia, who is certified by the dean of a dental school in the Commonwealth and who is serving full time on the faculty of a dental school or its affiliated clinics intramurally in the Commonwealth.

1. A full-time faculty license shall remain valid only while the license holder is serving full time on the faculty of a dental school in the Commonwealth. When any such license holder ceases to continue serving full time on the faculty of the dental school for which the license was issued, the licensee shall surrender the license, which shall be null and void upon termination of full-time employment. The dean of the dental school shall notify the board within five working days of such termination of full-time employment.

2. A full-time faculty licensee working in a faculty intramural clinic [ ~~is~~ *affiliated with* ] a dental school may accept a fee for service.

D. A temporary permit, a teacher's license and a full-time faculty license may be revoked for any grounds for which the license of a regularly licensed dentist or dental hygienist may be revoked and for any act indicating the inability of the permittee or licensee to practice dentistry that is consistent with the protection of the public health and safety as determined by the generally accepted standards of dental practice in Virginia.

E. Applicants for a full-time faculty license or temporary permit shall be required to ~~pass an examination on~~ *attest to having read and understand [ and to remaining current with ]* the laws and the regulations governing the practice of dentistry in Virginia.

**[ 18 VAC 60-20-100. Other application requirements.**

All applications for any license or permit issued by the board shall include:

1. A final certified transcript of the grades from the college from which the applicant received the dental degree, dental hygiene degree or certificate, or post-doctoral degree or certificate; ~~and~~

2. An original grade card issued by the Joint Commission on National Dental Examinations; ~~and~~

3. A current report from the Healthcare Integrity and Protection Data Bank (HIPDB). ]

**18 VAC 60-20-105. Inactive license.**

A. Any dentist or dental hygienist who holds a current, unrestricted license in Virginia may, upon a request on the renewal application and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be entitled to perform any act requiring a license to practice dentistry or dental hygiene in Virginia.

B. An inactive license may be reactivated upon submission of the required application, payment of the current renewal fee, and documentation of having completed continuing education hours equal to the requirement for the [ ~~period of time~~ *number of years in which the license has been inactive, not to exceed a total of 45 hours. Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months* ] immediately preceding the application for activation. [ ~~In no event shall more than three years~~ *45 hours of continuing education be required.* ] The board reserves the right to deny a request for reactivation to any licensee who has been determined to have committed an act in violation of § 54.1-2706 of the Code of Virginia.

PART IV.  
**GENERAL ANESTHESIA AND CONSCIOUS, SEDATION AND ANALGESIA.**

**18 VAC 60-20-106. General provisions.**

A. This part (18 VAC 60-20-106 et seq.) shall not apply to:

1. The administration of local anesthesia in dental offices; or
2. The administration of anesthesia in (i) a licensed hospital as defined in § 32.1-123 of the Code of Virginia or state-operated hospitals or (ii) a facility directly maintained or operated by the federal government.

B. [ *Appropriateness of administration of general anesthesia or sedation in a dental office.*

1. *Anesthesia and sedation may be provided in a dental office for patients who are Class I and II as classified by the American Society of Anesthesiologists (ASA).*

2. ] *Conscious sedation, deep sedation or general anesthesia shall not be provided in a dental office for patients in [ ASA ] risk categories of Class IV and V [ ~~;~~ *as classified by the American Society of Anesthesiologists (ASA) ].**

[ 3. ] *Patients in [ ASA risk category ] Class III shall only be provided [ general ] anesthesia or sedation [ by:*

a. *A dentist ] after consultation with their primary care physician or other medical specialist regarding potential risk and special monitoring requirements that may be necessary [ ; or*

b. *An oral and maxillofacial surgeon after performing an evaluation and documenting the ASA risk assessment*

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category of the patient and any special monitoring requirements that may be necessary.

C. Prior to administration of sedation or general anesthesia, the dentist shall discuss the nature and objectives of the anesthesia or sedation planned along with the risks, benefits and alternatives and shall obtain informed, written consent from the patient or other responsible party.

D. The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record.

E. A dentist who is administering anesthesia or sedation to patients prior to (insert effective date of regulations) shall have one year from that date to comply with the educational requirements set forth in this chapter for the administration of anesthesia or sedation. ]

## **18 VAC 60-20-107. Administration of anxiolysis or inhalation analgesia.**

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.
2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis or inhalation analgesia shall consist of the dentist and a second person [ in the operatory with the patient ] to assist, monitor and observe the patient. [ One member of the team shall be in the operatory monitoring the patient at all times once the administration has begun. ]

2. A dentist who utilizes anxiolysis or inhalation analgesia shall ensure that [ ~~a beginning and ending blood pressure has been taken and that~~ ] there is continuous visual monitoring of the patient to determine the level of consciousness.

3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of the dentist during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

## **18 VAC 60-20-110. Requirements to administer deep sedation/general anesthesia.**

A. Educational requirements. A dentist may employ or use deep sedation/general anesthesia on an outpatient basis by meeting one of the following educational criteria and by posting the educational certificate, in plain view of the patient, which verifies completion of the advanced training as required in subdivision 1 or 2 of this subsection. ~~The foregoing~~ These requirements shall not apply nor interfere with requirements for obtaining hospital staff privileges.

1. Has completed a minimum of one calendar year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program in conformity with published guidelines by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry, ~~effective October 1999~~), which are incorporated by reference in this chapter in effect at the time the training occurred; or

2. Completion of an American Dental Association approved residency in any dental specialty which incorporates into its curriculum [ a minimum of one calendar year of full-time training in clinical anesthesia and related clinical medical subjects (i.e. medical evaluation and management of patients), the standards of teaching ] comparable to those set forth in published guidelines by the American Dental Association [ ~~(Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry, effective October 1999), which are incorporated by reference in this chapter for Graduate and Postgraduate Training in Anesthesia~~ ] in effect at the time the training occurred.

~~[ B. Additional training required. ] After [ March 31, 2005 (one year from the effective date of this regulation) ], dentists who administer deep sedation/general anesthesia shall hold current certification in [ advanced resuscitative techniques, such as courses in ] Advanced Cardiac Life Support or Pediatric Advanced Life Support [ ~~from the American Heart Association, and~~ ] current Drug Enforcement Administration registration [ ~~, and training to the level consistent with Part I and Part II of the ADA guidelines for the use of conscious sedation, deep sedation and general anesthesia for dentists~~ ].~~

~~[ B. ] Exemptions Exceptions.~~

1. A dentist who has not met the requirements specified in subsection A of this section may treat patients under deep sedation/general anesthesia in his practice if a qualified anesthesiologist, or a dentist who fulfills the requirements specified in subsection A of this section, is present and is responsible for the administration of the anesthetic.

2. If a dentist fulfills [ the ] requirements himself to use general anesthesia and conscious sedation specified in subsection A [ ~~and B~~ ] of this section, he may employ the services of a certified nurse anesthetist.

~~[ D. C. ] Posting. Any dentist who utilizes deep sedation/general anesthesia shall post with the dental license and current registration with the Drug Enforcement Administration, the certificate of education required under [ subsections subsection ] A [ ~~and B~~ ] of this section.~~

~~[ E. D. ]~~ *Emergency equipment and techniques. A dentist who administers deep sedation/general anesthesia shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway and cardiopulmonary resuscitation, and shall maintain the following emergency equipment in the dental facility:*

1. Full face mask for children or adults, as appropriate for the patient being treated;
2. Oral and nasopharyngeal airways;
3. Endotracheal tubes for children or adults, or both, with appropriate connectors;
4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both;
5. Source of delivery of oxygen under controlled positive pressure;
6. Mechanical (hand) respiratory bag;
7. Pulse oximetry and blood pressure monitoring equipment available and used in the treatment room;
8. Appropriate emergency drugs for patient resuscitation; ~~[ and ]~~
9. EKG monitoring equipment and temperature measuring devices ~~[ -; ]~~;
10. Pharmacologic antagonist agents;
11. External defibrillator (manual or automatic); and
12. For intubated patients, an End-Tidal CO<sup>2</sup> monitor. ]

~~[ F. E. ]~~ *Monitoring requirements.*

1. The ~~[ anesthesia treatment ]~~ team for deep sedation/general anesthesia shall consist of the operating dentist, a second person to monitor and observe the patient and a third person to assist the operating dentist ~~[ , all of whom shall be in the operatory with the patient during the dental procedure ]~~.
2. Monitoring of the patient under deep sedation/general anesthesia ~~[ , including direct, visual observation of the patient by a member of the team, ]~~ is to begin ~~[ immediately after the patient has been induced and a maintenance level has been established prior to induction of anesthesia ]~~ and shall take place continuously during the dental procedure ~~[ and recovery from anesthesia ]~~. The person who administered the anesthesia ~~[ or another licensed practitioner qualified to administer the same level of anesthesia ]~~ must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.
3. Monitoring deep sedation/general anesthesia shall include the following: recording and reporting of blood pressure, pulse, respiration and other vital signs to the attending dentist.

**18 VAC 60-20-120. Requirements to administer conscious sedation; intravenous and intramuscular.**

A. Automatic qualification. Dentists qualified to administer deep sedation/general anesthesia may administer conscious sedation.

B. Educational requirements for administration of conscious sedation by any method.

[ 1. ] A dentist may employ or use any method of conscious sedation by meeting one of the following criteria:

~~[ 1. A dentist may administer conscious sedation upon a. ]~~ Completion of training for this treatment modality according to guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry, effective October 1999) and incorporated by reference in this chapter in effect at the time the training occurred, while enrolled at an approved accredited dental school program or while enrolled in a post-doctoral university or teaching hospital program; or

~~[ 2. b. Completion of an approved continuing education course consisting of 60 hours of didactic instruction plus the management of at least 20 patients per participant, demonstrating competency and clinical experience in parenteral conscious sedation and management of a compromised airway. The course content shall be consistent with guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred. ]~~

2. A dentist who was self-certified in anesthesia and conscious sedation prior to January 1989 may continue to administer ~~[ only ]~~ conscious sedation ~~[ if he completes 12 hours of approved continuing education directly related to administration of conscious sedation by March 31, 2005. A dentist qualified to administer conscious sedation by a certificate issued by the board shall maintain documentation of the required continuing education ]~~.

C. Educational requirement for enteral administration of conscious sedation only. A dentist may administer conscious sedation by an enteral method if he has completed ~~[ a ]~~ an approved continuing education ~~[ program of not less than [ 40 ] hours of [ clinical training for this treatment modality according to ]~~ didactic instruction plus 20 clinically-oriented experiences in enteral and/or combination inhalation-enteral conscious sedation techniques. The course content shall be consistent with ~~[ the ]~~ guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred.

D. Additional training required. After ~~[ March 31, 2005 ]~~ (one year from the effective date of this regulation), dentists who administer conscious sedation shall hold current certification in ~~[ advanced resuscitation techniques, such as ]~~ Advanced Cardiac Life Support ~~[ from the American Heart Association ]~~ as evidenced by a certificate ~~[ of completion ]~~ posted with the dental license ~~[ , ]~~ and current registration with the Drug Enforcement Administration.

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*E. Emergency equipment and techniques. A dentist who administers conscious sedation shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway and cardiopulmonary resuscitation, and shall maintain the following emergency airway equipment in the dental facility:*

1. Full face mask for children or adults, as appropriate for the patient being treated;
  2. Oral and nasopharyngeal airways;
  3. Endotracheal tubes for children or adults, or both, with appropriate connectors [; 4. and] a laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both [ . In lieu of a laryngoscope and endotracheal tubes, a dentist may maintain airway adjuncts designed for the maintenance of a patent airway and the direct delivery of positive pressure oxygen;
  4. Pulse oximetry;
  5. Blood pressure monitoring equipment;
  6. Pharmacologic antagonist agents; ]
- [ 5. 7. ] Source of delivery of oxygen under controlled positive pressure;
- [ 6. 8. ] Mechanical (hand) respiratory bag; and
- [ 7. 9. ] Appropriate emergency drugs for patient resuscitation.

**F. Monitoring requirements.**

1. The [ ~~treatment~~ administration ] team for conscious sedation shall consist of the operating dentist and a second person to assist, monitor and observe the patient.
2. Monitoring of the patient under conscious sedation [ , including direct, visual observation of the patient by a member of the team, ] is to [ begin prior to administration of sedation, or if medication is self-administered by the patient, when the patient arrives at the dental office and shall ] take place continuously during the dental procedure [ and recovery from sedation ]. The person who administers the sedation [ or another licensed practitioner qualified to administer the same level of sedation ] must remain on the premises of the dental facility until the patient is responsive and is discharged.

**18 VAC 60-20-130. General information. (Repealed.)**

~~A. Emergency equipment and techniques. A dentist who administers general anesthesia and conscious sedation (excluding nitrous oxide) shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway and cardiopulmonary resuscitation, and shall maintain the following emergency airway equipment in the dental facility:~~

1. Full face mask for children or adults, or both;
2. Oral and nasopharyngeal airways;

3. Endotracheal tubes for children or adults, or both, with appropriate connectors;
4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both;
5. Source of delivery of oxygen under controlled pressure; and
6. Mechanical (hand) respiratory bag.

~~B. Posting requirements. Any dentist who utilizes general anesthesia or conscious sedation shall post in each facility the certificate of education required under 18 VAC 60-20-110-A and 18 VAC 60-20-120-B or a certificate issued by the board.~~

~~C. Other.~~

1. The team for general anesthesia shall consist of the operating dentist, a second person to monitor and observe the patient, and a third person to assist the operating dentist.
2. The person in charge of the anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.

~~D. Scope of regulation. Part IV (18 VAC 60-20-110 et seq.) of this chapter shall not apply to administration of general anesthesia and conscious sedation in hospitals and surgical centers.~~

**18 VAC 60-20-135. Ancillary personnel.**

After [ ~~March 31, 2005~~ (one year from the effective date of this regulation) ], dentists who employ ancillary personnel to assist in the administration and monitoring of any form of conscious sedation or deep sedation/general anesthesia shall maintain documentation that such personnel have:

1. Minimal training resulting in current certification in [ basic resuscitation techniques, such as ] Basic Cardiac Life Support [ ~~from the American Heart Association and or~~ ] an approved, clinically oriented course devoted primarily to responding to clinical emergencies offered by an approved provider of continuing education as set forth in 18 VAC 60-20-50 C; or
2. Current certification as a certified anesthesia assistant (CAA) by the American Association of Oral and Maxillofacial Surgeons or the American Dental Society of Anesthesiology (ADSA).

**[ 18 VAC 60-20-190. Nondelegable duties; dentists.**

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;
2. Performing surgical or cutting procedures on hard or soft tissue;
3. Prescribing or parenterally administering drugs or medicaments;
4. Authorization of work orders for any appliance or prosthetic device or restoration to be inserted into a patient's mouth;

5. Operation of high speed rotary instruments in the mouth;
6. Performing pulp capping procedures;
7. Administering and monitoring general anesthetics and conscious sedation except as provided for in § 54.1-2701 of the Code of Virginia *and 18 VAC 60-20-107 C, 18 VAC 60-20-110 F, and 18 VAC 60-20-120 F*;
8. Administering nitrous oxide or oxygen inhalation analgesia;
9. Condensing, contouring or adjusting any final, fixed or removable prosthodontic appliance or restoration in the mouth;
10. Final positioning and attachment of orthodontic bonds and bands;
11. Taking impressions for master casts to be used for prosthetic restoration of teeth or oral structures;
12. Final cementation of crowns and bridges; and
13. Placement of retraction cord. ]

### **18 VAC 60-20-195. Radiation certification.**

No person not otherwise licensed by this board shall place or expose dental x-ray film unless he has (i) satisfactorily completed a course or examination recognized by the Commission on Dental Accreditation of the American Dental Association, (ii) been certified by the American Registry of Radiologic Technologists, (iii) satisfactorily completed a course and passed an examination in compliance with guidelines provided by the board, or (iv) ~~passed the board's examination in radiation safety and hygiene followed by on-the-job training. Any individual not able to successfully complete the board's examination after two attempts may be certified only by completing (i), (ii) or (iii) of this provision satisfactorily completed a radiation course and passed an examination given by the Dental Assisting National Board.~~ Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient.

#### DOCUMENTS INCORPORATED BY REFERENCE

~~Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (October 1999), American Dental Association.~~

1995 Current Dental Terminology, Second Edition, 1995-2000, Code on Dental Procedures and Nomenclature, American Dental Association.

Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, October 1995, American Dental Association.

VA.R. Doc. No. R02-176; Filed November 8, 2004, 12:36 p.m.

## **BOARD OF MEDICINE**

Title of Regulation: **18 VAC 85-20. Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, and Chiropractic (amending 18 VAC 85-20-30, 18 VAC 85-20-40, 18 VAC 85-20-50, 18 VAC 85-20-80, 18 VAC 85-20-90, 18 VAC 85-20-100, 18 VAC 85-20-105; adding 18 VAC 85-20-25, 18 VAC 85-20-26, 18 VAC 85-20-27, 18 VAC 85-20-28 and 18 VAC 85-20-29).**

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

Public Hearing Date: January 21, 2005 - 8:15 a.m.

Public comments may be submitted until 5 p.m. on January 28, 2005.

(See Calendar of Events section for additional information)

Agency Contact: William L. Harp, M.D., Executive Director, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9908, FAX (804) 662-9943, or e-mail [william.harp@dhp.virginia.gov](mailto:william.harp@dhp.virginia.gov).

Basis: Section 54.1-2400 of the Code of Virginia provides the Board of Medicine the authority to promulgate regulations to administer the regulatory system.

In addition, §§ 54.1-2914, 54.1-2915, and 54.1-2916 of the Code of Virginia establish grounds by which the board may refuse to license or certify an applicant or take disciplinary action against a current license or certificate holder. While regulations on standards of conduct do not duplicate standards set forth in law, they do supplement and interpret the statutory provisions.

Purpose: The purpose of this regulatory action is to establish in regulation the standards by which practitioners of the healing arts must conduct their practice. In § 54.1-2914 A 7, the Code of Virginia defines one grounds for a finding of unprofessional conduct as "Conducts his practice in a manner contrary to the standard of ethics of his branch of the healing arts." The board has used the code of ethics of the American Medical Association and other organizations as guidance but has not specifically adopted ethical standards in regulation. This regulatory action expands the current regulations on standards of professional conduct, which already included rules for advertising, recommending vitamins and minerals, prescribing for weight loss, solicitation or remuneration in exchange for referral, and sexual contact. Amended rules will also provide standards relating to ethical behavior in the care and treatment of patients, maintenance and disclosure of records, and in the responsibility of a practitioner for delegation of services to subordinates under their supervision. Throughout the substance of these rules, there are measures that will benefit patient health and safety. For example, a patient's health and safety may benefit from a requirement for the practitioner to communicate and involve the patient in his care, to fully inform the patient, and to maintain patient information with confidentiality.

While the vast majority of practitioners conduct their practices ethically, there are those who have not followed professional standards for communicating and informing patients, for maintaining accurate and legible records, for providing records

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in a timely manner, or for sexual contact with patients. Others who seek to act professionally and ethically have been desirous of specific guidance from the board on matters such as the retention of records and prescribing for self and family. With adoption of these rules, the board's intent is to not only protect the health, welfare and safety of the public against inappropriate and unethical actions by its licensees, but also to give regulatory guidance for practice in a professional manner.

Substance: The substantive provisions of this regulatory action include the following additions to Part II, Standards of Professional Conduct:

18 VAC 85-20-25. Treating and prescribing for self or family. This section specifies the conditions under which it would be ethical for a practitioner to prescribe for self or family, including adherence to the law that requires a bona fide practitioner-patient relationship and maintenance of a patient record. Practitioner can prescribe Schedule VI drugs but should not prescribe other scheduled drugs unless the prescribing occurs in an emergency situation or in isolated settings where there is no other qualified practitioner available to the patient, or it is for a single episode of an acute illness through one prescribed course of medication.

18 VAC 85-20-26. Patient records. Requirements for patient records include compliance with provisions of § 32.1-127.1:03 related to the confidentiality and disclosure of patient records; provision of records in a timely manner and in accordance with applicable law; proper management and completion of records; maintenance of records for a minimum of six years following the last patient encounter with several exceptions; informing all patients concerning the time frame for record retention and destruction; and destruction in a manner that protects patient confidentiality, such as by incineration or shredding.

18 VAC 85-20-27. Confidentiality. The proposed regulation prohibits a practitioner from willfully or negligently breaching the confidentiality between a practitioner and a patient. If a breach of confidence is required by applicable law or beyond the control of the practitioner, it is not be considered negligent or willful.

18 VAC 85-20-28. Practitioner-patient communication; termination of relationship. Subsection A sets out the standards for ethical communication with patients to include provision of accurate information to patients in terms that are understandable and encourage participation. It would be unethical for a practitioner to deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

Before surgery or any invasive procedure is performed, there is a requirement for informed consent in accordance with the policies of the health care entity and a requirement to inform patients of the risks, benefits, and alternatives. Provisions allow for consent from a legally authorized representative in lieu of the patient under certain circumstances and for an exception to the requirement for consent prior to performance of surgery or an invasive procedure in an emergency situation

when a delay in obtaining consent would likely result in imminent harm to the patient. For the purposes of this provision, "invasive procedure" is defined. Practitioners must adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them in research activities.

Subsection B provides the professional standard for termination of the practitioner/patient relationship by either party and requires the practitioner to make a copy of the patient record available.

18 VAC 85-20-29. Practitioner responsibility. This section lists practitioner actions that are considered irresponsible and unethical, including knowingly allowing subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility; engaging in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care; or exploiting the practitioner/patient relationship for personal gain.

In most of the current regulations for ethical standards, it is stated that "it shall be unprofessional conduct for a licensee to..." In its review of the regulations, the board determined that the standard of conduct should be stated and then a violation of the regulation, as determined in a case decision by the board, would provide grounds for disciplinary action. Accordingly, changes in terminology are applied to current regulations.

Additionally, substantive changes were made in the following sections:

18 VAC 85-20-30. Advertising ethics. There is a new requirement for practitioner responsibility and accountability for the validity and truthfulness of the content of an advertisement to ensure that it is not deceptive, misleading or false.

18 VAC 85-20-40. Vitamins, minerals and food supplements. Rather than requiring that the rationale for use of vitamins, minerals or food supplements be therapeutically proven and not experimental, the amended regulation requires that recommendation or direction for such be based upon a reasonable expectation that use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use. The amended regulation is more reasonable and in keeping with the accepted standard for a recommendation.

The current rule prohibits recommending "toxic" doses, which is problematic and ill-defined. The amended rule would prohibit a recommended dose that would be contraindicated based on the individual patient's overall medical condition and medications.

18 VAC 85-20-90. Pharmacotherapy for weight loss. The rules for prescribing "anorectic" drugs are amended to refer to all "controlled substances," Schedules III through VI, used for the purpose of weight reduction or control in the treatment of obesity, since many of the current drugs are not "anorectics." The conditions that must be met include performance of an appropriate history and a review of laboratory work, as

indicated, including testing for thyroid function. Rather than requiring an EKG for every patient, the amended rule requires an electrocardiogram to be performed and interpreted within 90 days of initial prescribing for treatment of obesity if the drug could adversely affect cardiac function.

Rather than weighing the patient at least once a month as is currently required, the amended rule requires that the patient be seen within the first 30 days following initiation of pharmacotherapy for weight loss and that the treating physician direct the follow-up care, including the intervals for patient visits and the continuation of or any subsequent changes in pharmacotherapy. The prohibition against prescribing amphetamine-like substances for use as an anorectic agent in children under 12 years of age is eliminated.

18 VAC 85-20-100. Sexual contact. The amended regulation defines in subsection A what is meant by sexual contact for purposes of interpreting statutory prohibitions in §§ 54.1-2914. Subsection B specifies the prohibition against sexual contact with a patient, and subsection C sets the rule concerning a former patient.

Subsections D and E are new language and set the conditions under which sexual contact between a practitioner and a key third party or between a medical supervisor and a medical trainee could constitute unprofessional conduct.

Issues: There are numerous advantages to the public associated with the proposed regulatory action. By having standards of conduct more clearly stated in regulation, all consumers of services provided by licensees should benefit from specific rules on communication with patients, maintenance of accurate records, access to patient records, confidentiality, and informed consent. In addition, the public is better protected by amendments to rules on advertising, pharmacotherapy for weight loss and sexual contact.

There are no disadvantages to the public of the proposed standards of conduct for licensees of the board.

The primary advantage to the agency comes from a more definitive set of standards of professional conduct for licensees. For example, a standard for maintenance of patient records and for prescribing for self and family will be available to practitioners, who often call the board office for guidance on these issues. Additionally, the board will be able to rely on a clearer standard to cite in a disciplinary case in which a practitioner may be guilty of unprofessional conduct. In the past, the board has cited § 54.1-2914 (7), which states that: "Any practitioner of the healing arts regulated by the board shall be considered guilty of unprofessional conduct if he...conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts." Without fully setting out the standards in regulation, it could be argued that a licensee was expected to conduct himself and his practice according to a standard that had not been adopted by the regulatory board and was unknown to the licensee. More explicit regulations on standards of professional conduct will provide guidance for certain situations and more specific grounds for disciplinary action if the standards are violated.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has

analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The proposed regulations will expand the scope of professional ethical standards to include treating and prescribing for self or family, patient records, confidentiality, communication with patients and termination of practitioner/patient relationship, and practitioner responsibility. The proposed changes will also update the current standards on advertising ethics, the use of vitamins, minerals, and food supplements, the use of anabolic steroids, referral ethics, the use of pharmacotherapy for weight loss, sexual contact, and providing information to the Board of Medicine upon request.

Estimated economic impact. These regulations contain professional ethical standards for practice of medicine, osteopathy, podiatry, and chiropractic. Recently, a disciplinary sanction imposed by the Board of Medicine (the board) on one of its regulants was overturned by the court of appeals based in part because the board did not have regulations addressing the standards of conduct related to the dispute.<sup>1</sup> Prior to this lawsuit, the board has been using the code of ethics of the American Medical Association and of the other related professional organizations as guidance, but its regulations did not contain many of these ethical standards. As a result of this court case, the board conducted an extensive review of professional ethics used by the American Medical Association and other related professional associations, reviewed the list of 42 grounds for disciplinary action recommended by the Federation of State Medical Boards, combed through the standards already addressed in the Code of Virginia or the regulations, and is proposing to expand the scope of ethical standards to cover five new areas and to update standards in eight existing areas.

In general, the proposed regulations will require that treating or prescribing be based on a bona fide relationship; that practitioners do not prescribe to himself or family nonschedule VI drugs or narcotics except under certain circumstances; that practitioners maintain, manage, and destroy patient records according to the specific criteria to ensure patient confidentiality; that practitioners do not breach the practitioner/patient confidentiality; that practitioners do not mislead or make deliberate false statements regarding the medications, treatment, diagnosis, and prognosis; that the practitioners present medical information in understandable language to patients; that practitioners inform patients of the risks, benefits, and alternatives before an invasive procedure; that practitioners do not terminate their relationship with a

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<sup>1</sup> Court of Appeals of Virginia, Record No. 0016-02-2.

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# Proposed Regulations

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patient without a notice allowing reasonable time for the patient; that practitioners do not delegate tasks outside the scope of a subordinate's area; and that practitioners do not exploit the practitioner/patient relationship for personal gain.

Furthermore, the proposed language will clarify and update the ethics rules on: advertising; the use of vitamins, minerals, and food supplements; the use of anabolic steroids; solicitation or remuneration in exchange for referral; pharmacotherapy for weight loss; sexual contact; and providing information to the Board of Medicine. The proposed changes under this category are mainly clarifications of the current requirements.

Because this regulation will be expanded to address more ethical standards and because it updates the existing standards, it will probably be more informative regarding what constitutes a breach of ethical standards and consequently what may be subject to a disciplinary action. Most practitioners are probably already in compliance with most of the proposed standards and are not expected to be affected significantly by the proposed changes on average. Even though there may be a small number of regulants who may have to change their practices to comply with the proposed rules, the significance and the types of potential economic effects are likely to be case specific. Thus, the compliance costs may increase for some regulants by an unknown amount. Also, the proposed changes may cause an increase in the number of complaints and fact-finding investigations. As a rough estimate, the Department of Health expects approximately 7.6 additional informal hearings costing about \$22,897 per year.<sup>2</sup>

The proposed regulation requires that practitioners inform or notify patients of the records retention schedule so patients will be aware of when their records may be no longer available. Given that a practitioner may have accumulated thousands of inactive patients over the years, this requirement seems to have the potential to create significant compliance costs for some of the practitioners. Also, practitioners may not have the accurate address information for most inactive patients. Perhaps, the potential mailing costs of notifications may be significantly reduced if the scope of this requirement is limited to only active or recently active patients.

Some benefits may come from more clearly delineated and stated ethical standards. More informative standards could improve compliance and may provide a higher protection against ethical misconduct for consumers, practitioners, subordinates, and public in general. Also, having ethics standards in regulations could serve as an insurance against similar potential lawsuits that occurred in the past and could improve the enforceability of disciplinary actions.

Businesses and entities affected. The proposed regulations apply to approximately 29,106 doctors of medicine, 1,085 doctors of osteopathic medicine, 488 doctors of podiatry, 1,589 doctors of chiropractic, and 2,750 interns/residents.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The impact of proposed regulations on employment depends on how significantly the current practitioners will have to change their business practices to comply with the proposed ethics standards. Provided that most practitioners are already conducting their businesses in compliance with the proposed regulations, no significance effect on employment is expected.

Effects on the use and value of private property. The proposed ethics standards should not have any significant effect on the value of physical real property. Also, unless the proposed regulations introduce significant compliance costs on practitioners, no significant effect on the use and value of practitioner businesses is expected.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Medicine concurs with the analysis of the Department of Planning and Budget for the proposed regulation, 18 VAC 85-20, Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic relating to standards of professional conduct for licensees.

## Summary:

*The proposed amendments expand the current regulations on professional conduct to include standards for treating and prescribing for self and family; maintenance, retention and release of patient records; patient confidentiality; practitioner-patient communication and termination of that relationship; and practitioner responsibilities. In addition, substantive amendments are proposed for advertising ethics, the recommendation for vitamins and minerals, pharmacotherapy for weight loss, and sexual contact.*

### PART II.

#### STANDARDS OF PROFESSIONAL CONDUCT.

#### **18 VAC 85-20-25. Treating and prescribing for self or family.**

*A. Treating or prescribing shall be based on a bona fide practitioner-patient relationship, and prescribing shall meet the criteria set forth in § 54.1-3303 of the Code of Virginia.*

*B. A practitioner shall not prescribe a controlled substance to himself or a family member, other than Schedule VI as defined in § 54.1-3455 of the Code of Virginia, unless the prescribing occurs in an emergency situation or in isolated settings where there is no other qualified practitioner available to the patient, or it is for a single episode of an acute illness through one prescribed course of medication.*

*C. When treating or prescribing for self or family, the practitioner shall maintain a patient record documenting compliance with statutory criteria for a bona fide practitioner-patient relationship.*

#### **18 VAC 85-20-26. Patient records.**

*A. Practitioners shall comply with the provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.*

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<sup>2</sup> The number of cases and the costs are estimated based on the percentage of regulants affected by these regulations compared to the total number of regulants for which similar ethical standards are proposed, 10 additional cases expected for all professions, and expected cost of \$3,000 per case.

B. Practitioners shall provide patient records to another practitioner or to the patient or his authorized representative in a timely manner in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage patient records and shall maintain timely, accurate, legible and complete patient records.

D. Practitioners shall maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

1. Records of a minor child, including immunizations, which shall be maintained until the child reaches the age of 18 or the age of emancipation, whichever comes first, except the minimum time for record retention shall be six years regardless of the age of the child at the last patient encounter;

2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his legally authorized representative; or

3. Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

E. From (insert effective date of regulations) practitioners shall post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

F. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

### **18 VAC 85-20-27. Confidentiality.**

A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidence that is required by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

### **18 VAC 85-20-28. Practitioner-patient communication; termination of relationship.**

A. Communication with patients.

1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately inform patients or their legally authorized representative of any medical diagnoses, prognosis and prescribed treatment or plan of care. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

2. Practitioners shall present information relating to the patient's care to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care.

3. Before surgery or any invasive procedure is performed, informed consent shall be obtained from the patient in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended surgery or invasive procedure that a reasonably prudent practitioner practicing in Virginia in the same or a similar specialty would tell a patient.

a. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

b. An exception to the requirement for consent prior to performance of surgery or an invasive procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

c. For the purposes of this provision, "invasive procedure" means any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the health care entity is to document specific informed consent from the patient or surrogate decision maker prior to proceeding.

4. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research that affects their care.

B. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make a copy of the patient record available, except in situations where denial of access is allowed by law.

2. Except as provided in § 54.1-2962.2 of the Code of Virginia, a practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

### **18 VAC 85-20-29. Practitioner responsibility.**

A. A practitioner shall not:

1. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

2. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

3. Exploit the practitioner/patient relationship for personal gain.

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B. *Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 2 of this section.*

## **18 VAC 85-20-30. Advertising ethics.**

A. Any statement specifying a fee, whether standard, discounted or free, for professional services which does not include the cost of all related procedures, services and products which, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.

B. Advertising a discounted or free service, examination, or treatment and charging for any additional service, examination, or treatment which that is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bonafide emergency. This provision may not be waived by agreement of the patient and the practitioner.

C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.

D. A licensee or certificate holder's authorization of or use in any advertising for his practice of the term "board certified" or any similar words or phrase calculated to convey the same meaning shall constitute misleading or deceptive advertising under § 54.1-2914 of the Code of Virginia, unless the licensee or certificate holder discloses the complete name of the specialty board which conferred the aforementioned certification.

E. ~~It shall be considered unprofessional conduct for a licensee of the board to publish an advertisement which shall not advertise information that is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner or practitioners responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years.~~

## **18 VAC 85-20-40. Vitamins, minerals and food supplements.**

A. ~~The use or recommendations recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that use or recommendation shall be documented by the practitioner. The rationale for said use must be therapeutically proven and not experimental recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including~~

~~preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.~~

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in ~~toxic~~ doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

## **18 VAC 85-20-50. Anabolic steroids.**

~~It shall be considered unprofessional conduct for a licensee of the board to~~ A practitioner shall not sell, prescribe, or administer anabolic steroids to any patient for other than accepted therapeutic purposes.

## **18 VAC 85-20-80. Solicitation or remuneration in exchange for referral.**

~~It shall be unprofessional conduct for a licensee of the board to~~ A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in § 37.1-179 of the Code of Virginia, or hospital as defined in § 32.1-123 of the Code of Virginia.

Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by ~~Title 42, USC § 1320a-7b(b) of the United States Code~~, as amended, or any regulations promulgated thereto.

## **18 VAC 85-20-90. Pharmacotherapy for weight loss.**

A. ~~It shall be unprofessional conduct for a physician to~~ A practitioner shall not prescribe amphetamine, Schedule II, for the purpose of weight reduction or control.

B. ~~It shall be unprofessional conduct for a physician to~~ A practitioner shall not prescribe ~~anorectic drugs controlled substances~~, Schedules III through VI, for the purpose of weight reduction or control in the treatment of obesity, unless the following conditions are met:

~~1. A comprehensive~~ An appropriate history, and physical examination, and ~~interpreted electrocardiogram~~ are performed and recorded at the time of initiation of ~~treatment~~ pharmacotherapy for obesity by the prescribing physician, and the physician reviews the results of laboratory work, as indicated, including testing for thyroid function;

~~2. If the drug to be prescribed could adversely affect cardiac function, the physician shall review the results of an electrocardiogram performed and interpreted within 90 days of initial prescribing for treatment of obesity;~~

~~3. A diet and exercise program for weight loss is prescribed and recorded;~~

~~4. The patient is weighed at least once a month seen within the first 30 days following initiation of pharmacotherapy for weight loss by the prescribing physician or a licensed practitioner with prescriptive authority working under the supervision of the prescribing~~

physician, at which time a recording shall be made of blood pressure, pulse, and any other tests as may be necessary for monitoring potential adverse effects of drug therapy;

~~4. No more than a 30-day supply of such drugs shall be prescribed or dispensed at any one time;~~

~~5. No such drugs shall be prescribed or dispensed for more than 90 days unless the patient:~~

~~a. Has a recorded weight loss of at least 12 pounds in the first 90 days of therapy;~~

~~b. 5. The treating physician shall direct the follow-up care, including the intervals for patient visits and the continuation of or any subsequent changes in pharmacotherapy. Continuation of prescribing for treatment of obesity shall occur only if the patient has continued progress toward achieving or maintaining a target weight; and e. has no significant adverse effects from the prescribed program.~~

~~C. It shall be unprofessional conduct for a physician to prescribe amphetamine like substances for use as an anorectic agent in children under 12 years of age.~~

**18 VAC 85-20-100. Sexual contact with patients.**

A. For purposes of § 54.1-2914 A 7 and A ~~46~~ 14 of the Code of Virginia *and this section*, sexual contact ~~between a practitioner and a patient~~ includes, but is not limited to, sexual behavior or involvement with a patient including verbal or physical behavior ~~which that~~.

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

**B. Sexual contact with a patient.**

1. The determination of when a person is a patient for purposes of § 54.1-2914 A ~~46~~ 14 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. *The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.*

~~C. A patient's consent to, initiation of, or participation in sexual behavior or involvement with a practitioner does not change the nature of the conduct nor lift the statutory prohibition. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.~~

*D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient means spouse or partner, parent or child, guardian, or legal representative of the patient.*

*E. Sexual contact between a medical supervisor and a medical trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.*

**18 VAC 85-20-105. Refusal to provide information.**

~~It shall be considered unprofessional conduct for a licensee to~~ *A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.*

**NOTICE:** The forms used in administering 18 VAC 85-20, Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, and Chiropractic, are not being published due to the number of forms; however, the name of each form is listed below. The forms are available for public inspection at the Board of Medicine, 6603 W. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

**FORMS**

Instructions for Completing Application to Practice Medicine for Graduates of Approved Institutions (rev. 7/03).

Instructions for Completing an Application to Practice Medicine for Graduates of Nonapproved Institutions (rev. 7/03).

Instructions for Completing PMLEXIS Examination/License Application (rev. 7/03).

Information for Completing Chiropractic Endorsement Application (rev. 7/03).

Instructions for Completing Podiatry Endorsement Application (rev. 7/03).

Instructions for Completing Osteopathic Medicine Licensure Application (rev. 7/03).

Form A, Claims History Sheet (rev. 12/02).

Form B, Activity Questionnaire (rev. 12/02).

Form C, Clearance from Other State Boards (rev. 12/02).

Form E, Disciplinary Inquiry (rev. 12/02).

Application for a License to Practice Medicine and Surgery (rev. 7/03).

Application for a License to Practice Osteopathic Medicine (rev. 7/03).

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Application for a License to Practice Podiatry (rev. 7/03).

Application for a License to Practice Chiropractic (rev. 7/03).

Form H, Virginia Request for Podiatry Disciplinary Action (rev. ~~4/03~~ 4/04).

Form I, National Board of Podiatric Medical Examiners Request for Scores on Part I and II (rev. 1/03).

Requirements and Instructions for an Intern/Resident License (rev. 3/04).

Intern/Resident, Form A, Memorandum from Associate Dean of Graduate Medical Education (rev. 3/04).

Intern/Resident, Form B, Certificate of Professional Education (rev. 3/04).

Application for a Temporary License for Intern/Resident Training Program (rev. 3/04).

Form G, Intern Resident, Request for Status Report of ECFMG Certification (eff. 3/04).

Form H, Report of Clinical Rotations (rev. 12/02).

Transfer Request, Intern Resident (eff. 3/04).

Instructions for Completing an Application for a Limited License to Practice Medicine as a Full-time Faculty Member or as a Full-time Fellow Foreign Medical Graduates Pursuant to 54.1-2936 (rev. ~~3/03~~ 3/04).

Application for a Limited License to Practice Medicine as a Full-time Faculty Member or as a Full-time Fellow Foreign Medical Graduates Pursuant to 54.1-2936 (rev. ~~2/03~~ 3/04).

Form G, Request for Status Report of Educational Commission for Foreign Medical Graduates Certification (rev. ~~12/02~~ 3/04).

Form L, Certificate of Professional Education (rev. ~~12/02~~ 9/04).

Continued Competency Activity and Assessment Form (rev. 4/00).

Instructions for Reinstatement of Medicine and Surgery Licensure Application (rev. ~~7/03~~ 3/04).

Application for Reinstatement of License to Practice Medicine (rev. ~~7/03~~ 3/04).

Form A, MD Reinstatement, Claims History Sheet (rev. ~~4/03~~ 3/04).

Form B, MD Reinstatement, Activity Questionnaire Form (rev. ~~4/03~~ 3/04).

Form C, MD Reinstatement, State Questionnaire Form (rev. ~~4/03~~ 2/04).

MD Reinstatement, Disciplinary Inquiries to Federation of State Medical Boards (rev. ~~4/03~~ 3/04).

Instructions for Reinstatement of Osteopathy Medicine Licensure Application (rev. ~~7/03~~ 2/04).

Application for Reinstatement of License to Practice Osteopathy Osteopathic Medicine (rev. ~~7/03~~ 3/04).

Form A, Osteopathy Reinstatement, Claims History (rev. ~~3/03~~ 3/04).

Instructions for Reinstatement of Chiropractic Licensure Application (rev. ~~7/03~~ 2/04).

Application for Reinstatement of License to Practice as a Chiropractor (rev. ~~7/03~~ 3/04).

Instructions for Reinstatement of Podiatry Licensure Application (rev. ~~7/03~~ 3/04).

Application for Reinstatement of License to Practice Podiatry (rev. ~~7/03~~ 3/04).

Application for Reinstatement of License to Practice Medicine/Osteopathy After Petition for Reinstatement Denied or License Revoked (rev. 3/03).

Application for Reinstatement of License to Practice Medicine/Osteopathy (rev. 2/03).

Application for Reinstatement of License to Practice Chiropractic (rev. 3/03).

Renewal Notice and Application, 0101 Medicine and Surgery (rev. 7/03).

Renewal Notice and Application, 0102 Osteopathy and Surgery (rev. 7/03).

Renewal Notice and Application, 0103 Podiatry (rev. 7/03).

Renewal Notice and Application, 0104 Chiropractic (rev. 7/03).

Renewal Notice and Application, 0108 Naturopath (rev. 12/02).

Renewal Notice and Application, 0109 University and Limited License (rev. 12/02).

Renewal Notice and Application, 0116 Interns and Residents (rev. 12/02).

Application for Registration for Volunteer Practice (eff. 12/02).

Sponsor Certification for Volunteer Registration (eff. 1/03).

Guidelines for Completing the Practitioner Profile Questionnaire (rev. 12/02).

Practitioner's Help Section (rev. 11/02).

Practitioner Questionnaire (rev. 11/02).

VA.R. Doc. No. R03-263; Filed November 8, 2004, 12:38 p.m.

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**Title of Regulation: 18 VAC 85-40. Regulations Governing the Practice of Respiratory Care Practitioners (adding 18 VAC 85-40-85 through 18 VAC 85-40-91).**

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

**Public Hearing Date: January 21, 2005 - 8:15 a.m.**

Public comments may be submitted until 5 p.m. on January 28, 2005.

(See Calendar of Events section for additional information)

**Agency Contact:** William L. Harp, M.D., Executive Director, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9908, FAX (804) 662-9943, or e-mail [william.harp@dhp.virginia.gov](mailto:william.harp@dhp.virginia.gov).

**Basis:** Section 54.1-2400 of the Code of Virginia provides the Board of Medicine the authority to promulgate regulations to administer the regulatory system.

In addition, §§ 54.1-2914, 54.1-2915, and 54.1-2916 of the Code of Virginia establish grounds by which the board may refuse to license or certify an applicant or take disciplinary action against a current license or certificate holder. While regulations on standards of conduct do not duplicate standards set forth in law, they do supplement and interpret the statutory provisions.

**Purpose:** The purpose of this regulatory action is to establish in regulation the standards by which practitioners of the healing arts must conduct their practice. Section 54.1-2914 A 7 of the Code of Virginia defines one grounds for a finding of unprofessional conduct as "Conducts his practice in a manner contrary to the standard of ethics of his branch of the healing arts." The board has used the code of ethics of the American Medical Association and other organizations as guidance but has not specifically adopted ethical standards in regulation. Amended rules will provide standards relating to ethical behavior in the care and treatment of patients, maintenance and disclosure of records, and in the responsibility of a practitioner for delegation of services to subordinates under their supervision. Throughout the substance of these rules, there are measures that will benefit patient health and safety. For example, a patient's health and safety may benefit from a requirement for the practitioner to communicate and involve the patient in his care, to fully inform the patient, and to maintain patient information with confidentiality.

While the vast majority of practitioners conduct their practices ethically, there are those who have not followed professional standards for communicating and informing patients, for maintaining accurate and legible records, for providing records in a timely manner, or for sexual contact with patients. Others who seek to act professionally and ethically have been desirous of specific guidance from the board on matters such as the retention of records and informed consent. With adoption of these rules, the board's intent is to not only protect the health, welfare and safety of the public against inappropriate and unethical actions by its licensees, but also to give regulatory guidance for practice in a professional manner.

**Substance:** The substantive provisions of this regulatory action include the following standards for professional conduct:

18 VAC 85-40-85. Confidentiality. The proposed regulation prohibits a practitioner from willfully or negligently breaching the confidentiality between a practitioner and a patient. If a breach of confidence is required by applicable law or beyond the control of the practitioner, it is not considered negligent or willful.

18 VAC 85-40-86. Patient records. Proposed regulations set requirements for confidentiality and disclosure of patient

records; maintenance of accurate, timely records; record retention for a minimum of six years with certain exceptions; and appropriate destruction of records.

18 VAC 85-40-87. Practitioner-patient communication; termination of relationship. Subsection A sets out the standards for ethical communication with patients to include provision of accurate information to patients in terms that are understandable and encourage participation. It would be unethical for a practitioner to deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

Before any invasive procedure is performed, there is a requirement for informed consent in accordance with the policies of the health care entity and a requirement to inform patients of the risks, benefits, and alternatives. Provisions allow for consent from a legally authorized representative in lieu of the patient under certain circumstances and for an exception to the requirement for consent prior to performance of an invasive procedure in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient. For the purposes of this provision, "invasive procedure" is defined. Practitioners must adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them in research activities.

Subsection B provides the professional standard for termination of the practitioner/patient relationship by either party and requires the practitioner to make a copy of the patient record available.

18 VAC 85-40-88. Practitioner responsibility. This section lists practitioner actions that are considered irresponsible and unethical, including knowingly allowing subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility; engaging in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care; or exploiting the practitioner/patient relationship for personal gain.

18 VAC 85-40-89. Solicitation or remuneration in exchange for referral. Proposed regulations are identical to current requirements for licensees regulated under 18 VAC 85-20 (doctors of medicine, osteopathic medicine, podiatry and chiropractic). There is a prohibition on knowingly and willfully soliciting or receiving any remuneration for referral of an individual to a health care facility or institution.

18 VAC 85-40-90. Sexual contact. Proposed regulations define in subsection A what is meant by sexual contact for purposes of interpreting statutory prohibitions in § 54.1-2914 of the Code of Virginia. Subsection B specifies the prohibition against sexual contact with a patient, and subsection C sets the rule concerning a former patient.

Subsections D and E set the conditions under which sexual contact between a practitioner and a key third party or between a medical supervisor and a medical trainee could constitute unprofessional conduct.

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18 VAC 85-40-91. Refusal to provide information. The proposed regulation is identical to current requirements for licensees regulated under 18 VAC 85-20; it makes it unprofessional conduct to refuse to provide information or records as requested or required by the board or one of its investigators in the enforcement of law and regulation.

Issues: There are numerous advantages to the public associated with the proposed regulatory action. By having standards of conduct more clearly stated in regulation, all consumers of services provided by licensees should benefit from specific rules on communication with patients, maintenance of accurate records, access to patient records, confidentiality, sexual contact, and informed consent.

There are no disadvantages to the public of the proposed standards of conduct for licensees of the board.

The primary advantage to the agency comes from a more definitive set of standards of professional conduct for licensees. For example, a standard for retention of patient records will be available to practitioners, who often call the board office for guidance on these issues. Additionally, the board will be able to rely on a clearer standard to cite in a disciplinary case in which a practitioner may be guilty of unprofessional conduct. In the past, the board has cited § 54.1-2914 A 7, which states that: "Any practitioner of the healing arts regulated by the board shall be considered guilty of unprofessional conduct if he...conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts." Without fully setting out the standards in regulation, it could be argued that a licensee was expected to conduct himself and his practice according to a standard that had not been adopted by the regulatory board and was unknown to the licensee. More explicit regulations on standards of professional conduct will provide guidance for certain situations and more specific grounds for disciplinary action if the standards are violated.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The proposed regulations will establish professional ethical standards for patient records, confidentiality, communication with patients and termination of practitioner/patient relationship, practitioner responsibility, referral ethics, sexual contact, and providing information to the Board of Medicine upon request.

Estimated economic impact. These regulations contain professional ethical standards for practice of respiratory care.

Recently, a disciplinary sanction imposed by the Board of Medicine (the board) on one of its regulants was overturned by the court of appeals based in part because the board did not have regulations addressing the standards of conduct related to the dispute.<sup>1</sup> Prior to this lawsuit, the board has been using the code of ethics of the American Medical Association and of the other related professional organizations as guidance, but its regulations did not contain many of these ethical standards. As a result of this court case, the board conducted an extensive review of professional ethics used by the American Medical Association and other related professional associations, reviewed the list of 42 grounds for disciplinary action recommended by the Federation of State Medical Boards, combed through the standards already addressed in the Code of Virginia or the regulations, and is proposing to establish ethical standards to cover seven areas.

In general, the proposed regulations will require that practitioners maintain, manage, and destroy patient records according to the specific criteria to ensure patient confidentiality; that practitioners do not breach the practitioner/patient confidentiality; that practitioners do not mislead or make deliberate false statements regarding the medications, treatment, diagnosis, and prognosis; that practitioners inform patients of the risks, benefits, and alternatives before an invasive procedure; that the practitioners present medical information in understandable language to patients; that practitioners do not terminate their relationship with a patient without a notice allowing reasonable time for the patient; that practitioners do not delegate tasks outside the scope of a subordinate's area; that practitioners do not exploit the practitioner/patient relationship for personal gain; that practitioners do not seek remuneration in exchange for referral; that practitioners do not have sexual contact with patients or with supervisees, if that relationship would have an adverse affect on patient care; and that practitioners provide information to the Board of Medicine if requested.

The proposed changes will establish explicit standards the board is currently using as guidance. Because this regulation will establish more clearly the scope of ethical standards, it will probably be more informative regarding what constitutes a breach of ethical standards and consequently what may be subject to a disciplinary action. Most practitioners are probably already in compliance with most of the proposed standards and are not expected to be affected significantly by the proposed changes on average. Even though there may be a small number of regulants who may have to change their practices to comply with the proposed rules, the significance and the types of potential economic effects are likely to be case specific. Thus, the compliance costs may increase for some regulants by an unknown amount. Also, the proposed changes may cause an increase in the number of complaints and fact-finding investigations. As a rough estimate, the Department of Health expects approximately 0.7 additional informal hearings costing about \$2,030 per year.<sup>2</sup>

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<sup>1</sup> Court of Appeals of Virginia, Record No. 0016-02-2.

<sup>2</sup> The number of cases and the costs are estimated based on the percentage of regulants affected by these regulations compared to the total number of regulants for which similar ethical standards are proposed, 10 additional cases expected for all professions, and expected cost of \$3,000 per case.

The proposed regulation requires that practitioners inform or notify patients of the records retention schedule so patients will be aware of when their records may be no longer available. Given that a practitioner may have accumulated thousands of inactive patients over the years, this requirement seems to have the potential to create significant compliance costs for some of the practitioners. Also, practitioners may not have the accurate address information for most inactive patients. Perhaps, the potential mailing costs of notifications may be significantly reduced if the scope of this requirement is limited to only active or recently active patients.

Some benefits may come from more clearly delineated and stated ethical standards. More informative standards could improve compliance and may provide a higher protection against ethical misconduct for consumers, practitioners, subordinates, and public in general. Also, having ethics standards in regulations could serve as an insurance against similar potential lawsuits that occurred in the past and could improve the enforceability of disciplinary actions.

Businesses and entities affected. The proposed regulations apply to approximately 3,104 respiratory care practitioners.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The impact of proposed regulations on employment depends on how significantly the current practitioners will have to change their business practices to comply with the proposed ethics standards. Provided that most practitioners are already conducting their businesses in compliance with the proposed regulations, no significance effect on employment is expected.

Effects on the use and value of private property. The proposed ethics standards should not have any significant effect on the value of physical real property. Also, unless the proposed regulations introduce significant compliance costs on practitioners, no significant effect on the use and value of practitioner businesses is expected.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Medicine concurs with the analysis of the Department of Planning and Budget for the proposed regulation, 18 VAC 85-40, Regulations Governing the Practice of Respiratory Care relating to standards of professional conduct for licensees.

Summary:

*The proposed amendments establish standards for professional conduct including maintenance, retention and release of patient records; patient confidentiality; practitioner-patient communication and termination of that relationship; solicitation or remuneration for referrals; sexual contact; and practitioner responsibilities.*

PART V.

STANDARDS OF PROFESSIONAL CONDUCT.

**18 VAC 85-40-85. Confidentiality.**

*A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidence that is required by applicable law or beyond the*

*control of the practitioner shall not be considered negligent or willful.*

**18 VAC 85-40-86. Patient records.**

*A. Practitioners shall comply with the provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.*

*B. Practitioners shall provide patient records to another practitioner or to the patient or his authorized representative in a timely manner in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.*

*C. Practitioners shall properly manage and keep timely, accurate, legible and complete patient records.*

*D. Practitioners who are employed by a health care institution or other entity in which the individual practitioner does not own or maintain his own records shall maintain patient records in accordance with the policies and procedures of the employing entity.*

*E. Practitioners who are self-employed or employed by an entity in which the individual practitioner owns and is responsible for patient records shall:*

*1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:*

*a. Records of a minor child, including immunizations, which shall be maintained until the child reaches the age of 18 or the age of emancipation, whichever comes first, except the minimum time for record retention shall be six years regardless of the age of the child at the last patient encounter;*

*b. Records that have previously been transferred to another practitioner or health care provider or provided to the patient; or*

*c. Records that are required by contractual obligation or federal law to be maintained for a longer period of time.*

*2. From (insert effective date of regulations), post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.*

*3. When closing, selling or relocating his practice, meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.*

**18 VAC 85-40-87. Practitioner-patient communication; termination of relationship.**

*A. Communication with patients.*

*1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or his legally authorized representative in terms that are understandable and encourage participation in decisions regarding the patient's care.*

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## Proposed Regulations

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2. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure provided or directed by the practitioner in the treatment of any disease or condition.

3. Before an invasive procedure is performed, informed consent shall be obtained from the patient in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended procedure that a reasonably prudent practitioner practicing respiratory care in Virginia would tell a patient.

a. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

b. An exception to the requirement for consent prior to performance of an invasive procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

c. For the purposes of this provision, "invasive procedure" means any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the health care entity is to document specific informed consent from the patient or surrogate decision maker prior to proceeding.

4. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research that affects their care.

### B. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make the patient record available, except in situations where denial of access is allowed by law.

2. A practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

### 18 VAC 85-40-88. Practitioner responsibility.

#### A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;

2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with

patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 3 of this section.

### 18 VAC 85-40-89. Solicitation or remuneration in exchange for referral.

A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in § 37.1-179 of the Code of Virginia or hospital as defined in § 32.1-123 of the Code of Virginia.

Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by 42 USC § 1320 a-7b(b), as amended, or any regulations promulgated thereto.

### 18 VAC 85-40-90. Sexual contact.

A. For purposes of § 54.1-2914 A 7 and A 14 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior that:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

#### B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2914 A 14 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For

purposes of this section, key third party of a patient means spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

**18 VAC 85-40-91. Refusal to provide information.**

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

**NOTICE:** The forms used in administering 18 VAC 85-40, Regulations Governing the Practice of Respiratory Care Practitioners, are not being published due to the number of forms; however, the name of each form is listed below. The forms are available for public inspection at the Board of Medicine, 6603 W. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

**FORMS**

- Instructions for Completing a Respiratory Care Practitioner Application (rev. 44/02 6/04).
- Application for a License to Practice as a Respiratory Care Practitioner (rev. 44/02 6/04).
- Instructions for Completing Reinstatement Application for of Respiratory Care Practitioner License (eff. 10/04 rev. 3/04).
- Application for Reinstatement as a of License to Practice Respiratory Care Practitioner (eff. 3/03 rev. 3/04).
- Form A, Claims History Sheet (rev. 44/02 6/04).
- Form B, Activity Questionnaire (rev. 44/02 6/04).
- Form C, Clearance from Other State Boards (rev. 44/02 3/03).
- Form L, Certificate of Professional Education (rev. 44/02 9/04).
- Verification of Certification Request Form (NBRTC) (rev. 44/02 6/04).
- Renewal Notice and Application, 0117 Respiratory Care (rev. 2/03).
- Application for Registration for Volunteer Practice (eff. 12/02).
- Sponsor Certification for Volunteer Registration (eff. 1/03).

VA.R. Doc. No. R03-263; Filed November 8, 2004, 12:38 p.m.

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**Title of Regulation:** 18 VAC 85-50. Regulations Governing the Practice of Physician Assistants (adding 18 VAC 85-50-175 through 18 VAC 85-50-184).

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

**Public Hearing Date:** January 21, 2005 - 8:15 a.m.

Public comments may be submitted until 5 p.m. on January 28, 2005.

(See Calendar of Events section for additional information)

**Agency Contact:** William L. Harp, M.D., Executive Director, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9908, FAX (804) 662-9943, or e-mail william.harp@dhp.virginia.gov.

**Basis:** Section 54.1-2400 of the Code of Virginia provides the Board of Medicine the authority to promulgate regulations to administer the regulatory system.

In addition, §§ 54.1-2914, 54.1-2915, and 54.1-2916 of the Code of Virginia establish grounds by which the board may refuse to license or certify an applicant or take disciplinary action against a current license or certificate holder. While regulations on standards of conduct do not duplicate standards set forth in law, they do supplement and interpret the statutory provisions.

**Purpose:** The purpose of this regulatory action is to establish in regulation the standards by which practitioners of the healing arts must conduct their practice. Section 54.1-2914 A 7 of the Code of Virginia defines one grounds for a finding of unprofessional conduct as "Conducts his practice in a manner contrary to the standard of ethics of his branch of the healing arts." The board has used the code of ethics of the American Medical Association and other organizations as guidance but has not specifically adopted ethical standards in regulation. Amended rules will provide standards relating to ethical behavior in the care and treatment of patients, maintenance and disclosure of records, and in the responsibility of a practitioner for delegation of services to subordinates under their supervision. Throughout the substance of these rules, there are measures that will benefit patient health and safety. For example, a patient's health and safety may benefit from a requirement for the practitioner to communicate and involve the patient in his care, to fully inform the patient, and to maintain patient information with confidentiality.

While the vast majority of practitioners conduct their practices ethically, there are those who have not followed professional standards for communicating and informing patients, for maintaining accurate and legible records, for providing records in a timely manner, or for sexual contact with patients. Others who seek to act professionally and ethically have been desirous of specific guidance from the board on matters such as the retention of records and informed consent. With adoption of these rules, the board's intent is to not only protect the health, welfare and safety of the public against inappropriate and unethical actions by its licensees but also to give regulatory guidance for practice in a professional manner.

**Substance:** The substantive provisions of this regulatory action include the following standards for professional conduct:

18 VAC 85-50-175. Confidentiality. The proposed regulation prohibits a practitioner from willfully or negligently breaching the confidentiality between a practitioner and a patient. If a breach of confidence is required by applicable law or beyond

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## Proposed Regulations

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the control of the practitioner, it is not considered negligent or willful.

18 VAC 85-50-176. Treating and prescribing for self or family. This section specifies the conditions under which it would be ethical for a practitioner to prescribe for self or family, including adherence to the law that requires a bona fide practitioner-patient relationship and maintenance of a patient record. Practitioners can prescribe Schedule VI drugs but should not prescribe other scheduled drugs unless the prescribing occurs in an emergency situation or in isolated settings where there is no other qualified practitioner available to the patient, or it is for a single episode of an acute illness through one prescribed course of medication.

18 VAC 85-50-177. Patient records. Proposed regulations set requirements for confidentiality and disclosure of patient records; maintenance of accurate, timely records; and providing patient records to another practitioner or the patient in accordance with provisions of law.

18 VAC 85-20-178. Practitioner-patient communication. This section sets out the standards for ethical communication with patients to include provision of accurate information to patients in terms that are understandable and encourage participation. It would be unethical for a practitioner to deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

Before any surgery or invasive procedure is performed, there is a requirement for informed consent in accordance with the policies of the health care entity and a requirement to inform patients of the risks, benefits, and alternatives. Provisions allow for consent from a legally authorized representative in lieu of the patient under certain circumstances and for an exception to the requirement for consent prior to performance of an invasive procedure in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient. For the purposes of this provision, "invasive procedure" is defined.

18 VAC 85-50-179. Practitioner responsibility. This section lists practitioner actions that are considered irresponsible and unethical, including knowingly allowing subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility; engaging in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care; or exploiting the practitioner/patient relationship for personal gain.

18 VAC 85-50-180. Vitamins, minerals and food supplements. The regulation requires that recommendation or direction for such be based upon a reasonable expectation that use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use. The proposed rule would also prohibit a recommended dose that would be contraindicated based on the individual patient's overall medical condition and medications.

18 VAC 85-50-181. Pharmacotherapy for weight loss. There are new rules proposed for prescribing "controlled

substances," Schedules III through VI used for the purpose of weight reduction or control in the treatment of obesity, which are identical to the current and amended rules for physicians. The conditions that must be met include performance of an appropriate history and a review of laboratory work, as indicated, including testing for thyroid function. The proposed rule requires an electrocardiogram to be performed and interpreted within 90 days of initial prescribing for treatment of obesity, if the drug could adversely affect cardiac function.

The proposal also requires that the patient be seen within the first 30 days following initiation of pharmacotherapy for weight loss and that the treating physician direct the follow-up care, including the intervals for patient visits and the continuation of or any subsequent changes in pharmacotherapy.

18 VAC 85-50-182. Anabolic steroids. The current prohibition in 18 VAC 85-20 for physicians on prescribing anabolic steroids, except for accepted therapeutic purposes, is included in regulations for physician assistants who also have prescriptive authority.

18 VAC 85-50-183. Sexual contact. Proposed regulations define in subsection A what is meant by sexual contact for purposes of interpreting statutory prohibitions in §§ 54.1-2914 of the Code of Virginia. Subsection B specifies the prohibition against sexual contact with a patient, and subsection C sets the rule concerning a former patient.

Subsections D and E set the conditions under which sexual contact between a practitioner and a key third party or between a medical supervisor and a medical trainee could constitute unprofessional conduct.

18 VAC 85-50-184. Refusal to provide information. The proposed regulation is identical to current requirements for licensees regulated under 18 VAC 85-20; it makes it unprofessional conduct to refuse to provide information or records as requested or required by the board or one of its investigators in the enforcement of law and regulation.

Issues: There are numerous advantages to the public associated with the proposed regulatory action. By having standards of conduct more clearly stated in regulation, all consumers of services provided by licensees should benefit from specific rules on communication with patients, maintenance of accurate records, access to patient records, confidentiality, sexual contact and informed consent.

There are no disadvantages to the public of the proposed standards of conduct for licensees of the board.

The primary advantage to the agency comes from a more definitive set of standards of professional conduct for licensees. For example, a standard for retention of patient records will be available to practitioners, who often call the board office for guidance on these issues. Additionally, the board will be able to rely on a clearer standard to cite in a disciplinary case in which a practitioner may be guilty of unprofessional conduct. In the past, the board has cited § 54.1-2914 A 7, which states that: "Any practitioner of the healing arts regulated by the board shall be considered guilty of unprofessional conduct if he...conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts." Without fully setting out the standards in

regulation, it could be argued that a licensee was expected to conduct himself and his practice according to a standard that had not been adopted by the regulatory board and was unknown to the licensee. More explicit regulations on standards of professional conduct will provide guidance for certain situations and more specific grounds for disciplinary action if the standards are violated.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The proposed regulations will establish professional ethical standards for treating and prescribing for self or family, patient records, confidentiality, communication with patients and termination of practitioner/patient relationship, practitioner responsibility, the use of vitamins, minerals, and food supplements, the use of pharmacotherapy for weight loss, the use of anabolic steroids, sexual contact, and providing information to the Board of Medicine upon request.

Estimated economic impact. These regulations contain professional ethical standards for practice of physician assistants. Recently, a disciplinary sanction imposed by the Board of Medicine (the board) on one of its regulants was overturned by the court of appeals based in part because the board did not have regulations addressing the standards of conduct related to the dispute.<sup>1</sup> Prior to this lawsuit, the board has been using the code of ethics of the American Medical Association and of the other related professional organizations as guidance, but its regulations did not contain many of these ethical standards. As a result of this court case, the board conducted an extensive review of professional ethics used by the American Medical Association and other related professional associations, reviewed the list of 42 grounds for disciplinary action recommended by the Federation of State Medical Boards, combed through the standards already addressed in the Code of Virginia or the regulations, and is proposing to establish ethical standards to cover ten areas.

In general, the proposed regulations will require that practitioners maintain and manage patient records according to the specific criteria to ensure patient confidentiality; that practitioners do not breach the practitioner/patient confidentiality; that practitioners do not prescribe drugs other than schedule VI drugs for self or family except under certain circumstances; that practitioners do not mislead or make deliberate false statements regarding the medications,

treatment, diagnosis, and prognosis; that the practitioners present medical information in understandable language to patients; that practitioners inform patients of the risks, benefits, and alternatives before an invasive procedure; that practitioners do not delegate tasks outside the scope of a subordinate's area; that practitioners do not exploit the practitioner/patient relationship for personal gain; that the practitioners do not use vitamins, minerals, and food supplements unless a favorable outcome is expected; that practitioners do not prescribe certain drugs for weight loss; that practitioners do not prescribe anabolic steroids other than accepted therapeutic purposes; that practitioners do not have sexual contact with patients or with supervisees, if that relationship would have an adverse affect on patient care; and that practitioners provide information to the Board of Medicine if requested.

The proposed changes will establish explicit standards the board is currently using as guidance. Because this regulation will establish more clearly the scope of ethical standards, it will probably be more informative regarding what constitutes a breach of ethical standards and consequently what may be subject to a disciplinary action. Most practitioners are probably already in compliance with most of the proposed standards and are not expected to be affected significantly by the proposed changes on average. Even though there may be a small number of regulants who may have to change their practices to comply with the proposed rules, the significance and the types of potential economic effects are likely to be case specific. Thus, the compliance costs may increase for some regulants by an unknown amount. Also, the proposed changes may cause an increase in the number of complaints and fact-finding investigations. As a rough estimate, the Department of Health expects approximately 0.2 additional informal hearings costing about \$688 per year.<sup>2</sup>

Some benefits may come from more clearly delineated and stated ethical standards. More informative standards could improve compliance and may provide a higher protection against ethical misconduct for consumers, practitioners, subordinates, and public in general. Also, having ethics standards in regulations could serve as an insurance against similar potential lawsuits that occurred in the past and could improve the enforceability of disciplinary actions.

Businesses and entities affected. The proposed regulations apply to approximately 1,052 physician assistants.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The impact of proposed regulations on employment depends on how significantly the current practitioners will have to change their business practices to comply with the proposed ethics standards. Provided that most practitioners are already conducting their businesses in compliance with the proposed regulations, no significance effect on employment is expected.

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<sup>1</sup> Court of Appeals of Virginia, Record No. 0016-02-2.

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<sup>2</sup> The number of cases and the costs are estimated based on the percentage of regulants affected by these regulations compared to the total number of regulants for which similar ethical standards are proposed, 10 additional cases expected for all professions, and expected cost of \$3,000 per case.

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# Proposed Regulations

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Effects on the use and value of private property. The proposed ethics standards should not have any significant effect on the value of physical real property. Also, unless the proposed regulations introduce significant compliance costs on practitioners, no significant effect on the use and value of practitioner businesses is expected.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Medicine concurs with the analysis of the Department of Planning and Budget for the proposed regulation, 18 VAC 85-50, Regulations Governing the Practice of Physician Assistants relating to standards of professional conduct for licensees.

## Summary:

*The proposed amendments establish standards for professional conduct for physician assistants including prescribing for self or family; maintenance, retention and release of patient records; patient confidentiality; practitioner-patient communication and termination of that relationship; solicitation or remuneration for referrals; sexual contact; and practitioner responsibilities.*

## PART VI. STANDARDS OF PROFESSIONAL CONDUCT.

### **18 VAC 85-50-175. Confidentiality.**

*A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidence that is required by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.*

### **18 VAC 85-50-176. Treating and prescribing for self or family.**

*A. Treating or prescribing shall be based on a bona fide practitioner-patient relationship, and prescribing shall meet the criteria set forth in § 54.1-3303 of the Code of Virginia.*

*B. A practitioner shall not prescribe a controlled substance to himself or a family member, other than Schedule VI as defined in § 54.1-3455 of the Code of Virginia, unless the prescribing occurs in an emergency situation or in isolated settings where there is no other qualified practitioner available to the patient, or it is for a single episode of an acute illness through one prescribed course of medication.*

*C. When treating or prescribing for self or family, the practitioner shall maintain a patient record documenting compliance with statutory criteria for a bona fide practitioner-patient relationship.*

### **18 VAC 85-50-177. Patient records.**

*A. Practitioners shall comply with the provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.*

*B. Practitioners shall properly manage patient records and shall maintain timely, accurate, legible and complete records.*

*C. Practitioners shall provide patient records to another practitioner or to the patient or his authorized representative in a timely manner and in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.*

### **18 VAC 85-50-178. Practitioner-patient communication.**

*A. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately inform patients or their legally authorized representative of any medical diagnoses, prognosis and prescribed treatments or plans of care. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.*

*B. Practitioners shall present information relating to the patient's care to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care and shall refer to or consult with other health care professionals if so indicated.*

*C. Before surgery or any invasive procedure is performed, informed consent shall be obtained from the patient in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended surgery or invasive procedure that a reasonably prudent practitioner practicing in Virginia in the same or a similar specialty would tell a patient.*

*1. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.*

*2. An exception to the requirement for consent prior to performance of surgery or an invasive procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.*

*3. For the purposes of this provision, "invasive procedure" means any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the health care entity is to document specific informed consent from the patient or surrogate decision maker prior to proceeding.*

### **18 VAC 85-50-179. Practitioner responsibility.**

*A. A practitioner shall not:*

*1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;*

*2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;*

*3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or*

*4. Exploit the practitioner/patient relationship for personal gain.*

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 3 of this section.

**18 VAC 85-50-180. Vitamins, minerals and food supplements.**

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

**18 VAC 85-50-181. Pharmacotherapy for weight loss.**

A. A practitioner shall not prescribe amphetamine, Schedule II, for the purpose of weight reduction or control.

B. A practitioner shall not prescribe controlled substances, Schedules III through VI, for the purpose of weight reduction or control in the treatment of obesity, unless the following conditions are met:

1. An appropriate history and physical examination are performed and recorded at the time of initiation of pharmacotherapy for obesity by the prescribing physician, and the physician reviews the results of laboratory work, as indicated, including testing for thyroid function;
2. If the drug to be prescribed could adversely affect cardiac function, the physician shall review the results of an electrocardiogram performed and interpreted within 90 days of initial prescribing for treatment of obesity;
3. A diet and exercise program for weight loss is prescribed and recorded;
4. The patient is seen within the first 30 days following initiation of pharmacotherapy for weight loss, by the prescribing physician or a licensed practitioner with prescriptive authority working under the supervision of the prescribing physician, at which time a recording shall be made of blood pressure, pulse, and any other tests as may be necessary for monitoring potential adverse effects of drug therapy; and
5. The treating physician shall direct the follow-up care, including the intervals for patient visits and the continuation of or any subsequent changes in pharmacotherapy. Continuation of prescribing for treatment of obesity shall occur only if the patient has continued progress toward achieving or maintaining a target weight and has no significant adverse effects from the prescribed program.

**18 VAC 85-50-182. Anabolic steroids.**

A physician assistant shall not prescribe or administer anabolic steroids to any patient for other than accepted therapeutic purposes.

**18 VAC 85-50-183. Sexual contact.**

A. For purposes of § 54.1-2914 A 7 and A 14 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior that:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or
2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2914 A 14 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient means spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

**18 VAC 85-50-184. Refusal to provide information.**

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

**NOTICE:** The forms used in administering 18 VAC 85-50, Regulations Governing the Practice of Physician Assistants,

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are not being published due to the number of forms; however, the name of each form is listed below. The forms are available for public inspection at the Board of Medicine, 6603 W. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

## FORMS

Instructions for Completing a Physician Assistant Licensure Application (rev. ~~7/04~~ 2/04).

Application for a ~~License to Practice~~ Licensure as a Physician Assistant (rev. ~~3/03~~ 7/03).

Form #B, Activity Questionnaire (rev. 3/03).

Form #C, Clearance from Other State Boards (rev. 3/03).

Form #L, Certificate of Physician Assistant Education (eff. ~~3/03~~ 9/04).

Form #2, Physician Assistant Invasive Procedures Protocol (rev. 3/03).

Renewal Notice and Application, 0110 Physician Assistant (rev. 12/02).

Instructions for ~~Subsequent Employment to~~ Completing a Practice Application as a Physician Assistant (rev. ~~8/04~~ 9/04).

Application for ~~Employment~~ to Practice as a Physician Assistant (rev. ~~3/03~~ 6/04).

Request for Prescriptive Authority from the PA (rev. ~~4/03~~ 4/04).

Alternate Supervisors Signature Form (rev. 3/03).

Form #1-A, Addendum to Protocol of Physician Assistant Duties (rev. 3/03).

Application for Registration for Volunteer Practice (eff. 12/02).

Sponsor Certification for Volunteer Registration (eff. 1/03).

Physician Assistant Volunteer License Application (eff. 3/03).

VA.R. Doc. No. R03-263; Filed November 8, 2004, 12:39 p.m.

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**Title of Regulation:** 18 VAC 85-80. Regulations for Licensure of Occupational Therapists (adding 18 VAC 85-80-120 through 18 VAC 85-80-125).

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

**Public Hearing Date:** January 21, 2005 - 8:15 a.m.

Public comments may be submitted until 5 p.m. on January 28, 2005.

(See Calendar of Events section for additional information)

**Agency Contact:** William L. Harp, M.D., Executive Director, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9908, FAX (804) 662-9943, or e-mail william.harp@dhp.virginia.gov.

**Basis:** Section 54.1-2400 of the Code of Virginia provides the Board of Medicine the authority to promulgate regulations to administer the regulatory system.

In addition, §§ 54.1-2914, 54.1-2915, and 54.1-2916 of the Code of Virginia establish grounds by which the board may refuse to license or certify an applicant or take disciplinary action against a current license or certificate holder. While regulations on standards of conduct do not duplicate standards set forth in law, they do supplement and interpret the statutory provisions.

**Purpose:** The purpose of this regulatory action is to establish in regulation the standards by which practitioners of the healing arts must conduct their practice. Section 54.1-2914 A 7 of the Code of Virginia defines one grounds for a finding of unprofessional conduct as "Conducts his practice in a manner contrary to the standard of ethics of his branch of the healing arts." The board has used the code of ethics of the American Medical Association and other organizations as guidance but has not specifically adopted ethical standards in regulation. Amended rules will provide standards relating to ethical behavior in the care and treatment of patients, maintenance and disclosure of records, and in the responsibility of a practitioner for delegation of services to subordinates under their supervision. Throughout the substance of these rules, there are measures that will benefit patient health and safety. For example, a patient's health and safety may benefit from a requirement for the practitioner to communicate and involve the patient in his care, to fully inform the patient, and to maintain patient information with confidentiality.

While the vast majority of practitioners conduct their practices ethically, there are those who have not followed professional standards for communicating and informing patients, for maintaining accurate and legible records, for providing records in a timely manner, or for sexual contact with patients. Others who seek to act professionally and ethically have been desirous of specific guidance from the board on matters such as the retention of records and informed consent. With adoption of these rules, the board's intent is to not only protect the health, welfare and safety of the public against inappropriate and unethical actions by its licensees but also to give regulatory guidance for practice in a professional manner.

**Substance:** The substantive provisions of this regulatory action include the following standards for professional conduct:

18 VAC 85-80-120. Confidentiality. The proposed regulation prohibits a practitioner from willfully or negligently breaching the confidentiality between a practitioner and a patient. If a breach of confidence is required by applicable law or beyond the control of the practitioner, it is not considered negligent or willful.

18 VAC 85-80-121. Patient records. Proposed regulations set requirements for confidentiality and disclosure of patient records, and for maintenance of accurate, timely records. If an occupational therapist is employed by a health care institution or other entity, he must maintain records in accordance with the policies of that entity. If he is self-employed, the regulations set standards for record retention at

a minimum of six years, with certain exceptions, and for appropriate destruction of records.

18 VAC 85-80-122. Practitioner-patient communication; termination of relationship. Subsection A sets out the standards for ethical communication with patients to include provision of accurate information to patients in terms that are understandable and encourage participation. It would be unethical for a practitioner to deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

Subsection B provides the professional standard for termination of the practitioner/patient relationship by either party and requires the practitioner to make a copy of the patient record available.

18 VAC 85-80-123. Practitioner responsibility. This section lists practitioner actions that are considered irresponsible and unethical, including knowingly allowing subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility; engaging in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care; or exploiting the practitioner/patient relationship for personal gain.

18 VAC 85-80-124. Sexual contact. Proposed regulations define in subsection A what is meant by sexual contact for purpose of interpreting statutory prohibitions in § 54.1-2914 of the Code of Virginia. Subsection B specifies the prohibition against sexual contact with a patient, and subsection C sets the rule concerning a former patient.

Subsections D and E set the conditions under which sexual contact between a practitioner and a key third party or between a medical supervisor and a medical trainee could constitute unprofessional conduct.

18 VAC 85-80-125. Refusal to provide information. The proposed regulation is identical to current requirements for licensees regulated under 18 VAC 85-20; it makes it unprofessional conduct to refuse to provide information or records as requested or required by the board or one of its investigators in the enforcement of law and regulation.

Issues: There are numerous advantages to the public associated with the proposed regulatory action. By having standards of conduct more clearly stated in regulation, all consumers of services provided by licensees should benefit from specific rules on communication with patients, maintenance of accurate records, access to patient records, confidentiality, sexual contact, and informed consent.

There are no disadvantages to the public of the proposed standards of conduct for licensees of the board.

The primary advantage to the agency comes from a more definitive set of standards of professional conduct for licensees. For example, a standard for retention of patient records will be available to practitioners, who often call the board office for guidance on these issues. Additionally, the board will be able to rely on a clearer standard to cite in a disciplinary case in which a practitioner may be guilty of

unprofessional conduct. In the past, the board has cited § 54.1-2914 A 7, which states that: "Any practitioner of the healing arts regulated by the board shall be considered guilty of unprofessional conduct if he...conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts." Without fully setting out the standards in regulation, it could be argued that a licensee was expected to conduct himself and his practice according to a standard that had not been adopted by the regulatory board and was unknown to the licensee. More explicit regulations on standards of professional conduct will provide guidance for certain situations and more specific grounds for disciplinary action if the standards are violated.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The proposed regulations will establish professional ethical standards for patient records, confidentiality, communication with patients and termination of practitioner/patient relationship, practitioner responsibility, sexual contact, and providing information to the Board of Medicine upon request.

Estimated economic impact. These regulations contain professional ethical standards for practice of occupational therapy. Recently, a disciplinary sanction imposed by the Board of Medicine (the board) on one of its regulants was overturned by the court of appeals based in part because the board did not have regulations addressing the standards of conduct related to the dispute.<sup>1</sup> Prior to this lawsuit, the board has been using the code of ethics of the American Medical Association and of the other related professional organizations as guidance, but its regulations did not contain many of these ethical standards. As a result of this court case, the board conducted an extensive review of professional ethics used by the American Medical Association and other related professional associations, reviewed the list of 42 grounds for disciplinary action recommended by the Federation of State Medical Boards, combed through the standards already addressed in the Code of Virginia or the regulations, and is proposing to establish ethical standards to cover six areas.

In general, the proposed regulations will require that practitioners maintain, manage, and destroy patient records according to the specific criteria to ensure patient confidentiality; that practitioners do not breach the practitioner/patient confidentiality; that practitioners do not

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<sup>1</sup> Court of Appeals of Virginia, Record No. 0016-02-2.

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mislead or make deliberate false statements regarding the medications, treatment, diagnosis, and prognosis; that the practitioners present medical information in understandable language to patients; that practitioners do not terminate their relationship with a patient without a notice allowing reasonable time for the patient; that practitioners do not delegate tasks outside the scope of a subordinate's area; that practitioners do not exploit the practitioner/patient relationship for personal gain; that practitioners do not have sexual contact with patients or with supervisees, if that relationship would have an adverse affect on patient care; and that practitioners provide information to the Board of Medicine if requested.

The proposed changes will establish explicit standards the board is currently using as guidance. Because this regulation will establish more clearly the scope of ethical standards, it will probably be more informative regarding what constitutes a breach of ethical standards and consequently what may be subject to a disciplinary action. Most practitioners are probably already in compliance with most of the proposed standards and are not expected to be affected significantly by the proposed changes on average. Even though there may be a small number of regulants who may have to change their practices to comply with the proposed rules, the significance and the types of potential economic effects are likely to be case specific. Thus, the compliance costs may increase for some regulants by an unknown amount. Also, the proposed changes may cause an increase in the number of complaints and fact-finding investigations. As a rough estimate, the Department of Health expects approximately 0.5 additional informal hearings costing about \$1,461 per year.<sup>2</sup>

The proposed regulation requires that practitioners inform or notify patients of the records retention schedule so patients will be aware of when their records may be no longer available. Given that a practitioner may have accumulated thousands of inactive patients over the years, this requirement seems to have the potential to create significant compliance costs for some of the practitioners. Also, practitioners may not have the accurate address information for most inactive patients. Perhaps, the potential mailing costs of notifications may be significantly reduced if the scope of this requirement is limited to only active or recently active patients.

Some benefits may come from more clearly delineated and stated ethical standards. More informative standards could improve compliance and may provide a higher protection against ethical misconduct for consumers, practitioners, subordinates, and public in general. Also, having ethics standards in regulations could serve as an insurance against similar potential lawsuits that occurred in the past and could improve the enforceability of disciplinary actions.

Businesses and entities affected. The proposed regulations apply to approximately 2,235 occupational therapists.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The impact of proposed regulations on employment depends on how significantly the current practitioners will have to change their business practices to comply with the proposed ethics standards. Provided that most practitioners are already conducting their businesses in compliance with the proposed regulations, no significance effect on employment is expected.

Effects on the use and value of private property. The proposed ethics standards should not have any significant effect on the value of physical real property. Also, unless the proposed regulations introduce significant compliance costs on practitioners, no significant effect on the use and value of practitioner businesses is expected.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Medicine concurs with the analysis of the Department of Planning and Budget for the proposed regulation, 18 VAC 85-80, Regulations Governing the Licensure of Occupational Therapists relating to standards of professional conduct for licensees.

Summary:

*The proposed amendments establish standards for professional conduct including maintenance, retention and release of patient records; patient confidentiality; practitioner-patient communication and termination of that relationship; sexual contact; and practitioner responsibilities.*

PART V.

STANDARDS OF PROFESSIONAL CONDUCT.

**18 VAC 85-80-120. Confidentiality.**

*A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidence that is required by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.*

**18 VAC 85-80-121. Patient records.**

*A. Practitioners shall comply with the provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.*

*B. Practitioners shall provide patient records to another practitioner or to the patient or his authorized representative in a timely manner and in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.*

*C. Practitioners shall properly manage and keep timely, accurate, legible and complete patient records.*

*D. Practitioners who are employed by a health care institution, school system or other entity in which the individual practitioner does not own or maintain his own records shall maintain patient records in accordance with the policies and procedures of the employing entity.*

*E. Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall:*

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<sup>2</sup> The number of cases and the costs are estimated based on the percentage of regulants affected by these regulations compared to the total number of regulants for which similar ethical standards are proposed, 10 additional cases expected for all professions, and expected cost of \$3,000 per case.

1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

a. Records of a minor child, including immunizations, shall be maintained until the child reaches the age of 18 or the age of emancipation, whichever comes first, except the minimum time for record retention shall be six years regardless of the age of the child at the last patient encounter;

b. Records that have previously been transferred to another practitioner or health care provider or provided to the patient; or

c. Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

2. From (insert effective date of regulations), post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

F. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

### **18 VAC 85-80-122. Practitioner-patient communication; termination of relationship.**

A. Communication with patients.

1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or his legally authorized representative in terms that are understandable and encourage participation in decisions regarding the patient's care.

2. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a treatment or procedure provided or directed by the practitioner in the treatment of any disease or condition.

3. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research that affects their care.

B. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make the patient record available, except in situations where denial of access is allowed by law.

2. A practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

### **18 VAC 85-80-123. Practitioner responsibility.**

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;

2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or their area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 3 of this section.

### **18 VAC 85-80-124. Sexual contact.**

A. For purposes of § 54.1-2914 A 7 and A 14 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior that:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2914 A 14 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient means

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spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

## **18 VAC 85-80-125. Refusal to provide information.**

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

**NOTICE:** The forms used in administering 18 VAC 85-80, Regulations Governing the Licensure of Occupational Therapists, are not being published due to the number of forms; however, the name of each form is listed below. The forms are available for public inspection at the Board of Medicine, 6603 W. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

### FORMS

Instructions for Completing an Occupational Therapist Licensure Application (rev. 3/03).

Application for a License to Practice as an Occupational Therapist (rev. 3/03).

Form A, Claims History Sheet (rev. 3/03).

Form B, Activity Questionnaire (rev. 3/03).

Form C, Clearance from Other State Boards (rev. 3/03).

Form L, Certificate of Professional Education (rev. ~~3/03~~ 9/04).

Board Approved Practice, Occupational Therapist Traineeship (rev. 3/03).

Instructions for Completing Reinstatement of Licensure Application for Occupational Therapy Licensure (rev. ~~4/03~~ 3/04).

Application for Reinstatement as an of Licensure to Practice Occupational Therapist Therapy (rev. ~~3/03~~ 3/04).

Instructions for Supervised Practice, Occupational Therapy Reinstatement (rev. ~~3/03~~ 3/04).

Supervised Practice Application, Occupational Therapy Reinstatement (rev. ~~3/03~~ 3/04).

Report of Supervised Practice for Reinstatement, Form #B (rev. ~~3/03~~ 3/04).

Renewal Notice and Application (rev. 11/02).

Continued Competency Activity and Assessment Form (rev. 9/00).

Application for Registration for Volunteer Practice (eff. 12/02).

Sponsor Certification for Volunteer Registration (eff. 1/03).

VA.R. Doc. No. R03-263; Filed November 8, 2004, 12:39 p.m.

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**Title of Regulation:** 18 VAC 85-101. Regulations Governing the Licensure of Radiologic Technologists and Radiologic Technologists Limited (adding 18 VAC 85-101-161 through 18 VAC 85-101-166).

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

**Public Hearing Date:** January 21, 2005 - 8:15 a.m.

Public comments may be submitted until 5 p.m. on January 28, 2005.

(See Calendar of Events section for additional information)

**Agency Contact:** William L. Harp, M.D., Executive Director, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9908, FAX (804) 662-9943, or e-mail william.harp@dhp.virginia.gov.

**Basis:** Section 54.1-2400 of the Code of Virginia provides the Board of Medicine the authority to promulgate regulations to administer the regulatory system.

In addition, §§ 54.1-2914, 54.1-2915, and 54.1-2916 of the Code of Virginia establish grounds by which the board may refuse to license or certify an applicant or take disciplinary action against a current license or certificate holder. While regulations on standards of conduct do not duplicate standards set forth in law, they do supplement and interpret the statutory provisions.

**Purpose:** The purpose of the regulatory action is to establish in regulation the standards by which practitioners of the healing arts must conduct their practice. Section 54.1-2914 A 7 of the Code of Virginia defines one grounds for a finding of unprofessional conduct as "Conducts his practice in a manner contrary to the standard of ethics of his branch of the healing arts." The board has used the code of ethics of the American Medical Association and other organizations as guidance but has not specifically adopted ethical standards in regulation. Amended rules will provide standards relating to ethical behavior in the care and treatment of patients, maintenance and disclosure of records, and in the responsibility of a practitioner for delegation of services to subordinates under their supervision. Throughout the substance of these rules, there are measures that will benefit patient health and safety. For example, a patient's health and safety may benefit from a requirement for the practitioner to communicate and involve the patient in his care, to fully inform the patient, and to maintain patient information with confidentiality.

While the vast majority of practitioners conduct their practices ethically, there are those who have not followed professional standards for communicating and informing patients, for maintaining accurate and legible records, for providing records in a timely manner, or for sexual contact with patients. With adoption of these rules, the board's intent is to not only protect the health, welfare and safety of the public against inappropriate and unethical actions by its licensees, but also to give regulatory guidance for practice in a professional manner.

**Substance:** The substantive provisions of this regulatory action include the following standards for professional conduct:

18 VAC 85-101-161. Confidentiality. The proposed regulation prohibits a practitioner from willfully or negligently breaching the confidentiality between a practitioner and a patient. If a breach of confidence is required by applicable law or beyond the control of the practitioner, it is not considered negligent or willful.

18 VAC 85-101-162. Patient records. Proposed regulations set requirements for confidentiality and disclosure of patient records; and for maintenance of accurate, timely records. Since rad techs are always employed by a health care institution or other entity, they are required to maintain records in accordance with the policies of that entity.

18 VAC 85-101-163. Practitioner-patient communication; termination of relationship. This section sets out the standards for ethical communication with patients to include provision of accurate information to patients in terms that are understandable and encourage participation. It would be unethical for a practitioner to deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition. Practitioners are also required to refer or consult with other health care professionals, if indicated and to adhere to provisions of the Code if involving a patient in research activities.

18 VAC 85-101-164. Practitioner responsibility. This section lists practitioner actions that are considered irresponsible and unethical, including knowingly allowing subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility; engaging in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care; or exploiting the practitioner/patient relationship for personal gain.

18 VAC 85-101-165. Sexual contact. Proposed regulations define in subsection A what is meant by sexual contact for purpose of interpreting statutory prohibitions in § 54.1-2914 of the Code of Virginia. Subsection B specifies the prohibition against sexual contact with a patient, and subsection C sets the rule concerning a former patient.

Subsections D and E set the conditions under which sexual contact between a practitioner and a key third party or between a medical supervisor and a medical trainee could constitute unprofessional conduct.

18 VAC 85-101-166. Refusal to provide information. The proposed regulation is identical to current requirements for licensees regulated under 18 VAC 85-20; it makes it unprofessional conduct to refuse to provide information or records as requested or required by the board or one of its investigators in the enforcement of law and regulation.

**Issues:** There are numerous advantages to the public associated with the proposed regulatory action. By having standards of conduct more clearly stated in regulation, all consumers of services provided by licensees should benefit

from specific rules on communication with patients, maintenance of accurate records, access to patient records, confidentiality, sexual contact and informed consent.

There are no disadvantages to the public of the proposed standards of conduct for licensees of the board.

The primary advantage to the agency comes from a more definitive set of standards of professional conduct for licensees. For example, a standard for retention of patient records will be available to practitioners, who often call the board office for guidance on these issues. Additionally, the Board will be able to rely on a clearer standard to cite in a disciplinary case in which a practitioner may be guilty of unprofessional conduct. In the past, the board has cited § 54.1-2914 A 7, which states that: "Any practitioner of the healing arts regulated by the board shall be considered guilty of unprofessional conduct if he...conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts." Without fully setting out the standards in regulation, it could be argued that a licensee was expected to conduct himself and his practice according to a standard that had not been adopted by the regulatory board and was unknown to the licensee. More explicit regulations on standards of professional conduct will provide guidance for certain situations and more specific grounds for disciplinary action if the standards are violated.

**Department of Planning and Budget's Economic Impact Analysis:** The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

**Summary of the proposed regulation.** The proposed regulations will establish professional ethical standards for patient records, confidentiality, communication with patients, practitioner responsibility, sexual contact, and providing information to the Board of Medicine upon request.

**Estimated economic impact.** These regulations contain professional ethical standards for practice of radiologic technology. Recently, a disciplinary sanction imposed by the Board of Medicine (the board) on one of its regulants was overturned by the court of appeals based in part because the board did not have regulations addressing the standards of conduct related to the dispute.<sup>1</sup> Prior to this lawsuit, the board has been using the code of ethics of the American Medical Association and of the other related professional organizations as guidance, but its regulations did not contain many of these ethical standards. As a result of this court case, the board

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<sup>1</sup> Court of Appeals of Virginia, Record No. 0016-02-2.

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# Proposed Regulations

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conducted an extensive review of professional ethics used by the American Medical Association and other related professional associations, reviewed the list of 42 grounds for disciplinary action recommended by the Federation of State Medical Boards, combed through the standards already addressed in the Code of Virginia or the regulations, and is proposing to establish ethical standards to cover six areas.

In general, the proposed regulations will require that practitioners maintain and manage patient records according to the specific criteria to ensure patient confidentiality; that practitioners do not breach the practitioner/patient confidentiality; that practitioners do not mislead or make deliberate false statements regarding the medications, treatment, diagnosis, and prognosis; that the practitioners present medical information in understandable language to patients; that practitioners do not delegate tasks outside the scope of a subordinate's area; that practitioners do not exploit the practitioner/patient relationship for personal gain; that practitioners do not have sexual contact with patients or with supervisees, if that relationship would have an adverse affect on patient care; and that practitioners provide information to the Board of Medicine if requested.

The proposed changes will establish explicit standards the board is currently using as guidance. Because this regulation will establish more clearly the scope of ethical standards, it will probably be more informative regarding what constitutes a breach of ethical standards and consequently what may be subject to a disciplinary action. Most practitioners are probably already in compliance with most of the proposed standards and are not expected to be affected significantly by the proposed changes on average. Even though there may be a small number of regulants who may have to change their practices to comply with the proposed rules, the significance and the types of potential economic effects are likely to be case specific. Thus, the compliance costs may increase for some regulants by an unknown amount. Also, the proposed changes may cause an increase in the number of complaints and fact-finding investigations. As a rough estimate, the Department of Health expects approximately 0.8 additional informal hearings costing about \$2,323 per year.<sup>2</sup>

Some benefits may come from more clearly delineated and stated ethical standards. More informative standards could improve compliance and may provide a higher protection against ethical misconduct for consumers, practitioners, subordinates, and public in general. Also, having ethics standards in regulations could serve as an insurance against similar potential lawsuits that occurred in the past and could improve the enforceability of disciplinary actions.

Businesses and entities affected. The proposed regulations apply to approximately 3,553 radiologic technology practitioners.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The impact of proposed regulations on employment depends on how significantly the current practitioners will have to change their business practices to comply with the proposed ethics standards. Provided that most practitioners are already conducting their businesses in compliance with the proposed regulations, no significance effect on employment is expected.

Effects on the use and value of private property. The proposed ethics standards should not have any significant effect on the value of physical real property. Also, unless the proposed regulations introduce significant compliance costs on practitioners, no significant effect on the use and value of practitioner businesses is expected.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Medicine concurs with the analysis of the Department of Planning and Budget for the proposed regulation, 18 VAC 85-101, Regulations Governing the Licensure of Radiologic Technologists and Radiologic Technologists-Limited relating to standards of professional conduct for licensees.

Summary:

*The proposed amendments establish standards for professional conduct including maintenance of patient records; patient confidentiality; practitioner-patient communication; sexual contact; and practitioner responsibilities.*

PART VII.  
STANDARDS OF PROFESSIONAL CONDUCT.

**18 VAC 85-101-161. Confidentiality.**

*A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidence that is required by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.*

**18 VAC 85-101-162. Patient records.**

*A. Practitioners shall comply with the provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.*

*B. Practitioners shall properly manage patient records and shall maintain timely, accurate, legible and complete records.*

*C. Practitioners shall maintain a patient record in accordance with policies and procedures of the employing institution or entity.*

**18 VAC 85-101-163. Practitioner-patient communication.**

*A. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or his legally authorized representative in terms that are understandable and encourage participation in decisions regarding the patient's care.*

*B. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.*

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<sup>2</sup> The number of cases and the costs are estimated based on the percentage of regulants affected by these regulations compared to the total number of regulants for which similar ethical standards are proposed, 10 additional cases expected for all professions, and expected cost of \$3,000 per case.

C. A practitioner shall refer to or consult with other health care professionals, if so indicated.

D. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research that affects their care.

**18 VAC 85-101-164. Practitioner responsibility.**

A. A practitioner shall not:

1. Perform procedures or techniques or provide interpretations that are outside the scope of his practice or for which he is not trained and individually competent;
2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or their area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;
3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or
4. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 3 of this section.

**18 VAC 85-101-165. Sexual contact.**

A. For purposes of § 54.1-2914 A 7 and A 14 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior which:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or
2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2914 A 14 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.
2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient shall mean: spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a practitioner and a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

**18 VAC 85-101-166. Refusal to provide information.**

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

**NOTICE:** The forms used in administering 18 VAC 85-101, Regulations Governing the Licensure of Radiologic Technologists and Radiologic Technologists-Limited, are not being published due to the number of forms; however, the name of each form is listed below. The forms are available for public inspection at the Board of Medicine, 6603 W. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

Instructions for Completing an Application for Licensure as a Radiologic Technologist By Examination/Endorsement (rev. 44/02 6/04).

Application for a License as a Radiologic Technologist (rev. 44/02 6/04).

Form A, Claims History Sheet (rev. 44/02 6/04).

Form B, Activity Questionnaire (rev. 44/02 6/04).

Form C, Clearance from Other States (rev. 44/02 6/04).

Form E, Certification Request from ARRT (rev. 44/02 6/04).

Form F, Traineeship Application (rev. 44/02 6/04).

Form L, Certificate of Radiologic Technology Education (eff. 44/02 6/04).

Instructions for Completing an Application for Licensure as a Radiologic Technologist-Limited (rev. 2/03 6/04).

Application for a License to Practice as a Radiologic Technologist Technology-Limited (rev. 3/03 6/04).

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# Proposed Regulations

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Form #1 ~~(a) and (b)~~ T/A (1) and T/A (2), Radiologic Technologist-Limited Training Application for Abdomen/Pelvis pursuant to Virginia Regulations 18 VAC 85-101-60 B (3) (rev. ~~3/03~~ 6/04).

Form #2 ~~(a) and (b)~~ T/C (1) and T/C (2), Radiologic Technologist-Limited Clinical Training Application (rev. ~~3/03~~ 6/04).

Form T/E, Radiologic Technologist-Limited Traineeship Application (rev. 6/04).

Instructions for Completing Reinstatement of Radiologic Technology Licensure (rev. ~~4/03~~ 4/04).

Application for Reinstatement ~~as a~~ of License to Practice Radiologic Technologist (eff. ~~3/03~~ 4/04).

Instructions for Completing Reinstatement of Radiologic Technologist-Limited Licensure (rev. ~~4/03~~ 4/04).

Application for Reinstatement ~~as a~~ of License to Practice Radiologic Technologist-Limited (eff. ~~3/03~~ 4/04).

License Renewal Notice and Application, 0120 Radiologic Technologist (rev. 11/02).

License Renewal Notice and Application, 0122 Limited Radiologic Technologist (eff. 11/02).

Application for Registration for Volunteer Practice (eff. 12/02).

Sponsor Certification for Volunteer Registration (eff. 1/03).

V.A.R. Doc. No. R03-263; Filed November 8, 2004, 12:40 p.m.

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**Title of Regulation:** 18 VAC 85-110. Regulations Governing the Practice of Licensed Acupuncturists (adding 18 VAC 85-110-175 through 18 VAC 85-110-183).

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

**Public Hearing Date:** January 21, 2005 - 8:15 a.m.

Public comments may be submitted until 5 p.m. on January 28, 2005.

(See Calendar of Events section for additional information)

**Agency Contact:** William L. Harp, M.D., Executive Director, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9908, FAX (804) 662-9943, or e-mail [william.harp@dhp.virginia.gov](mailto:william.harp@dhp.virginia.gov).

**Basis:** Section 54.1-2400 of the Code of Virginia provides the Board of Medicine the authority to promulgate regulations to administer the regulatory system.

In addition, §§ 54.1-2914, 54.1-2915, and 54.1-2916 of the Code of Virginia establish grounds by which the board may refuse to license or certify an applicant or take disciplinary action against a current license or certificate holder. While regulations on standards of conduct do not duplicate standards set forth in law, they do supplement and interpret the statutory provisions.

**Purpose:** The purpose of this regulatory action is to establish in regulation the standards by which practitioners of the healing arts must conduct their practice. Section 54.1-2914 A 7 of the Code of Virginia defines one grounds for a finding of unprofessional conduct as "Conducts his practice in a manner contrary to the standard of ethics of his branch of the healing arts." The board has used the code of ethics of the American Medical Association and other organizations as guidance but has not specifically adopted ethical standards in regulation. Amended rules will provide standards relating to ethical behavior in the care and treatment of patients, maintenance and disclosure of records, and in the responsibility of a practitioner for delegation of services to subordinates under their supervision. Throughout the substance of these rules, there are measures that will benefit patient health and safety. For example, a patient's health and safety may benefit from a requirement for the practitioner to communicate and involve the patient in his care, to fully inform the patient, and to maintain patient information with confidentiality.

While the vast majority of practitioners conduct their practices ethically, there are those who have not followed professional standards for communicating and informing patients, for maintaining accurate and legible records, for providing records in a timely manner, or for sexual contact with patients. Others who seek to act professionally and ethically have been desirous of specific guidance from the board on matters such as the retention of records and informed consent. With adoption of these rules, the board's intent is to not only protect the health, welfare and safety of the public against inappropriate and unethical actions by its licensees, but also to give regulatory guidance for practice in a professional manner.

**Substance:** The substantive provisions of this regulatory action include the following standards for professional conduct:

18 VAC 85-110-175. Confidentiality. The proposed regulation prohibits a practitioner from willfully or negligently breaching the confidentiality between a practitioner and a patient. If a breach of confidence is required by applicable law or beyond the control of the practitioner, it is not considered negligent or willful.

18 VAC 85-110-176. Patient records. Proposed regulations set requirements for confidentiality and disclosure of patient records; maintenance of accurate, timely records; and providing patient records to another practitioner or the patient in accordance with provisions of law. Regulations also provide rules for record retention for a minimum of six years with certain exceptions, for appropriate destruction of records and for notification to patients about record retention.

18 VAC 85-110-177. Practitioner-patient communication. This section sets out the standards for ethical communication with patients to include provision of accurate information to patients in terms that are understandable and encourage participation. It would be unethical for a practitioner to deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

Before any acupuncture procedure is performed, there is a requirement for informed consent and a requirement to inform patients of the risks, benefits, and alternatives. Provisions allow for consent from a legally authorized representative in lieu of the patient under certain circumstances.

18 VAC 85-110-178. Practitioner responsibility. This section lists practitioner actions that are considered irresponsible and unethical, including knowingly allowing subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility; engaging in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care; or exploiting the practitioner/patient relationship for personal gain.

18 VAC 85-110-179. Advertising ethics. The rules require truth and full disclosure in advertising related to the fee for certain procedures or treatments and any claim of board certification. They prohibit charging for a service within 72 hours of performing an advertised free service and require the practitioner to be responsible and accountable for the validity and truthfulness of the content of an advertisement to ensure that it is not deceptive, misleading or false.

18 VAC 85-110-180. Vitamins, minerals and food supplements. The regulation requires that recommendation or direction for such be based upon a reasonable expectation that use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use. The proposed rule would also prohibit a recommended dose that would be contraindicated based on the individual patient's overall medical condition and medications.

18 VAC 85-110-181. Solicitation or remuneration in exchange for referral. Proposed regulations are identical to current requirements for licensees regulated under 18 VAC 85-20 (doctors of medicine, osteopathic medicine, podiatry and chiropractic). There is a prohibition on knowingly and willfully soliciting or receiving any remuneration for referral of an individual to a health care facility or institution.

18 VAC 85-110-182. Sexual contact. Proposed regulations define in subsection A what is meant by sexual contact for purposes of interpreting statutory prohibitions in §§ 54.1-2914 of the Code of Virginia. Subsection B specifies the prohibition against sexual contact with a patient, and subsection C sets the rule concerning a former patient.

Subsections D and E set the conditions under which sexual contact between a practitioner and a key third party or between a medical supervisor and a medical trainee could constitute unprofessional conduct.

18 VAC 85-110-183. Refusal to provide information. The proposed regulation is identical to current requirements for licensees regulated under 18 VAC 85-20; it makes it unprofessional conduct to refuse to provide information or records as requested or required by the board or one of its investigators in the enforcement of law and regulation.

Issues: There are numerous advantages to the public associated with the proposed regulatory action. By having standards of conduct more clearly stated in regulation, all

consumers of services provided by licensees should benefit from specific rules on communication with patients, maintenance of accurate records, access to patient records, confidentiality, sexual contact, and informed consent.

There are no disadvantages to the public of the proposed standards of conduct for licensees of the board.

The primary advantage to the agency comes from a more definitive set of standards of professional conduct for licensees. For example, a standard for retention of patient records will be available to practitioners, who often call the board office for guidance on these issues. Additionally, the board will be able to rely on a clearer standard to cite in a disciplinary case in which a practitioner may be guilty of unprofessional conduct. In the past, the board has cited § 54.1-2914 (7), which states that: "Any practitioner of the healing arts regulated by the board shall be considered guilty of unprofessional conduct if he...conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts." Without fully setting out the standards in regulation, it could be argued that a licensee was expected to conduct himself and his practice according to a standard that had not been adopted by the regulatory board and was unknown to the licensee. More explicit regulations on standards of professional conduct will provide guidance for certain situations and more specific grounds for disciplinary action if the standards are violated.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The proposed regulations will establish professional ethical standards for patient records, confidentiality, communication with patients and termination of practitioner/patient relationship, practitioner responsibility, advertising ethics, the use of vitamins, minerals, and food supplements, referral ethics, sexual contact, and providing information to the Board of Medicine upon request.

Estimated economic impact. These regulations contain professional ethical standards for practice of licensed acupuncturists. Recently, a disciplinary sanction imposed by the Board of Medicine (the board) on one of its regulants was overturned by the court of appeals based in part because the board did not have regulations addressing the standards of conduct related to the dispute.<sup>1</sup> Prior to this lawsuit, the board has been using the code of ethics of the American Medical

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<sup>1</sup> Court of Appeals of Virginia, Record No. 0016-02-2.

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# Proposed Regulations

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Association and of the other related professional organizations as guidance, but its regulations did not contain many of these ethical standards. As a result of this court case, the board conducted an extensive review of professional ethics used by the American Medical Association and other related professional associations, reviewed the list of 42 grounds for disciplinary action recommended by the Federation of State Medical Boards, combed through the standards already addressed in the Code of Virginia or the regulations, and is proposing to establish ethical standards to cover nine areas.

In general, the proposed regulations will require that practitioners maintain, manage, and destroy patient records according to the specific criteria to ensure patient confidentiality; that practitioners do not breach the practitioner/patient confidentiality; that practitioners do not mislead or make deliberate false statements regarding the medications, treatment, diagnosis, and prognosis; that practitioners inform patients of the risks, benefits, and alternatives before the recommended treatment; that the practitioners present medical information in understandable language to patients; that practitioners do not terminate their relationship with a patient without a notice allowing reasonable time for the patient; that practitioners do not delegate tasks outside the scope of a subordinate's area; that practitioners do not exploit the practitioner/patient relationship for personal gain; that practitioners do not adhere to the misleading or deceptive advertising; that the practitioners do not use vitamins, minerals, and food supplements unless a favorable outcome is expected; that practitioners do not seek remuneration in exchange for referral; that practitioners do not have sexual contact with patients or with supervisees, if that relationship would have an adverse affect on patient care; and that practitioners provide information to the Board of Medicine if requested.

The proposed changes will establish explicit standards the board is currently using as guidance. Because this regulation will establish more clearly the scope of ethical standards, it will probably be more informative regarding what constitutes a breach of ethical standards and consequently what may be subject to a disciplinary action. Most practitioners are probably already in compliance with most of the proposed standards and are not expected to be affected significantly by the proposed changes on average. Even though there may be a small number of regulants who may have to change their practices to comply with the proposed rules, the significance and the types of potential economic effects are likely to be case specific. Thus, the compliance costs may increase for some regulants by an unknown amount. Also, the proposed changes may cause an increase in the number of complaints and fact-finding investigations. As a rough estimate, the Department of Health expects approximately 0.1 additional informal hearings costing about \$165 per year.<sup>2</sup>

The proposed regulation requires that practitioners inform or notify patients of the records retention schedule so patients will be aware of when their records may be no longer

available. Given that a practitioner may have accumulated thousands of inactive patients over the years, this requirement seems to have the potential to create significant compliance costs for some of the practitioners. Also, practitioners may not have the accurate address information for most inactive patients. Perhaps, the potential mailing costs of notifications may be significantly reduced if the scope of this requirement is limited to only active or recently active patients.

Some benefits may come from more clearly delineated and stated ethical standards. More informative standards could improve compliance and may provide a higher protection against ethical misconduct for consumers, practitioners, subordinates, and public in general. Also, having ethics standards in regulations could serve as an insurance against similar potential lawsuits that occurred in the past and could improve the enforceability of disciplinary actions.

Businesses and entities affected. The proposed regulations apply to approximately 253 licensed acupuncturists.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The impact of proposed regulations on employment depends on how significantly the current practitioners will have to change their business practices to comply with the proposed ethics standards. Provided that most practitioners are already conducting their businesses in compliance with the proposed regulations, no significance effect on employment is expected.

Effects on the use and value of private property. The proposed ethics standards should not have any significant effect on the value of physical real property. Also, unless the proposed regulations introduce significant compliance costs on practitioners, no significant effect on the use and value of practitioner businesses is expected.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Medicine concurs with the analysis of the Department of Planning and Budget for the proposed regulation, 18 VAC 85-110, Regulations Governing the Practice of Licensed Acupuncturists, relating to standards of professional conduct for licensees.

## Summary:

*The proposed amendments establish standards for professional conduct for licensed acupuncturists including maintenance, retention and release of patient records; patient confidentiality; practitioner-patient communication and termination of that relationship; advertising ethics, recommendations for vitamins, minerals and food supplements, solicitation or remuneration for referrals; sexual contact; and practitioner responsibilities.*

### PART V.

#### STANDARDS OF PROFESSIONAL CONDUCT.

#### **18 VAC 85-110-175. Confidentiality.**

*A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidence that is required by applicable law or beyond the*

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<sup>2</sup> The number of cases and the costs are estimated based on the percentage of regulants affected by these regulations compared to the total number of regulants for which similar ethical standards are proposed, 10 additional cases expected for all professions, and expected cost of \$3,000 per case.

control of the practitioner shall not be considered negligent or willful.

## **18 VAC 85-110-176. Patient records.**

A. Practitioners shall comply with the provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.

B. Practitioners shall provide patient records to another practitioner or to the patient or his authorized representative in a timely manner and in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage patient records and shall maintain timely, accurate, legible and complete patient records.

D. Practitioners shall maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

1. Records of a minor child, including immunizations, which shall be maintained until the child reaches the age of 18 or the age of emancipation, whichever comes first, except the minimum time for record retention shall be six years regardless of the age of the child at the last patient encounter;

2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient; or

3. Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

E. From (insert effective date of regulations) practitioners shall post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

F. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

## **18 VAC 85-110-177. Practitioner-patient communication; termination of relationship.**

A. Communication with patients.

1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately inform patients or their legally authorized representative of any professional assessment and prescribed treatment or plan of care. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

2. Practitioners shall present information to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care.

3. Before any acupuncture treatment or procedure is performed, informed consent shall be obtained from the patient. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended treatment that a reasonably prudent licensed acupuncturist practicing in Virginia would tell a patient. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

B. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make a copy of the patient record available, except in situations where denial of access is allowed by law.

2. A practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

## **18 VAC 85-110-178. Practitioner responsibility.**

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;

2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 2 of this section.

## **18 VAC 85-110-179. Advertising ethics.**

A. Any statement specifying a fee, whether standard, discounted or free, for professional services which does not include the cost of all related procedures, services and products which, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.

B. Advertising a discounted or free service, examination, or treatment and charging for any additional service,

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# Proposed Regulations

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examination, or treatment that is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bonafide emergency. This provision may not be waived by agreement of the patient and the practitioner.

C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.

D. A licensee's authorization of or use in any advertising for his practice of the term "board certified" or any similar words or phrase calculated to convey the same meaning shall constitute misleading or deceptive advertising under § 54.1-2914 of the Code of Virginia, unless the licensee discloses the complete name of the specialty board which conferred the aforementioned certification.

E. A licensee of the board shall not advertise information that is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner or practitioners responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years.

## **18 VAC 85-110-180. Vitamins, minerals and food supplements.**

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

## **18 VAC 85-110-181. Solicitation or remuneration in exchange for referral.**

A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in § 37.1-179 of the Code of Virginia or hospital as defined in § 32.1-123 of the Code of Virginia.

Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by 42 USC

§ 1320a-7b(b) , as amended, or any regulations promulgated thereto.

## **18 VAC 85-110-182. Sexual contact.**

A. For purposes of § 54.1-2914 A 7 and A 14 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior that:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or
2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2914 A 14 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.
2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient means spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

**18 VAC 85-110-183. Refusal to provide information.**

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

## **18 VAC 85-110-183. Refusal to provide information.**

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

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| <p><b>NOTICE:</b> The forms used in administering 18 VAC 85-110, Regulations Governing the Practice of Licensed Acupuncturists, are not being published due to the number of forms; however, the name of each form is listed below. The forms are available for public inspection at the Board of</p> |
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Medicine, 6603 W. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

Instructions for Completing the an Application for Licensed a License to Practice as an Acupuncturist for Graduates of Approved Institutions or Programs in the United States (rev. 12/02 4/04).

Instructions for Completing the an Application for Licensed a License to Practice as an Acupuncturist for Graduates of Nonapproved Educational Programs (rev. 12/02 3/04).

Application for a License to Practice as an Acupuncturist (rev. 12/02).

Form A, Claims History Sheet (rev. 12/02 3/04).

Form B, Activity Questionnaire (rev. 12/02 3/04).

Form C, Clearance from Other State Boards (rev. 12/02 3/04).

Form L, Certification of Professional Education (rev. 12/02 9/04).

Verification of NCCAOM Certification (rev. 12/02 3/04).

Renewal Notice and Application, 0121 Licensed Acupuncturist (rev. 12/02).

Recommendation for Examination by a Physician (eff. 12/01).

Application for Registration for Volunteer Practice (eff. 12/02).

Sponsor Certification for Volunteer Registration (eff. 1/03).

VA.R. Doc. No. R03-263; Filed November 8, 2004, 12:40 p.m.

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Title of Regulation: 18 VAC 85-120. Regulations Governing the Certification of Athletic Trainers (adding 18 VAC 85-120-155 through 18 VAC 85-120-162).

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

Public Hearing Date: January 21, 2005 - 8:15 a.m.

Public comments may be submitted until 5 p.m. on January 28, 2005.

(See Calendar of Events section for additional information)

Agency Contact: William L. Harp, M.D., Executive Director, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9908, FAX (804) 662-9943, or e-mail william.harp@dhp.virginia.gov.

Basis: Section 54.1-2400 of the Code of Virginia provides the Board of Medicine the authority to promulgate regulations to administer the regulatory system.

In addition, §§ 54.1-2914, 54.1-2915, and 54.1-2916 of the Code of Virginia establish grounds by which the board may refuse to license or certify an applicant or take disciplinary action against a current license or certificate holder. While regulations on standards of conduct do not duplicate

standards set forth in law, they do supplement and interpret the statutory provisions.

Purpose: The purpose of the regulatory action is to establish in regulation the standards by which practitioners of the healing arts must conduct their practice. Section 54.1-2914 A 7 of the Code of Virginia defines one grounds for a finding of unprofessional conduct as "Conducts his practice in a manner contrary to the standard of ethics of his branch of the healing arts." The board has used the code of ethics of the American Medical Association and other organizations as guidance but has not specifically adopted ethical standards in regulation. Amended rules will provide standards relating to ethical behavior in the care and treatment of patients, maintenance and disclosure of records, and in the responsibility of a practitioner for delegation of services to subordinates under their supervision. Throughout the substance of these rules, there are measures that will benefit patient health and safety. For example, a patient's health and safety may benefit from a requirement for the practitioner to communicate and involve the patient in his care, to fully inform the patient, and to maintain patient information with confidentiality.

While the vast majority of practitioners conduct their practices ethically, there are those who have not followed professional standards for communicating and informing patients, for maintaining accurate and legible records, for providing records in a timely manner, or for sexual contact with patients. Others who seek to act professionally and ethically have been desirous of specific guidance from the board on matters such as the retention of records and informed consent. With adoption of these rules, the board's intent is to not only protect the health, welfare and safety of the public against inappropriate and unethical actions by its licensees, but also to give regulatory guidance for practice in a professional manner.

Substance: The substantive provisions of this regulatory action include the following standards for professional conduct:

18 VAC 85-120-155. Confidentiality. The proposed regulation prohibits a practitioner from willfully or negligently breaching the confidentiality between a practitioner and a patient. If a breach of confidence is required by applicable law or beyond the control of the practitioner, it is not considered negligent or willful.

18 VAC 85-120-156. Patient records. Proposed regulations set requirements for confidentiality and disclosure of patient records; maintenance of accurate, timely records; and for providing patient records to another practitioner or the patient in accordance with provisions of law. If an athletic trainer is employed by a health care institution or other entity, he must maintain records in accordance with the policies of that entity. If he is self-employed, the regulations set standards for record retention at a minimum of six years, with certain exceptions, and for appropriate destruction of records and appropriate notification to patients.

18 VAC 85-120-157. Practitioner-patient communication. This section sets out the standards for ethical communication with patients to include provision of accurate information to patients in terms that are understandable and encourage

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participation. It would be unethical for a practitioner to deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

Practitioners must adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them in research activities.

18 VAC 85-120-158. Practitioner responsibility. This section lists practitioner actions that are considered irresponsible and unethical, including knowingly allowing subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility; engaging in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care; or exploiting the practitioner/patient relationship for personal gain.

18 VAC 85-120-159. Vitamins, minerals and food supplements. The regulation requires that recommendation or direction for such be based upon a reasonable expectation that use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use. The proposed rule would also prohibit a recommended dose that would be contraindicated based on the individual patient's overall medical condition and medications.

18 VAC 85-120-160. Anabolic steroids. The current prohibition in 18 VAC 85-20 for physicians on prescribing or administering anabolic steroids, except for accepted therapeutic purposes, is included in regulations for athletic trainers. While athletic trainers cannot prescribe, this rule would prohibit administration of steroids.

18 VAC 85-120-161. Sexual contact. Proposed regulations define in subsection A what is meant by sexual contact for purposes of interpreting statutory prohibitions in §§ 54.1-2914 of the Code of Virginia. Subsection B specifies the prohibition against sexual contact with a patient, and subsection C sets the rule concerning a former patient.

Subsections D and E set the conditions under which sexual contact between a practitioner and a key third party or between a medical supervisor and a medical trainee could constitute unprofessional conduct.

18 VAC 85-120-162. Refusal to provide information. The proposed regulation is identical to current requirements for licensees regulated under 18 VAC 85-20; it makes it unprofessional conduct to refuse to provide information or records as requested or required by the board or one of its investigators in the enforcement of law and regulation.

**Issues:** There are numerous advantages to the public associated with the proposed regulatory action. By having standards of conduct more clearly stated in regulation, all consumers of services provided by licensees should benefit from specific rules on communication with patients, maintenance of accurate records, access to patient records, confidentiality, sexual contact, and informed consent.

There are no disadvantages to the public of the proposed standards of conduct for licensees of the board.

The primary advantage to the agency comes from a more definitive set of standards of professional conduct for licensees. For example, a standard for retention of patient records will be available to practitioners, who often call the board office for guidance on these issues. Additionally, the board will be able to rely on a clearer standard to cite in a disciplinary case in which a practitioner may be guilty of unprofessional conduct. In the past, the board has cited § 54.1-2914 (7), which states that: "Any practitioner of the healing arts regulated by the board shall be considered guilty of unprofessional conduct if he...conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts." Without fully setting out the standards in regulation, it could be argued that a licensee was expected to conduct himself and his practice according to a standard that had not been adopted by the regulatory board and was unknown to the licensee. More explicit regulations on standards of professional conduct will provide guidance for certain situations and more specific grounds for disciplinary action if the standards are violated.

**Department of Planning and Budget's Economic Impact Analysis:** The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

**Summary of the proposed regulation.** The proposed regulations will establish professional ethical standards for patient records, confidentiality, communication with patients, practitioner responsibility, the use of vitamins, minerals, and food supplements, the use of anabolic steroids, sexual contact, and providing information to the Board of Medicine upon request.

**Estimated economic impact.** These regulations contain professional ethical standards for athletic trainers. Recently, a disciplinary sanction imposed by the Board of Medicine (the board) on one of its regulants was overturned by the court of appeals based in part because the board did not have regulations addressing the standards of conduct related to the dispute.<sup>1</sup> Prior to this lawsuit, the board has been using the code of ethics of the American Medical Association and of the other related professional organizations as guidance, but its regulations did not contain many of these ethical standards. As a result of this court case, the board conducted an extensive review of professional ethics used by the American Medical Association and other related professional associations, reviewed the list of 42 grounds for disciplinary action recommended by the Federation of State Medical Boards, combed through the standards already addressed in

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<sup>1</sup> Court of Appeals of Virginia, Record No. 0016-02-2.

the Code of Virginia or the regulations, and is proposing to establish ethical standards to cover eight areas.

In general, the proposed regulations will require that practitioners maintain, manage, and destroy patient records according to the specific criteria to ensure patient confidentiality; that practitioners do not breach the practitioner/patient confidentiality; that practitioners do not mislead or make deliberate false statements regarding the medications, treatment, diagnosis, and prognosis; that the practitioners present medical information in understandable language to patients; that practitioners do not delegate tasks outside the scope of a subordinate's area; that practitioners do not exploit the practitioner/patient relationship for personal gain; that practitioners do not use vitamins, minerals, and food supplements unless a favorable outcome is expected; that practitioners do not sell, dispense, or administer anabolic steroids; that practitioners do not have sexual contact with patients or with supervisees, if that relationship would have an adverse affect on patient care; and that practitioners provide information to the Board of Medicine if requested.

The proposed changes will establish explicit standards the board is currently using as guidance. Because this regulation will establish more clearly the scope of ethical standards, it will probably be more informative regarding what constitutes a breach of ethical standards and consequently what may be subject to a disciplinary action. Most practitioners are probably already in compliance with most of the proposed standards and are not expected to be affected significantly by the proposed changes on average. Even though there may be a small number of regulants who may have to change their practices to comply with the proposed rules, the significance and the types of potential economic effects are likely to be case specific. Thus, the compliance costs may increase for some regulants by an unknown amount. Also, the proposed changes may cause an increase in the number of complaints and fact-finding investigations. As a rough estimate, the Department of Health expects approximately 0.1 additional informal hearings costing about \$436 per year.<sup>2</sup>

The proposed regulation requires that practitioners inform or notify patients of the records retention schedule so patients will be aware of when their records may be no longer available. Given that a practitioner may have accumulated a large number of inactive patients over the years, this requirement seems to have the potential to create significant compliance costs for some of the practitioners. Also, practitioners may not have the accurate address information for most inactive patients. Perhaps, the potential mailing costs of notifications may be significantly reduced if the scope of this requirement is limited to only active or recently active patients.

Some benefits may come from more clearly delineated and stated ethical standards. More informative standards could improve compliance and may provide a higher protection against ethical misconduct for consumers, practitioners, subordinates, and public in general. Also, having ethics

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<sup>2</sup> The number of cases and the costs are estimated based on the percentage of regulants affected by these regulations compared to the total number of regulants for which similar ethical standards are proposed, 10 additional cases expected for all professions, and expected cost of \$3,000 per case.

standards in regulations could serve as an insurance against similar potential lawsuits that occurred in the past and could improve the enforceability of disciplinary actions.

Businesses and entities affected. The proposed regulations apply to approximately 667 athletic trainers.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. The impact of proposed regulations on employment depends on how significantly the current practitioners will have to change their business practices to comply with the proposed ethics standards. Provided that most practitioners are already conducting their businesses in compliance with the proposed regulations, no significance effect on employment is expected.

Effects on the use and value of private property. The proposed ethics standards should not have any significant effect on the value of physical real property. Also, unless the proposed regulations introduce significant compliance costs on practitioners, no significant effect on the use and value of practitioner businesses is expected.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Medicine concurs with the analysis of the Department of Planning and Budget for the proposed regulation, 18 VAC 85-120, Regulations Governing the Licensure of Athletic Trainers, relating to standards of professional conduct for licensees.

#### Summary:

*The proposed amendments establish standards for professional conduct for athletic trainers including maintenance, retention and release of patient records; patient confidentiality; practitioner-patient communication and termination of that relationship; recommendations for use of vitamins and minerals; anabolic steroids; sexual contact; and practitioner responsibilities.*

#### PART VI.

#### STANDARDS OF PROFESSIONAL CONDUCT.

#### **18 VAC 85-120-155. Confidentiality.**

*A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidence that is required by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.*

#### **18 VAC 85-120-156. Patient records.**

*A. Practitioners shall comply with the provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.*

*B. Practitioners shall provide patient records to another practitioner or to the patient or his authorized representative in a timely manner and in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.*

*C. Practitioners shall properly manage patient records and keep timely, accurate, legible and complete patient records.*

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D. Practitioners who are employed by a health care institution, school system or other entity in which the individual practitioner does not own or maintain his own records shall maintain patient records in accordance with the policies and procedures of the employing entity.

E. Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall:

1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

a. Records of a minor child, including immunizations, which shall be maintained until the child reaches the age of 18 or the age of emancipation, whichever comes first, except the minimum time for record retention shall be six years regardless of the age of the child at the last patient encounter;

b. Records that have previously been transferred to another practitioner or health care provider or provided to the patient; or

c. Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

F. From (insert effective date of regulations), athletic trainers who maintain their own patient records shall post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

G. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

## **18 VAC 85-120-157. Practitioner-patient communication.**

A. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or his legally authorized representative in terms that are understandable and encourage participation in decisions regarding the patient's care.

B. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure provided or directed by the practitioner in the treatment of any disease or condition.

C. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research that affects their care.

## **18 VAC 85-120-158. Practitioner responsibility.**

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;

2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 3 of this section.

## **18 VAC 85-120-159. Vitamins, minerals and food supplements.**

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

## **18 VAC85-120-160 Anabolic steroids.**

An athletic trainer shall not sell, dispense, or administer anabolic steroids to any patient.

## **18 VAC 85-120-161. Sexual contact.**

A. For purposes of § 54.1-2914 A 7 and A 14 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior that:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2914 A 14 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or

professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient means spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

**18 VAC 85-120-162. Refusal to provide information.**

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

**NOTICE:** The forms used in administering 18 VAC 85-120, Regulations Governing the Certification of Athletic Trainers, are not being published due to the number of forms; however, the name of each form is listed below. The forms are available for public inspection at the Board of Medicine, 6603 W. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

**FORMS**

Instructions for Completing an Athletic Trainer Licensure Application (rev. 5/04).

Application for a License to Practice as an Athletic Trainer (rev. 5/04).

Form A, Claims History (rev. 5/04).

Form B, Activity Questionnaire (rev. 5/04).

Form C, Clearance from Other State Boards (rev. 5/04).

Form L, Certificate of Professional Education (rev. 5/04 9/04).

Provisional License to Practice as an Athletic Trainer Pursuant to 18 VAC 85-120-80 (rev. 5/04).

Renewal Notice (eff. 5/04).

License Renewal Notice and Application (rev. 5/04).

Application for Registration for Volunteer Practice (eff. 12/02).

Sponsor Certification for Volunteer Registration (eff. 1/03).

VA.R. Doc. No. R03-263; Filed November 8, 2004, 12:41 p.m.

**TITLE 22. SOCIAL SERVICES**

**STATE BOARD OF SOCIAL SERVICES**

**Title of Regulation: 22 VAC 40-325. Fraud Reduction/Elimination Effort (amending 22 VAC 40-325-10 and 22 VAC 40-325-20).**

**Statutory Authority:** §§ 63.2-217 and 63.2-526 of the Code of Virginia.

**Public Hearing Date:** N/A -- Public comments may be submitted until January 28, 2005.

(See Calendar of Events section for additional information)

**Agency Contact:** Mrs. S. Michelle Lauter, Manager, Department of Social Services, Division of Fraud Management, 7 N. Eighth Street, Richmond, VA 23219, telephone (804) 726-7679, FAX (804) 726-7669, or e-mail michelle.lauter@dss.virginia.gov.

**Basis:** Section 63.2-217 of the Code of Virginia provides that the State Board of Social Services shall adopt such regulations as necessary to carry out the purpose of Title 63.2 of the Code of Virginia. Section 63.2-526 mandates the Department of Social Services to establish a statewide fraud control program. The provisions of 22 VAC 40-325 are directly related to the statutory authority by describing the requirements of both the Department of Social Services and the local departments of social services for establishing and maintaining the statewide fraud control program.

**Purpose:** Pursuant to § 63.2-526 D of the Code of Virginia, the Fraud Reduction/Elimination Effort Program, a statewide public assistance fraud prevention and investigation program, is funded from (i) general funds appropriated for fraud control activities, (ii) any federal funds available for this purpose, and (iii) balances in the Fraud Recovery Special Fund. The fund is composed of overpayment moneys recovered by local departments of social services related to Temporary Assistance to Needy Families (TANF) and Food Stamp programs and other federal benefit programs administered by the department net of any refunds due the federal government. Funds from the aforementioned three sources reimburse local departments of social services' direct program costs. With state general funds unappropriated for this program after the first year of program operation, the program was funded at the rate of 50% by available federal TANF and Food Stamp Program administrative funds and at the rate of 50% by the balances in the fund. Given the limited financial ability of present and past public assistance customers who must make financial restitution, and the limited staffing resources of local departments of social services to aggressively pursue overpayment recoveries, the fund balances are not sufficient to match the federal share of

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funding. The program is therefore unable to support itself under the current funding methodology.

The primary goal of the amended regulation is to redefine the criteria for reimbursement to local departments for direct program costs, such that local agencies would be reimbursed in conformance with the funding formula resulting from the commissioner's collaborative state-local agency discussions. Redefining reimbursement criteria to adequately fund the FREE Program protects the welfare of citizens by ensuring the continuation and maintenance of the department's statewide fraud reduction/elimination effort.

The department is also amending the regulation as necessary to address other programmatic issues regarding the FREE program.

Substance: The criteria for reimbursement for local program costs is redefined in order to ensure the continuation of the statewide fraud program. Revisions are made to include the responsibility of fraud detection, an integral component of fraud prevention and investigation. Additionally, the definition's section of the regulation is expanded for clarity. Maintaining the statewide Fraud Reduction/Elimination Effort Program enhances program integrity, and promotes the recovery of program overpayments due to the occurrence of fraud; thus contributing to the welfare of citizens.

Issues: The advantage to the public and the Commonwealth in implementing the amended regulation is that program integrity of the department's benefits programs is not jeopardized. Maintaining the FREE program ensures that public assistance benefits and services are received only by eligible individuals, and in the correct benefit amounts. There are no disadvantages in amending the regulation.

The primary issue associated with the revised regulation is the removal of the provision that local departments of social services, in order to receive full reimbursement of direct local cost associated with the FREE program, recover TANF and Food Stamp overpayments in an amount, net refund to the federal government, that equal or exceed their local share of direct FREE program costs.

22 VAC 40-325-20 C 1 b as presently written states that should a local department not recover the state share of collections equal to or exceeding the local share of cost, full reimbursement of local department direct FREE program cost will not be paid. No provision addresses the amount of reimbursement to be paid when a local department's state share of collections does not equal its local share of FREE program costs. Therefore, a local department not recovering overpayments matching program costs would receive no reimbursement; thus incurring a local share of cost of either 50% or 20%, depending on the funding formula in use.

Local departments presently do not realize their full recovery potential. In addition to activity associated with investigations of on-going fraud situations, local departments perform investigations on questionable applications, which if the application is denied due to information revealed from the investigation, a benefit cost saving occurs. However, local departments received no monetary incentive for this activity.

One of the provisions of § 63.2-526 B of the Code of Virginia is that each local department shall establish fraud prevention and investigation units only insofar as money is appropriated therefor. A local department, therefore, could terminate its fraud program if reimbursement is not available. Approving the amended regulation would require the department to implement an alternative methodology for funding local departments.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The proposed regulations require that expenditures incurred by dedicated fraud prevention units at local departments of social services are reimbursed according to a new methodology. The methodology is to be developed by a work group convened by the commissioner of Department of Social Services (DSS), consisting of representatives from local departments and senior managers from DSS. The proposed regulations also establish performance expectations for local departments of social services.

Estimated economic impact. The proposed regulations contain rules for the Fraud Reduction/Elimination Effort (FREE) program administered by the DSS. This is a statewide program to ensure that fraud prevention and investigation goals are pursued for Virginia's public assistance programs. Pursuant to § 63.2-526 of the Code of Virginia, each local department of social services is mandated to establish a fraud prevention and investigation unit, but only insofar as money is appropriated to cover their costs. Currently, DSS reimburses all administrative costs relating to the operation of these units and all 120 local departments have a fraud prevention and investigation unit. These units currently employ a total of about 93 full-time equivalent positions.

The funding sources of the FREE program include the fraud recovery special fund, the general fund, and federal funds. Even though the general fund had been a source of funding in the past, no appropriation is currently provided for this purpose. Thus, the program relies mainly on the fraud recovery special fund for its state share of costs. This fund receives overpayment moneys (net of the federal share) recovered by local departments primarily in the food stamp program and Temporary Assistance for Needy Families (TANF). In fiscal year 2003, payments into the fraud recovery special fund from food stamp and TANF collections was about \$1.4 million, compared to \$2.1 million incurred by fraud

prevention and investigation units in administrative costs. Based on these figures, the state share of revenues the program generates is about 64% of the administrative costs the state reimburses localities. Since the program does not generate enough revenues, DSS is unable to reimburse localities for the full administrative costs of local fraud units.

Thus, if the collections are not sufficient, local departments are no longer likely to be reimbursed for the full administrative costs of their local fraud units. The extent of the funding is likely to be determined by overpayment collections by localities from the food stamp and TANF programs. In 2003, the ratio of collections to expenditures was less than one for about 80 out of 120 local departments. Because these local departments may no longer receive full funding for their administrative expenses, under statute, they have the option to terminate their dedicated fraud prevention and investigation units. Even if they decide to terminate their dedicated fraud unit, localities will continue to deposit overpayment recoveries to the fund, but they will not get reimbursed for their costs from the fund.

Less than full funding of expenditures may cause some departments to reduce their fraud unit staff. However, it will be in the best interest of localities to maintain dedicated fraud units. As they will be receiving some funding, they will be able to reap the advantages of having a dedicated fraud prevention unit without incurring the full costs of having one. The local departments have an obligation to detect and pursue fraud. One option available for them outside the FREE program is designating some eligibility workers for fraud prevention and detection activities. The funding for eligibility workers is provided 50% from federal sources, 30% from state sources, and 20% from local sources. However, continued participation in the FREE program is probably a better choice for local departments. Designating eligibility workers to pursuing fraud activity would take away from resources originally dedicated to eligibility determinations.

The proposed regulations require that the commissioner of DSS convene a work group consisting of local department representatives and senior department managers to develop a methodology for allocation of available funds to localities for fraud prevention and detection. Since local departments and the senior department managers will determine the allocation methodology, the interests of both sides will be represented in the work group. The likely economic effects of the change in reimbursement policy will depend on the final methodology developed by the work group. However, as the reimbursement methodology is yet to be developed, the potential effects of the proposed change are not known at this time.

In general, the way localities are allocated available funds for their fraud prevention efforts will affect the incentives to localities to crack down on fraud and, consequently, the benefits of each dollar that the state reimburses them for their fraud prevention activities. For example, if the funds are allocated regardless of a unit's performance, the full benefit of each dollar spent on fraud prevention may not be realized. Neither does allocating funds purely based on the recoveries of overpayments guarantee that good performance is rewarded. This is because (1) for recoveries to occur

overpayments must have been made initially, which could be an indication of bad performance in preventing front-end fraud, and (2) distribution of overpayments among the localities may not be steady and may cause significant variations in the reimbursements regardless of how well the recovery efforts are orchestrated. For this specific case, it appears that fraud prevention efforts would be reasonably encouraged and supported by an allocation methodology that would provide a fixed amount of funding, independent of recoveries, to ensure continuity in fraud prevention efforts and a variable amount of funding based on indicators measuring staff performance as well as collection performance.

The proposed regulations will also allow DSS to develop, implement, and monitor local fraud unit performance expectations. DSS indicates that local department performances are already evaluated internally. The proposed language will provide authority to make this internal procedure external. Since performance evaluations are already done internally, there are not likely to be any significant additional costs as a result of the proposed changes. However, the external performance reviews may allow DSS to withhold funding if the performance expectations are not met. Thus, the proposed changes will provide some incentives to fraud units to maintain high performance standards. In addition, if the funding is reduced because performance expectations are not met, a local department may choose to no longer participate in the FREE program.

**Businesses and entities affected.** The proposed regulations apply to dedicated fraud units housed at 120 local departments of social services.

**Localities particularly affected.** The proposed regulations apply throughout the Commonwealth.

**Projected impact on employment.** The proposed funding methodology may cause some local departments to reduce staffing dedicated to fraud units, as they may no longer be reimbursed for the full costs of their fraud-related expenditures. Currently, local departments have approximately 93 full-time equivalent positions involved in detection and pursuing fraud. Thus, this change may reduce the demand for labor by an unknown amount.

**Effects on the use and value of private property.** The proposed regulations are not expected to affect the use and value of private property.

**Agency's Response to the Department of Planning and Budget's Economic Impact Analysis:** The Department of Social Services concurs with the economic impact analysis prepared by the Department of Planning and Budget.

### Summary:

*The proposed amendments require that expenditures incurred by dedicated fraud prevention units at local departments of social services are reimbursed according to a new methodology. The methodology is to be developed by a work group convened by the Commissioner of Department of Social Services (DSS), consisting of representatives from local departments and senior managers from DSS. The proposed amendments also*

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# Proposed Regulations

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*establish performance expectations for local departments of social services.*

## 22 VAC 40-325-10. Definitions.

For purposes of this chapter:

"Collections" means all overpayment monies collected, recovered or recouped by local departments of social services related to food stamps, TANF, and other federal benefit programs administered by the department.

"Department" means the ~~Virginia state~~ Department of Social Services.

"Direct costs" means the cost of salary, fringe benefits and supporting costs of operation. *Cost for supervisory and clerical staff is excluded from reimbursement.*

"Food stamps" means the program supervised by the Virginia Department of Social Services through which a household can receive *electronic food stamps stamp benefits* with which to purchase food products.

"Fraud Recovery Special Fund" means the special fund established under § ~~63.1-58.2-D~~ 63.2-526 D of the Code of Virginia.

"Fraud Reduction/Elimination Effort (Fraud FREE)" means the program established in compliance with § ~~63.1-58.2~~ 63.2-526 of the Code of Virginia to ensure that fraud prevention and investigation are aggressively pursued throughout the Commonwealth of Virginia.

~~Fraud FREE~~ prevention, *detection* and investigation units" means a person or persons whose job it is to work on all aspects of prevention, *detection* and investigation of fraud cases.

"General fund" means that portion of the budget of the Commonwealth of Virginia ~~which~~ *that* is made up of general tax revenues, the major sources of which are sales tax, income tax, and profits from the Virginia Lottery.

*"Investigation" means gathering evidence on questionable applications, on-going cases and closed cases to determine intent to defraud.*

~~Local departments~~ *department*" means ~~the local departments~~ *department* of social services of any county or city in this Commonwealth.

"Local share" means that portion of the administrative costs of operation ~~borne~~ *incurred* by local departments of social services.

*"Performance expectations" means qualitative and quantitative standards or measures against which responsibilities and agency/departmental objectives are assessed.*

"Private entities" means individuals or organizations other than federal, state or local personnel or agencies.

*"Public assistance" means Temporary Assistance for Needy Families (TANF); auxiliary grants to the aged, blind and disabled; medical assistance; energy assistance; food stamps; employment services; child care and general relief.*

~~"Reimbursed Reimbursement"~~ means the process by which the Department of Social Services provides monetary credit to local departments of social services for their *approved* administrative costs.

"State retained portion of collections" means the amount of collections less any refunds due to the federal government, consistent with federal reimbursement regulations.

"Supporting costs of operation" means program costs other than salaries and fringe benefits. These supporting costs of operation include travel, telephone, utilities, supplies, ~~and~~ allowance for space *and training and conference fees for positions funded by the FREE program.*

~~"TANF" means the Temporary Assistance for Needy Families program.~~

"Temporary Assistance for Needy Families (TANF)" means the program ~~which provides a monthly cash benefit to families which meet income and eligibility requirements~~ *administered by the department through which a relative can receive monthly cash assistance for the support of his eligible children.*

~~"Workload measures" means those validated measures, adopted and implemented by the department, used to determine necessary appropriations for personnel and operating costs for mandated programs and services.~~

## 22 VAC 40-325-20. The Fraud Reduction/Elimination Effort.

A. In compliance with § ~~63.1-58.2~~ 63.2-526 of the Code of Virginia, the department of Social Services shall establish a statewide fraud prevention ~~and control~~ , *detection and investigation* program to be named the Fraud Reduction/Elimination Effort (Fraud FREE).

1. The department shall develop and implement policies and procedures for the ~~Fraud FREE~~ program.

2. The department shall provide a detailed local reimbursement procedure, on an annual basis, to assist in the formulation of the ~~locality's~~ *local department's* FREE program operation plan. The department's procedure shall project the available funding and the number of local fraud ~~workers~~ *investigators* for each ~~locality~~ *local department* that the ~~Fraud FREE~~ program will support. The number of ~~workers~~ *investigators* shall be based on an evaluation of the available funding and appropriate criteria from one or more of the following: ~~an agency's~~ *a local department's* average TANF and Food Stamp caseload size, average number of monthly applications for food stamps and TANF, number of ~~local~~ *department* workers, geographic location, number of fraud investigations, program compliance, collections and ~~workload measures~~ *performance expectations*.

3. *The department shall develop, implement and monitor local FREE units performance expectations.*

B. Each local department of social services shall aggressively pursue fraud prevention, *detection* and ~~investigation~~ *investigations*.

1. Each local department shall conduct fraud prevention, *detection* and investigation activities consistent with the requirements of federal regulations, the Code of Virginia, the regulations contained herein and the department's ~~Fraud~~ FREE program policy.

Code of Virginia and the restrictions of § ~~63.1-58.2~~ 63.2-526 of the Code of Virginia.

VA.R. Doc. No. R04-14; Filed November 5, 2004, 1:30 p.m.

2. Each local department shall submit to the department, for annual approval, a program operation plan, *formatted by the department*, which shall include a description of the ~~program staffing~~ *local department's prevention, detection and investigative process, agreement with the Commonwealth's attorney, identification of staff charged with oversight or supervisory responsibility of the FREE program, performance expectation monitoring process, signed commitment to adhere to specified responsibilities identified in the Statement of Assurance section of the program operation plan, and, if requested, a proposed annual budget to include the identification of the FREE program investigators, their salary, fringe benefit amounts, supporting operating costs, hours worked per week and time dedicated to the FREE program.*

3. Upon request, each local department shall provide the department with an accounting of FREE program expenditures.

C. ~~Each local department shall establish a separate fraud unit to the extent that funding is available~~ *Funding for the FREE program shall be comprised of balances in the Fraud Recovery Special Fund, general funds appropriated for this activity, and any federal funds available for this purpose.*

1. In order to receive full reimbursement of the local share of direct costs and supporting costs of operation, a local ~~agency~~ *department* must:

a. Comply with all pertinent law, regulation and policy; and

b. ~~Collect overpayments, net refunds due to the federal government, which equal or exceed the local share of direct costs of its approved positions dedicated to Fraud FREE.~~ *In accordance with the law, each local department shall establish and maintain a FREE prevention, detection and investigation unit; and*

c. *Recover fraud and nonfraud related overpayments of designated federal assistance programs. Reimbursement to localities shall be made in accordance with the methodology for the allocation of funds to localities as developed by the work group convened by the commissioner, consisting of local department representatives and senior department managers. Each local department's level of reimbursement of direct and support operation costs is paid from available federal funds, general funds and state retained portion of collections.*

2. Local departments may contract with other local departments to share a fraud prevention, *detection* and investigation unit and may contract with private entities to perform fraud ~~investigation~~ *investigations*. Any private entity performing fraud ~~investigation~~ *investigations* shall comply with the requirements of § ~~2-1-155.3~~ 30-138 of the

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# FINAL REGULATIONS

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For information concerning Final Regulations, see Information Page.

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## 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 change from the proposed text of the regulation.

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## TITLE 10. FINANCE AND FINANCIAL INSTITUTIONS

### STATE CORPORATION COMMISSION

**REGISTRAR'S NOTICE:** The State Corporation Commission is exempt from the Administrative Process Act in accordance with § 2.2-4002 A 2 of the Code of Virginia, which exempts courts, any agency of the Supreme Court, and any agency that by the Constitution is expressly granted any of the powers of a court of record; however, under the provisions of § 2.2-4031, it is required to publish all proposed and final regulations.

**Titles of Regulations:** 10 VAC 5-100. Nonprofit Debt Counseling Agencies (repealing 10 VAC 5-100-10, 10 VAC 5-100-20 and 10 VAC 5-100-30).

**10 VAC 5-110. Nonprofit Credit Counseling (adding 10 VAC 5-110-10 and 10 VAC 5-110-20).**

**Statutory Authority:** §§ 6.1-363.15 and 12.1-13 of the Code of Virginia.

**Effective Date for 10 VAC 5-100:** June 30, 2005.

**Effective Date for 10 VAC 5-110:** November 15, 2004.

**Agency Contact:** E. J. Face, Jr., Commissioner, Bureau of Financial Institutions, State Corporation Commission, P.O. Box 640, Richmond, VA 23218, telephone (804) 371-9659, FAX (804) 371-9416, or e-mail [jface@scc.state.va.us](mailto:jface@scc.state.va.us).

#### Summary:

*The regulations establish surety bond standards for licensed nonprofit credit counseling agencies under the Nonprofit Credit Counseling Act (§ 6.1-363.2 et seq. of the Code of Virginia), require certain reports from licensees, and define various terms. The State Corporation Commission is also repealing its Nonprofit Debt Counseling Agencies regulations, which were previously adopted pursuant to former Chapter 10.1 of Title 6.1 of the Code of Virginia, which was repealed by Chapter 790 of the 2004 Acts of Assembly.*

AT RICHMOND, NOVEMBER 8, 2004

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. BFI-2004-00110

Ex Parte: In re: proposed nonprofit credit counseling regulations and repeal of "Nonprofit Debt Counseling Agencies" regulations

## ORDER ADOPTING A REGULATION

By Order entered in this case on September 1, 2004, the State Corporation Commission ("Commission") directed that notice be given of its proposal, acting pursuant to § 6.1-363.15 of the Nonprofit Credit Counseling Act, Chapter 10.2 of Title 6.1 of the Code of Virginia ("Chapter 10.2"), to promulgate regulations that would define various terms, establish surety bond standards, and require certain reports from licensed nonprofit credit counseling agencies. The Commission also proposed that Chapter 100 (10 VAC 5-100-10 *et seq.*) of Title 10 of the Virginia Administrative Code ("Chapter 100") be repealed. Notice of the proposed regulations and repeal of Chapter 100 was published in the Virginia Register on September 20, 2004, posted on the Commission's website, and sent by the Commissioner of Financial Institutions to all nonprofit credit counseling agencies licensed under former Chapter 10.1 of Title 6.1 of the Code of Virginia ("Chapter 10.1"). Interested parties were afforded the opportunity to file written comments or request a hearing on or before October 15, 2004. No comments or requests for hearing were filed.

NOW THE COMMISSION, having considered the record, the proposed regulation, and Staff recommendations, concludes that the proposed regulations should be adopted as proposed. The Commission further concludes that Chapter 100 should be repealed, but with a delayed effective date so that Chapter 100 will continue to apply to nonprofit credit counseling agencies while they are operating under licenses issued under Chapter 10.1. Accordingly, the Commission concludes that the effective date of the repeal should coincide with the latest date by which all licenses issued under Chapter 10.1 will automatically terminate pursuant to § 6.1-363.3 C of the Code of Virginia.

THEREFORE, IT IS ORDERED THAT:

- (1) The proposed regulations, 10 VAC 5-110-10 *et seq.*, attached hereto are adopted effective November 15, 2004.
- (2) Chapter 100 (10 VAC 5-100-10 *et seq.*) of Title 10 of the Virginia Administrative Code is repealed effective June 30, 2005.
- (3) The regulations shall be posted on the Commission's website at <http://www.state.va.us/scc/caseinfo.htm>.
- (3) AN ATTESTED COPY hereof, together with a copy of the regulations, shall be sent to the Registrar of Regulations for publication in the Virginia Register.
- (4) This case is dismissed from the Commission's docket of active cases.

AN ATTESTED COPY hereof shall be sent to the Commissioner of Financial Institutions, who shall forthwith mail a copy of this Order, together with a copy of the regulations, to all nonprofit credit counseling agencies currently operating under licenses previously issued by the

Commission under former Chapter 10.1 of Title 6.1 of the Code of Virginia, and other interested parties as he may designate.

CHAPTER 110.  
NONPROFIT CREDIT COUNSELING.

10 VAC 5-110-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Bureau," "commissioner," "debt management plan," and "licensee" shall have the meanings ascribed to them in § 6.1-363.2 of the Code of Virginia.

"Reporting period" means the first six months of a calendar year or the last six months of a calendar year, as the case may be.

10 VAC 5-110-20. Surety bond standards; reporting requirements.

A. Every licensee shall be bonded in a principal amount determined by the commissioner. The bond amount shall be equal to the licensee's average monthly volume of funds received from Virginia consumers under debt management plans during the preceding reporting period, rounded to the next highest multiple of \$10,000, but not exceeding \$350,000.

B. The amount of bond required of a new licensee shall be based upon the applicant's financial condition, capitalization, projected Virginia monthly volume of funds received under debt management plans, experience, and other factors deemed pertinent by the commissioner.

C. The minimum bond required shall be \$25,000.

D. The form of the bond will be prescribed and provided by the commissioner. The required bond shall be filed with the bureau prior to issuance of a license and shall be maintained continuously thereafter.

E. Licensees shall file a written report with the bureau within 45 days after the end of each reporting period. The report shall contain information regarding the volume of funds received from Virginia consumers under debt management plans and such other information as the commissioner may require concerning the licensee's business and operations. The commissioner may require additional reports as he deems necessary.

F. If the legal name of a licensee is changed, the licensee shall file with the bureau within 15 days a written notice of such change and a document effecting a change of name on its bond.

VA.R. Doc. No. R05-13; Filed November 8, 2004, 3:32 p.m.



TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Titles of Regulations: 12 VAC 30-10. State Plan Under Title XIX of the Social Security Act Medical Assistance Program; General Provisions (amending 12 VAC 30-10-650).

12 VAC 30-130. Amount, Duration and Scope of Selected Services (amending 12 VAC 30-130-290, 12 VAC 30-130-310, 12 VAC 30-130-320, 12 VAC 30-130-330, 12 VAC 30-130-400; adding 12 VAC 30-130-335).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Date: January 3, 2005.

Agency Contact: Javier Menendez, R.Ph., Manager, Pharmacy Services, Department of Medical Assistance Services, Division of Health Care Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-2196, FAX (804) 786-1680, or e-mail javier.menendez@dmas.virginia.gov.

Summary:

The amendments modify the drug utilization review program's claims process and provider requirements. The amendments update the referenced documents used to obtain data and allow DMAS to reject or deny claims that conflict with criteria established by the Drug Utilization Review Board.

Summary of Public Comment's and Agency's Response: No public comments were received the promulgating agency.

**REGISTRAR'S NOTICE:** The proposed regulation was adopted as published in 20:23 VA.R. 2503 July 26, 2004, without change. Therefore, pursuant to § 2.2-4031 A of the Code of Virginia, the text of the final regulation is not set out.

VA.R. Doc. No. R04-73; Filed November 3, 2004, 2:44 p.m.

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Titles of Regulations: 12 VAC 30-50. Amount, Duration and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-210).

12 VAC 30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12 VAC 30-80-40).

12 VAC 30-130. Amount, Duration and Scope of Selected Services (adding 12 VAC 30-130-1000).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia; Item 325 ZZ of Chapter 1042 of the 2003 Acts of Assembly.

Effective Date: January 3, 2005.

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# Final Regulations

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Agency Contact: Adrienne Fegans, Program Operations Administrator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-4112, FAX (804) 786-1680, or e-mail [adrienne.fegans@dmas.virginia.gov](mailto:adrienne.fegans@dmas.virginia.gov).

Summary:

*The amendments modify Medicaid's coverage of prescription pharmacy services in two ways: (i) implementation of the preferred drug list and prior authorization requirements for those prescription (legend) drugs that are not approved for the agency's preferred drug list or prior authorization requirements for preferred drugs or other drugs, including new drugs, due to clinical considerations as determined by the Pharmacy and Therapeutics Committee; and (ii) implementation of utilization review requirements in cases where recipients use high numbers of prescription drugs (high drug threshold). As part of the preferred drug list program, this action also institutes state supplemental rebates between the Commonwealth and pharmaceutical manufacturers. Furthermore, language is added, consistent with federal requirements, that sets out Virginia's methodology for its reimbursement of generic drugs, known as the Virginia Maximum Allowable Cost, in order to conform the state regulations with the federally approved State Plan.*

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

**REGISTRAR'S NOTICE:** The proposed regulation was adopted as published 20:23 VA.R. 2519 July 26, 2004, with the changes identified below. Pursuant to § 2.2-4031 A of the Code of Virginia, the adopted regulation is not published at length; however the sections that have changed since publication of the proposed are set out.

**12 VAC 30-50-210. [ No change from proposed. ]**

**12 VAC 30-80-40. Fee-for-service providers: pharmacy.**

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 Centers for Medicare and Medicaid Services (CMS) upper limit of VMAC cost) subject to the conditions, where applicable, set forth in subdivisions 6 and 7 of this section:

1. The upper limit established by the CMS for multiple source drugs pursuant to 42 CFR 447.331 and 447.332, as determined by the CMS 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 Medicaid Maximum Allowable Cost (VMAC) established by the Virginia Department of Medical Assistance Services to be inclusive of appropriate multiple source and specific high cost drugs plus a dispensing fee. *The VMAC methodology shall be defined as the 75th*

*percentile cost level, or the 60th percentile cost level for unit dose drugs, of the aggregate for each generic manufacturer's drug for each Generic Code Number (GCN). Manufacturers' costs are supplied by the most current First Data Bank file. Multiple source drugs may include but are not limited to Food and Drug Administration-rated products such as drugs established by a Virginia Voluntary Formulary (VVF) drugs, Federal Upper Limit Drugs and any other state or federally approved listing. "Multisource drugs" means covered outpatient drugs for which there are two or more drug products that:*

- a. Are included in the Centers for Medicare and Medicaid Services' state drug rebate program;
- b. Have been approved by the Federal Food and Drug Administration (FDA);
- c. Are included in the Approved Products with Therapeutic Equivalence Evaluations as generically equivalent; and
- d. Are sold or marketed in Virginia.

*3. The provider's usual and customary charge to the public, as identified by the claim charge.*

~~3.~~ 4. The Estimated Acquisition Cost (EAC), which shall be based on the published Average Wholesale Price (AWP) minus a percentage discount established by the General Assembly (as set forth in subdivision 8 of this section) or, in the absence thereof, by the following methodology set out in subdivisions a through c below.

- a. Percentage 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.

~~4. (Reserved.)~~

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

~~6.~~ 5. 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. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The dispensing fee of \$3.75 (effective July 1, 2003) shall remain in effect.

~~7.~~ 6. The Program pays additional reimbursement for unit dose dispensing ~~system~~ systems of dispensing drugs. DMAS defines its unit dose dispensing system coverage consistent with that of the Board of Pharmacy of the Department of Health Professions (18 VAC 110-20-420). This service is paid only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose per capita fee to be ~~submitted by the pharmacy for unit dose dispensing services to a nursing home resident calculated by DMAS'~~

fiscal agent based on monthly per nursing home resident service per pharmacy provider. Only one service fee per month may be submitted by paid to the pharmacy for each patient receiving unit dose dispensing services. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: ~~either the VMAC, based on the 60th percentile or maximum cost level, as identified by the state agency or CMS' upper limits subdivisions 1 through 4 of this section as applicable.~~ All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency. The original per capita fee shall be determined by a DMAS analysis of costs related to such dispensing, and shall be reevaluated at periodic intervals for appropriate adjustment. *The unit dose dispensing fee is \$5.00 per recipient per month per pharmacy provider.*

8. 7. Determination of EAC was the result of a report by the Office of the Inspector General that focused on appropriate Medicaid marketplace pricing of pharmaceuticals based on the documented costs to the pharmacy. An EAC of AWP minus 10.25% shall become effective July 1, 2002.

The dispensing fee of \$3.75 (effective July 1, 2003) shall remain in effect, creating a payment methodology based on the previous algorithm (least of 1 through 5 of this subsection above) plus a dispensing fee where applicable.

9. 8. Home infusion therapy.

a. The following therapy categories shall have a pharmacy service day rate payment allowable: hydration therapy, chemotherapy, pain management therapy, drug therapy, total parenteral nutrition (TPN). The service day rate payment for the pharmacy component shall apply to the basic components and services intrinsic to the therapy category. Submission of claims for the per diem rate shall be accomplished by use of the [ ~~HCFA~~ CMS ] 1500 claim form.

b. The cost of the active ingredient or ingredients for chemotherapy, pain management and drug therapies shall be submitted as a separate claim through the pharmacy program, using standard pharmacy format. Payment for this component shall be consistent with the current reimbursement for pharmacy services. Multiple applications of the same therapy shall be reimbursed one service day rate for the pharmacy services. Multiple applications of different therapies shall be reimbursed at 100% of standard pharmacy reimbursement for each active ingredient.

9. *Supplemental rebate agreement. Based on the requirements in § 1927 of the Social Security Act, the Commonwealth of Virginia has the following policies for the supplemental drug rebate program for Medicaid recipients:*

a. *The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for legend drugs provided to Medicaid recipients, submitted to CMS on February 5, 2004, and entitled Virginia Supplemental Drug Rebate Agreement Contract A and Amendment #2 to Contract A has been authorized by CMS.*

b. *The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for drugs provided to Medicaid recipients, submitted to CMS on February 5, 2004, and entitled Virginia Supplemental Drug Rebate Agreement Contract B and Amendment #2 to Contract B has been authorized by CMS.*

c. *The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for drugs provided to Medicaid recipients, submitted to CMS on February 5, 2004, and entitled Virginia Supplemental Drug Rebate Agreement Contract C, and Amendments #1 and #2 to Contract C has been authorized by CMS.*

d. *Supplemental drug rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.*

e. *Prior authorization requirements found in § 1927(d)(5) of the Social Security Act have been met.*

f. *Nonpreferred drugs are those that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Nonpreferred drugs will be made available to Medicaid beneficiaries through prior authorization.*

g. *Payment of supplemental rebates may result in a product's inclusion on the PDL.*

**12 VAC 30-130-1000. [ No change from proposed. ]**

VA.R. Doc. No. R04-54; Filed November 3, 2004, 2:46 p.m.

**TITLE 16. LABOR AND EMPLOYMENT**

**SAFETY AND HEALTH CODES BOARD**

Titles of Regulations: **16 VAC 25-155. Virginia Construction Industry General Requirements for Clearances, Construction of Electric Transmission and Distribution Lines and Equipment (adding 16 VAC 25-155-10).**

**16 VAC 25-175. Federal Identical Construction Industry Standards: Subpart V--Power Transmission and Distribution - General Requirements - Clearances (repealing 16 VAC 25-175-1926.950(c)(1)).**

Statutory Authority: § 40.1-22 of the Code of Virginia.

Effective Date: January 1, 2005.

Summary:

*The regulation modifies standards for the protection of construction industry employees working on live electricity transmission lines such that they are identical to the standards of protection afforded to general industry electrical transmission workers. Employers will now be*

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required to provide construction industry employees working on live electricity transmission lines with protection not only against the energized part of the wire the employee is working on, but also against any surrounding live electrical parts and power lines.

## CHAPTER 155.

### VIRGINIA CONSTRUCTION INDUSTRY GENERAL REQUIREMENTS FOR CLEARANCES, CONSTRUCTION OF ELECTRIC TRANSMISSION AND DISTRIBUTION LINES AND EQUIPMENT.

#### 16 VAC 25-155-10. General requirements.

A. No employee shall be permitted to approach or take any conductive object without an approved insulating handle closer to exposed energized parts than shown in subsection B of this section (Table V-1) unless:

1. The employee is insulated or guarded from the energized part (insulating gloves or insulating gloves and sleeves worn in accordance with 16 VAC 25-90-1910.269 (l)(3) are considered insulation of the employee only with regard to the energized part upon which work is being performed);
2. The energized part is insulated or guarded from him and any other conductive object at a different potential; or
3. The employee is isolated, insulated, or guarded from any other exposed conductive object(s), as during live-line bare-hand work.

B. Alternating current - minimum distance.

TABLE V-1 - ALTERNATING CURRENT - MINIMUM DISTANCES

| Voltage range (phase to phase) (kilovolt) | Minimum working and clear hot stick distance |
|---|--|
| 2.1 to 15                                 | 2 ft. 0 in.                                  |
| 15.1 to 35                                | 2 ft. 4 in.                                  |
| 35.1 to 46                                | 2 ft. 6 in.                                  |
| 46.1 to 72.5                              | 3 ft. 0 in.                                  |
| 72.6 to 121                               | 3 ft. 4 in.                                  |
| 138 to 145                                | 3 ft. 6 in.                                  |
| 161 to 169                                | 3 ft. 8 in.                                  |
| 230 to 242                                | 5 ft. 0 in.                                  |
| 345 to 362                                | (1) 7 ft. 0 in.                              |
| 500 to 552                                | (1) 11 ft. 0 in.                             |
| 700 to 765                                | (1) 15 ft. 0 in.                             |

(1) NOTE: For 345-362 kv., 500-552 kv., and 700-765 kv., minimum clear hot stick distance may be reduced provided that such distances are not less than the shortest distance between the energized part and the grounded surface.

#### 16 VAC 25-175-1926.950. General requirements.

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(c) Clearances. The provisions of [ 16 VAC 25-155 or ] paragraph ~~(e)(4)~~ or (2) of this section shall be observed.

~~1) No employee shall be permitted to approach or take any conductive object without an approved insulating handle closer to exposed energized parts than shown in Table V-1 unless:~~

~~(i) The employee is insulated or guarded from the energized part (gloves or gloves with sleeves rated for the voltage involved shall be considered insulation of the employee from the energized part), or~~

~~(ii) The energized part is insulated or guarded from him and any other conductive object at a different potential, or~~

~~(iii) The employee is insulated from any other exposed conductive object(s), as during live-line bare-hand work.~~

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VA.R. Doc. No. R03-176; Filed November 4, 2004, 1:20 p.m.

## TITLE 22. SOCIAL SERVICES

### STATE BOARD OF SOCIAL SERVICES

Title of Regulation: **22 VAC 40-141. Licensing Standards for Independent Foster Homes (amending 22 VAC 40-141-10 through 22 VAC 40-141-40, 22 VAC 40-141-60 through 22 VAC 40-141-130, 22 VAC 40-141-150, 22 VAC 40-141-170 through 22 VAC 40-141-210; adding 22 VAC 40-141-87).**

Statutory Authority: §§ 63.2-217 and 63.2-1734 of the Code of Virginia.

Effective Date: February 1, 2005.

Agency Contact: Cynthia Carneal, Operations Consultant, Department of Social Services, 7 N. Eighth St., Richmond, VA 23219, telephone (804) 726-7140, FAX (804) 726-7132, or e-mail [cynthia.carneal@dss.virginia.gov](mailto:cynthia.carneal@dss.virginia.gov).

#### Summary:

*The amendments allow parents and legal guardians to retain the custody of the children placed in an independent foster home, increase the length of time a child may remain in an independent foster home from 90 days to 180 days, and allow placements longer than 180 days in certain cases. Additionally, numerous health and safety standards are updated.*

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

REGISTRAR'S NOTICE: The proposed regulation was adopted as published 20:10 VA.R. 989-1001 January 26, 2004, with the changes identified below. Pursuant to § 2.2-4031 A of the Code of Virginia, the adopted regulation is not published at length; however the sections that have changed since publication of the proposed are set out.

CHAPTER 141.  
MINIMUM LICENSING STANDARDS FOR LICENSED  
INDEPENDENT FOSTER HOMES.

**22 VAC 40-141-10. [ No change from proposed. ]**

**22 VAC 40-141-20. Legal authority.**

The licensed independent foster parent is permitted by law to accept children for care who are entrusted to the provider by the parents or legal guardians *or whose parents have signed a placing agreement authorizing the child's temporary placement in the independent foster home.* ~~This~~ A temporary entrustment [ *agreement* ] transfers custody of the child from the parents or legal guardians to the independent foster parents. ~~The entrustment must be approved by the juvenile and domestic relations court if the child is to remain in placement more than 90 days.~~ *A placing agreement authorizes the child's placement in the independent foster home while allowing the parents or guardians to maintain legal custody. The local juvenile and domestic relations court must approve the temporary entrustment agreement if the child is to remain in the placement for more than 90 days.*

Individuals are exempt from licensure if they only provide care to children who are born to or adopted by the individual or children of relatives or personal friends. Subdivision A 4 of § 16.1-278.2 of the Code of Virginia referenced in the definition of an independent foster home refers to the placement decisions for children by local boards of social services or a public agency designated by the community policy and management team. Subdivision 6 of § 16.1-278.4 of the Code of Virginia refers to the court transfer of legal custody from the parent to another individual or agency. Subdivision 13 of § 16.1-278.8 of the Code of Virginia refers to the court's disposition of delinquent juveniles. Individuals receiving children under these provisions are not subject to licensure *under this regulation.*

Section ~~63.1-202~~ 63.2-1734 of the Code of Virginia establishes the authority of the State Board of Social Services to promulgate regulations for the activities, services and facilities to be employed by persons and agencies required to be licensed by § ~~63.1-496~~ 63.2-1701 of the Code of Virginia. Regulations shall be designed to ensure that such activities, services and facilities are conducive to the welfare of the children under the custody or control of such persons or agencies. Section ~~63.1-245~~ 63.2-1712 of the Code of Virginia states that it shall be a misdemeanor to operate or engage in the activities of a child welfare agency without first obtaining a license.

**22 VAC 40-141-30 through 22 VAC 40-141-120. [ No change from proposed. ]**

**22 VAC 40-141-130. Medical care of children.**

A. The provider shall have the name, address and telephone number of each child's physician easily accessible.

B. The provider shall have first aid supplies easily accessible to adults in the home, but not accessible to children *under the age of 13.*

C. First aid supplies shall include scissors, tweezers, sterile nonstick gauze pads, adhesive bandages in assorted sizes, a

sealed package of alcohol wipes or antiseptic cleansers, a thermometer, a chemical cold pack if an ice pack is not available, first aid instruction manual or cards, an insect bite or sting preparation, one triangular bandage, current [ *activated charcoal and* ] syrup of ipecac to be used only when instructed by the regional poison control center or child's physician, flexible roller or stretch gauze, disposable nonporous gloves, and an eye dressing or pad.

D. The provider shall receive medical history information, including immunizations received, for each child at the time of placement.

E. At the time of placement, the provider shall receive documentation of a physical examination of the child completed within 90 days before placement, or the child shall receive a physical examination within 30 days after placement. The current form required by the Virginia Department of Health or any other form which provides the same information to report immunizations received and the results of the physical examination shall be used.

Exception: If a child's parent objects to the child receiving immunizations or a physical examination on religious grounds, the parent must submit a signed statement noting the objection on religious grounds and certifying to the best of the parent's knowledge, the status of the child's health.

F. The provider shall ensure that the child receives necessary medical care and follow-up.

G. The provider shall give prescription drugs to children in care only in accordance with an order signed by a licensed physician or authentic prescription label and shall keep all prescription and nonprescription medications ~~locked~~ *inaccessible to children under the age of 13* and stored as instructed by the physician or pharmacist.

1. The provider shall keep in the child's record daily documentation of all prescription and nonprescription medication administered to a child in care.

*Exception: Providers are not required to record the amount of diaper ointment or sunscreen applied.*

2. Out-of-date and unused medications shall be properly discarded or returned to the child's parent or guardian.

H. *The provider may permit self-administration of medication by a child in care if:*

1. *The child is physically and mentally capable of properly taking medication without assistance.*

2. *The provider maintains a written statement from the parent or a physician documenting the child's capacity to take medication without assistance.*

3. *The provider assures that the child's medications and any other medical supplies are not accessible to children under the age of 13.*

~~H. 1.~~ *The provider shall report all major illnesses, injuries and accidents, missing children, the death of a child, and any placement of a child outside of the foster home to the child's parent and to the licensing representative within 24 hours. If*

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*the provider is not able to contact the parent or guardian, attempted contacts shall be documented.*

† J. The provider shall receive written authorization for *routine and emergency medical and dental* care for each child.

## **22 VAC 40-141-150 [ No change from proposed. ]**

## **22 VAC 40-141-170. [ No change from proposed. ]**

### **22 VAC 40-141-180. Services to children.**

A. The provider shall arrange for necessary services, as specified in the foster care service plan or *individual service plan*, and as recommended by a licensed physician or other professional working with the child, where applicable. *These services may include, but are not limited to:*

1. *Professional evaluations and counseling;*
2. *Educational services and tutoring; and*
3. *Transportation to necessary appointments and services.*

[ *Note: Individually planned interventions intended to reduce or ameliorate any diagnosed physical, mental or emotional disabilities should be performed by, in conjunction with, or under the written direction of a licensed practitioner. ]*

B. The provider shall enroll each school-age child in school within five days after placement when school is in session.

C. The provider shall promote the child's education by giving the child educational guidance and counseling in the child's selection of courses, establishing contact with the child's school, and working with the child's school to promote academic achievement and to resolve any problems brought to the provider's attention by the school.

D. In accordance with § ~~16.1-84~~ 16.1-281 of the Code of Virginia, the independent foster home, as a licensed child-welfare agency, shall prepare and submit to the local juvenile and domestic relations court a foster care service plan on every child *entrusted to the provider by an entrustment agreement* (i) within 30 days of signing the child's entrustment agreement for placements of 90 days or more or (ii) within 60 days of signing the entrustment agreement for placements for less than 90 days, unless the child is returned to the child's parents or guardians within 60 days of placement in the independent foster home. The *foster care service plan* shall include:

1. The reasons the child is placed with the independent foster home;
2. A summary of the child's situation at the time of placement in relation to the child's family. The summary shall include information about the child's health and educational status;
3. The permanency planning goal recommended for the child, including the projected length of stay in the home;
4. A description of the needs of the child and the child's family;

5. The programs, care, services, and other support that the independent foster home will offer or arrange for the child and the child's parents or guardians to meet those needs;

6. The target dates for completion of the services provided or arranged for the child and the child's family;

7. The participation, conduct, and financial support that will be sought from and the responsibilities of the child's parents or guardians;

8. The visitation or other contacts to be held between the child and the child's parents or guardians;

9. In writing and where appropriate for children age 16 and older, the programs and services which will help the child prepare for the transition from foster care to independent living; and

10. A copy of the independent foster home license.

E. *For every child placed in the independent foster home by a placing agreement, the provider, with the assistance of the parents or legal guardians, shall prepare an individualized service plan at the time of admission. The written individualized service plan shall outline the services needed and those that will be provided to the child and his family and identify the goals and objectives designed to reunite the child with his family. Copies of the child's individualized service plan shall be provided to the parents or legal guardians, to the child, if age 13 or older or upon the child's request, and a copy filed in the child's record. The individualized service plan shall describe:*

1. *The reasons why the child is placed in the independent foster home;*

2. *A summary of the child's situation at the time of placement in relation to the child's family, including a statement of the child's health and educational status;*

3. *A description of the child's needs;*

4. *The goals for the child, including the projected length of placement in the independent foster home;*

5. *The programs, care, services and other means of support that the independent foster home will offer or the arrangements for the child and the child's parent or guardian to provide services or supports;*

6. *Projected dates for completion of services provided or arranged for the child;*

7. *Projected level of involvement of the child's parents or guardians and visitation arrangements;*

8. *Where appropriate for children age 16 and older, the programs and services that will help the child prepare for independent living;*

F. *The individualized service plan shall be updated at least every 30 days.*

≡ G. In accordance with federal and state law, the provider shall ensure that the child's health and safety are the paramount concern throughout the placement, case planning, service provision and review process.

~~F.~~ *H.* If consistent with the child's health and safety, the *foster care plan or individualized service plan* shall be designed to support reasonable efforts which lead to the return of the child to his parents or guardians within the shortest ~~practicable~~ *feasible* time, which shall be specified in the plan.

~~G.~~ *I.* If the provider determines that it is not reasonably likely that the child can be returned to the child's prior family within a ~~practicable~~ *feasible* time, consistent with the best interests of the child, and in a separate section of the *foster care plan or individualized service plan*, the provider shall:

1. Describe the reasons for this conclusion; and
2. Determine and describe the opportunities for the court to consider placing the child with a relative or for the court to refer the child and the child's family to the local department of social services for further services and permanency planning.

~~H.~~ *J.* ~~For children to be in care with the independent foster home for longer than 90 days,~~ The provider shall submit the child's *foster care plan or individualized service plan* at the time of petitioning the local juvenile and domestic relations court for approval of the entrustment agreement *or to assess the care and custody of the child, whichever is appropriate.*

~~I.~~ *K.* The provider shall participate in all court hearings involving the ~~child's entrustment, service plans, and custody~~ *child*, as long as the child is placed in the independent foster home.

~~J.~~ *L.* The provider shall include the child whenever possible and appropriate to the child's age *and development*, the parents or prior guardians of the child, and professionals involved with the child in the development of the *foster care service plan or individualized service plan*.

~~K.~~ *M.* The provider shall follow the requirements of § 16.1-282 related to the review of the foster care service plan and shall petition the local juvenile and domestic relations court within five months of the court's approval of the entrustment agreement or within five months of the dispositional hearing at which the initial foster care plan was reviewed.

**22 VAC 40-141-190. [ No change from proposed. ]**

**22 VAC 40-141-200. Home safety.**

A. The provider shall have a plan for seeking assistance from police, firefighters, *poison control*, and medical professionals in an emergency. The telephone numbers for each shall be posted next to each telephone.

B. The home and grounds shall be in good physical repair and free of litter, debris, peeling or chipped paint, hazardous materials, and infestations of rodents and insects and shall present no hazard to the health and safety of the children receiving care.

C. The provider shall have a written, posted emergency evacuation plan and rehearse the plan at least monthly. Within the first 48 hours of a child's placement in the home, the provider shall review the plan with each child who is old enough to understand.

D. If the provider possesses firearms, ammunition, and other weapons, the provider shall keep the firearms unloaded and locked as well as the ammunition and other weapons locked. Ammunition shall be locked in a separate location.

E. The provider shall keep cleaning supplies and other toxic substances stored away from food, *and* locked ~~and~~ *or* out of the reach of children *under the age of 13*.

F. When infants or children who are not developmentally ready to climb or descend stairs are in the home, the provider shall have protective barriers installed securely at each opening to stairways.

G. Swimming and wading pools shall be set up according to the manufacturer's instructions. Outdoor swimming pools shall be enclosed by safety fences and gates with child-resistant locks. Wading pools shall be emptied, stored away when not in use and filled with clean water before the next use.

H. Radiators, oil and wood burning stoves, floor furnaces, portable electric space heaters, fireplaces, and similar heating devices used in areas accessible to children *under the age of 13* shall have protective barriers or screens.

I. All interior and exterior stairways with over three risers shall have hand rails at a height accessible to the children in the home.

J. Independent foster homes that provide care to preschool-age children *or to developmentally delayed children of comparable maturity to a preschool child* shall have protective, child-resistant covers over all electrical outlets. The covers shall not be of a size to present a swallowing or choking hazard.

*K. The provider shall comply with the requirements for state regulated care facilities relating to smoke detectors and fire extinguishers.*

*L. Infants shall be placed to sleep on a firm, tight-fitting mattress in a crib that meets current safety standards. To reduce the risk of suffocation, soft bedding of any kind shall not be used under or on top of the infant including, but not limited to, pillows, quilts, comforters, sheepskins, or stuffed toys.*

*M. Infants shall be placed on their backs when sleeping or napping unless otherwise directed by the child's physician. If an individual child's physician contraindicates placing the child in this position, the provider shall maintain a written statement, signed by the physician, in the child's record.*

~~[ N. Playpens, play yards, and portable cribs shall not be used for sleeping.~~

~~G.~~ *N.] Bunk beds or double decker beds shall have safety rails or mechanisms in place to reduce the risk of falls. Children under age 10 shall not use the upper levels of a double decker or bunk bed. Children of any age who have motor or developmental delays shall not use the upper bunk.*

~~[ P.~~ *O.] Pets shall be immunized for rabies and shall be treated for fleas, ticks, worms or other diseases as needed.*

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~~[ Q. Providers shall instruct children on safe procedures to follow when in close proximity to animals or when feeding animals, and ensure hand washing after handling animals or animal waste. P. Providers shall instruct children on safe and hygienic procedures to follow when handling, feeding or in close proximity to animals. ]~~

**22 VAC 40-141-210. [ No change from proposed. ]**

**NOTICE:** The form used in administering 22 VAC 40-141, Licensing Standards for Independent Foster Homes, is listed and published below.

## FORMS

~~Initial Application for State License to Operate an Independent Foster Home for Children, 3/99.~~

~~Application for Renewal of State License to Operate an Independent Foster Home for Children, 3/99.~~

~~Financial Statement for Independent Foster Homes, 3/99.~~

~~Home Study Assessment for Independent Foster Homes, [ 3/99 7/04 ].~~

**HOME STUDY ASSESSMENT FOR INDEPENDENT FOSTER HOMES**

**Please complete the following items as completely as possible. Use additional paper if needed. Submit this document along with the Initial Application for Licensure as an Independent Foster Home to the Division of Licensing Programs. If the applicant is a husband and wife, each individual is to complete this study.**

1. **Name, Address and Telephone Number of Applicant:**

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2. **Describe your reasons for wishing to become an independent foster home:**

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3. **Describe your experience with children, your own and those not related to you. Include any previous experience as a foster parent.**

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4. **Describe your abilities and experience in the following areas:**

**Providing care to and meeting the physical needs of children:**

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**Relating to children with respect, courtesy, patience and affection:**

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**Understanding children from varied backgrounds different from your own:**

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**Understanding and respecting the families of children to be placed with you:**

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**Assuring the safety and supervision of children**

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**Handling emergencies:**

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5. Describe your current and past employment, giving the name of the company or individual. Describe your financial resources which demonstrate your ability to meet the needs of your family.

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6. Describe the discipline techniques and parenting skills you use and will use with the children in your care:

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7. Do you have any current physical or mental health problems which may negatively impact the full time care of children in your home? If so, please explain.

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8. Describe your character and reputation.

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9. Describe the length and stability of your marriage. How do you resolve differences?

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10. Describe your current relationships with extended family members to include a discussion of conflicts which may negatively impact children in your care.

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11. Describe any training you have attended related to providing care and services to children.

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12. How will you provide supervision to the children in your care?

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13. Describe the services you will provide to the children in your care and any services you will utilize in the community.

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14. What do you believe are valid reasons a child should not be returned to his family?

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15. Describe the general pattern of your family life such as activities and daily routines.

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16. Please add any additional information you would like to be considered as part of your application for licensure as an independent foster parent.

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Revised 7/2004

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VA.R. Doc. No. R03-42; Filed November 5, 2004, 1:31 p.m.



**TITLE 24. TRANSPORTATION AND MOTOR VEHICLES**

CHAPTER 91.  
SUBDIVISION STREET REQUIREMENTS.

PART I.  
GENERAL PROVISIONS.

**COMMONWEALTH TRANSPORTATION BOARD**

**24 VAC 30-91-10. Definitions.**

Titles of Regulations: **24 VAC 30-90. Subdivision Street Requirements (REPEAL).**

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

**24 VAC 30-91. Subdivision Street Requirements (adding 24 VAC 30-91-10 through 24 VAC 30-91-160).**

"AASHTO" means the American Association of State Highway and Transportation Officials.

Statutory Authority: §§ 33.1-12, 33.1-69, 33.1-198, and 33.1-229 of the Code of Virginia.

"Abandon" in all its forms means the legislative action reserved [for and graded to] the local governing body to extinguish the public's right to a roadway under the jurisdiction of the Virginia Department of Transportation, pursuant to §§ 33.1-151 and 33.1-155 of the Code of Virginia.

Effective Date: January 1, 2005.

Agency Contact: Michael A. Estes, P.E., Attention: Kenneth M. Smith, Transportation Engineering Program Supervisor, Department of Transportation, Local Assistance Division, 1401 E. Broad Street, Richmond, VA 23219, telephone (804) 786-2576, FAX (804) 786-2603, or e-mail Ken.Smith@vdot.virginia.gov.

[ "Accessible route" means a continuous unobstructed, stable, firm and slip-resistant path connecting all accessible elements of a facility (may include parking access aisles, curb ramps, crosswalks at vehicular ways, walks, ramps and lifts) that can be approached, entered and used by persons with disabilities. An accessible route shall, to the maximum extent feasible, coincide with the route for the general public. ]

Summary:

*This regulation sets forth the requirements applicable to all subdivision streets in the Commonwealth that are designated to become part of the secondary system of state highways, including procedures for approval and criteria used to consider the acceptance of new streets for maintenance as part of the secondary system. (Note: This regulation does not apply to the Counties of Arlington or Henrico, but may apply in the independent cities or towns of more than 3,500 population pursuant to § 33.1-41.1 of the Code of Virginia.)*

"ADT" means average daily traffic count (see "Projected Traffic").

*The changes (i) clarify text to improve comprehensibility and usefulness; (ii) update obsolete titles and work unit names; (iii) move geometric standards from the regulatory requirements to a new section of the Road Design Manual; (iv) update the list of documents incorporated by reference; (v) address the impact of technical issues on the regulation; (definition of roles, design processes, right-of-way, sidewalks, flexibility of standards, traffic calming, utilities, etc.) (vi) update amounts for surety and maintenance fees; and (vii) provide a mechanism under which VDOT can recover administrative costs associated with new street development.*

[ ~~"Apartment building" means a building for residential occupancy containing more than two dwelling units that may be rented or occupied by the owner. For the purposes of this regulation, the term shall include townhouse and condominium buildings.~~ ]

"Board" means the Commonwealth Transportation Board.

*Due to the extensive nature of the changes, VDOT abandoned its initial approach to amend the existing regulation in favor of repealing the existing regulation and replacing it with a totally new regulation under the same title.*

[ "Clear zone" means the total border area of a roadway or shared use path that is sufficiently wide for an errant vehicle to avoid a serious accident. (See the Subdivision Street Design Guide (24 VAC 30-91-160) for details.) ]

"Commissioner" means the chief executive officer of the Virginia Department of Transportation [ ~~and the Vice-Chairman of the Commonwealth Transportation Board for the Commonwealth of Virginia~~ ].

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

"Complete development (land)" means the utilization of the available areas in a manner as to realize its highest density for the best potential use based on zoning, pending rezoning, the adopted comprehensive plan of the governing body, or the customary use of similar parcels of land.

"Complete development (streets)" means the development of a subdivision street in full compliance with all applicable provisions of these regulations to the necessary standards of design and construction for the effective and efficient accommodation of the traffic generated by the complete development of the land, both internal and external to the subdivision.

[ "County controlled grade separation structure" means a grade separation structure that does not qualify for maintenance by the department but was established within the right-of-way of a street intended for state maintenance. ]

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"County official" means the representative of the governing body appointed to serve as its agent in matters relating to subdivisions.

"Cul-de-sac" means a street with only one outlet and having an appropriate turnaround for a safe and convenient reverse traffic movement and more specifically the turning area.

"Dam" means an embankment or structure intended or used to impound, retain, or store water, either as a permanent pond or as a temporary storage facility.

"Department" means the Virginia Department of Transportation.

"Design manual" means the department's Road Design Manual [~~effective July 1, 1998~~ see 24 VAC 30-91-160], Location and Design Division.

"Design speed" means a speed selected for purposes of design and correlation of those features of a street such as curvature, super elevation, and sight distance, upon which the safe operation of vehicles is dependent.

"Developer" means an individual, corporation, or registered partnership engaged in the subdivision of land.

~~["Director of the Asset Management Division" means the department employee responsible for the maintenance program of the State Highway System and the secondary system of state highways or his designee ]~~

"Director of the Local Assistance Division" means the department employee responsible for [administering overseeing all programs administered by the Local Assistance Division, including] these requirements and the final acceptance of streets as part of the secondary system of state highways maintained by the department or his designee.

"Discontinue," in all its forms, means the legislative act of the Commonwealth Transportation Board, pursuant to § 33.1-150 of the Code of Virginia, that determines that a road no longer serves public convenience warranting its maintenance with funds at the disposal of the department.

"District administrator" means the department employee assigned the overall supervision of the departmental operations in each of the Commonwealth's nine construction districts.

"Drainage manual" means the department's Drainage Manual [~~effective April 2002~~ (see 24 VAC 30-91-160)], Location and Design Division.

"Dwelling unit" means a structure or part of a structure containing sleeping, kitchen, and bathroom facilities that is suitable for occupancy as a home or residence by one or more persons.

"Easement" means a grant of a right to use property of an owner for specific, limited use or purpose.

~~["Extrinsic structure" means any structure whose primary mission is not essential for the operation of a subdivision street. Customarily, an extrinsic structure is intended to separate the movement of people or products (e.g., utilities, unlicensed motor vehicles, golf carts, pedestrians, etc.) from those using the street. The term is primarily intended to~~

~~identify grade separation structures that are not essential for the purposes of the street but may also apply to other structures within the right of way. Pedestrian or bicycle facilities that are accepted for maintenance as part of the street are exempt from the term. ]~~

"Functional classification" means the process by which streets and highways are grouped into classes, or systems, according to the character of service they are intended to provide.

"Governing body" means the board of supervisors of the county but may also mean the local governing body of a town or city, if appropriate, in the application of these requirements.

"Intersection" means the juncture of two or more streets at which point there are three or more legs.

"Level of service" means a qualitative measure describing operational conditions within a traffic stream, and their perception by motorists and passengers. For the purposes of these requirements, the applicable provisions of the Highway Capacity Manual [; ~~Transportation Research Board,~~ (see 24 VAC 30-91-160)] shall serve as the basis for determining "levels of service."

"Level terrain" means that condition where highway sight distances, as governed by both horizontal and vertical restrictions, are generally long or could be made so without construction difficulty or major expense.

"Loop street" means a street whose two outlets are to the same street.

~~["Minimum entrance standards" means the department's Minimum Standards of Entrances to State Highways (24 VAC 30-71), Mobility Management Division ]~~

"Mountainous terrain" means that condition where longitudinal and traverse changes in the elevation of the ground with respect to the road or street are abrupt and where benching and side hill excavation are frequently required to obtain acceptable horizontal and vertical alignment.

"Neotraditional development" means a type of subdivision that creates a neighborhood or community design with qualities of a traditional small town, combining a mix of uses that may include retail establishments, offices, civic buildings, public squares, and multi-family and single-family housing, all within walking distance of one another [, as well as a mix of transportation facilities that focuses on the needs of pedestrians and bicyclists in addition to the needs of motorists]. These developments may include a variety of buildings and land use densities along the same street. Street layout may follow a grid pattern using narrow streets and having multiple connections to surrounding neighborhoods. These developments may be referred to as "villages" or "hamlets" within the ordinances of the governing body.

"Nonresidential street" means a subdivision street adjacent to property that is anticipated to develop for purposes other than residential use.

"Office building" means a building that is used primarily for conducting business transactions other than retail sales.

"Parking bay" means an [off-street] area for parking two or more vehicles that are served by a short driveway connecting

the parking area and the public street [~~or the parking space on a street needed by a vehicle or vehicles~~].

"Parking lane" means an area, generally seven or eight feet in width, adjacent to and parallel with the travel lane of a roadway that is used for parking vehicles.

"Pavement Design Guide" means the [~~edition of the~~] Pavement Design Guide for Subdivision and Secondary Roads in Virginia (effective August 1, 2000), Materials Division and Transportation Research Council see 24 VAC 30-91-160 ].

"Permit Manual" means the department's Land Use Permit Manual (24 VAC 30-150) [~~, Local Assistance Division Division~~].

"Phased development" (streets) means the method outlined in [~~24 VAC 30-91-130~~ 24 VAC 30-91-70 (Phased development of subdivision streets)] whereby the acceptance of certain subdivision streets into the secondary system of state highways may be considered before being completely developed in accordance with all applicable requirements (e.g., two lanes of a four-lane facility are considered for acceptance in advance of lanes 3 and 4 being finished).

"Plans" means the standard drawings, including profile and roadway typical section, that show the location, character, dimensions and details for the proposed construction of the subdivision street.

"Plat" means the schematic representation of the land divided or to be divided.

"Private streets" means subdivision streets that have not been dedicated to public use or that require the permission or invitation of a resident or owner to use the street. Such streets are not intended to be included in the secondary system of state highways.

"Privately maintained streets" means any public or private street that is not maintained by the department or the local governing body.

"Projected traffic" means the number of vehicles, normally expressed in average daily traffic (ADT), forecast to travel over the segment of the subdivision street involved.

"Public street" means a street dedicated to public use and available to the public's unrestricted use without regard to the jurisdictional authority responsible for its operation and maintenance.

[~~"PUD" means planned unit development, which is a form of development characterized by unified site design for a variety of types and densities of development and as more specifically defined in § 15.2-2201 of the Code of Virginia.~~]

"Requirements" means the design, construction, and related administrative considerations herein prescribed for the acceptance of a subdivision street for maintenance by the department as part of the secondary system of state highways.

"Resident engineer" means the department employee assigned to supervise departmental operations within a specified geographical portion of the Commonwealth,

consisting of one to four counties, or his designee. [In the context of either this regulation or the Subdivision Street Design Guide (24 VAC 30-91-160), the term can also refer to:

1. In districts having centralized functions for the review and approval of subdivision plans, either:

- a. The district land development manager for functions related to plan approval;
- b. The residency permit manager for functions related to construction, inspection, and acceptance of streets; or
- c. Any other position specifically designated to perform the functions described in subdivisions 1a and 1b of this definition.

2. In cities and towns that maintain and operate their own system of streets and elect to use the pavement and right-of-way width requirements of the Subdivision Street Design Guide (24 VAC 30-91-160) as a basis for street maintenance payments under the provisions of § 33.1-41.1 of the Code of Virginia, as well as the counties of Arlington and Henrico, the local official responsible for the review and approval of subdivision street design. ]

"Residential street" means a subdivision street adjacent to property that is anticipated to develop as single-family residences, apartment buildings, or other similar dwelling structures.

"Right-of-way" means the land, property, or interest therein, usually in a strip, acquired for or devoted to a public street designated to become part of the secondary system of state highways.

"Roadway" means the portion of the road or street within the limits of construction and all structures, ditches, channels, etc., necessary for the correct drainage thereof.

"Secondary system of state highways" means those public roads, streets, bridges, etc., established by a local governing body pursuant to § 33.1-229 of the Code of Virginia and subsequently accepted by the department for supervision and maintenance under the provisions of Articles 6 (§ 33.1-67 et seq.) and 11 (§ 33.1-150 et seq.) of Chapter 1 of Title 33.1 of the Code of Virginia.

"Shared [ use ] path" means a facility [ , as defined in § 46.2-100 of the Code of Virginia, ] that is [ set apart from the travelway and ] intended to be used by pedestrians and bicyclists [ and that is set apart from the roadway intended for motor vehicles ].

"Shopping center" means a building or buildings containing two or more stores that are used primarily for retail sales but may include commercial trade or professional uses.

"Single-family residence" means a structure, other than an apartment building, maintained and used as a single dwelling unit or any dwelling unit that has direct access to a street and shares neither heating facilities, hot water equipment, nor any other essential facility or service with any other dwelling unit.

"Specifications" means the department's Road and Bridge Specifications ([ effective 2002 24 VAC 30-91-160 ]), including related supplemental specifications and special provisions.

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"Standards" means the applicable drawings and related criteria contained in the department's Road and Bridge Standards (~~[ effective February 2004~~ 24 VAC 30-91-160 ).

"Subdivision" means the division of a lot, tract, or parcel into two or more lots, plats, sites, or other divisions of land for the purpose, whether immediate or future, of sale or of building development. Any resubdivision of a previously subdivided tract or parcel of land shall also be interpreted as a "subdivision." The division of a lot or parcel permitted by § 15.2-2244 of the Code of Virginia will not be considered a "subdivision" under this definition, provided no new road or street is thereby established. However, any further division of such parcels shall be considered a "subdivision."

"Subdivision street" means a public way for purposes of vehicular travel that results from the subdivision of land, including the entire area within the right-of-way. Public streets developed in accordance with these requirements and meeting the necessary public service provisions established herein shall be eligible for addition to the secondary system of state highways maintained by the department. Streets primarily intended to access property abutting or in the immediate vicinity of the street are deemed "local" subdivision streets.

"Subdivision Street Design Guide" means Appendix B of the Road Design Manual (~~effective July 1, 1998~~ 24 VAC 30-91-160 ).

"Swale" means a broad depression within which stormwater may drain during inclement weather, but which does not have a defined bed or banks.

"Through street" means a street that provides access between two other streets.

"Traveled way" means the portion of the subdivision street designated for the movement of vehicles, exclusive of shoulders, parking areas, turn lanes, etc.

"VDOT" means the Virginia Department of Transportation.

"VPD" means vehicles per day.

"VPH" means vehicles per hour.

"Watercourse" means a definite channel with bed and banks within which water flows, either continuously or in season.

## **24 VAC 30-91-20. Applicability [ , effective date, and transition ].**

[ A. Applicability. ] This regulation is intended to govern subdivision street development and the criteria for acceptance of these streets [ by the department for subsequent maintenance ]. The Subdivision Street Design Guide [ (24 VAC 30-91-160) ] offers guidance on the design and construction features of subdivision street development [ ~~that may differ from highway construction projects~~ and sets out design parameters deemed appropriate for most land development scenarios. However, the business of land development is fluid and the department, in consultation with local government officials, is prepared to consider innovative transportation approaches associated with land development proposals that are consistent with the geometric requirements of the Subdivision Street Design Guide (24 VAC 30-91-160) ].

However, when not specifically addressed in one of these documents, the relevant requirements of the Road Design Manual (~~[ effective July 1, 1998~~ 24 VAC 30-91-160 ), standards, specifications, Pavement Design Guide (~~[ effective August 1, 2000~~ 24 VAC 30-91-160 ) and associated instructions shall govern.

These requirements apply to all subdivision streets designated to [ ~~become~~ be maintained by the department as ] part of the secondary system of state highways. The department's review and approval shall apply only to streets proposed for addition to the secondary system of state highways maintained by the department. Any plans submitted for review that contain only streets proposed for maintenance by others may be reviewed for general guidance at the discretion of the resident engineer but will not be officially approved. However, any such review shall not represent the department's commitment to accept such streets for maintenance irrespective of the quality of the construction of the street or streets.

If a subdivision plan with streets proposed for VDOT acceptance [ ~~include~~ includes ] any streets that are not initially intended to be accepted [ ~~it~~ for maintenance by the department as part of ] the secondary system, the plan must include a notation identifying these streets. In the absence of this notation, the plans will not be approved. It is also recommended that any streets proposed to be privately maintained also have a notation on the plat and impacted deeds that clearly indicate that as a prerequisite for the streets future acceptance, the streets must be improved to the department's prevailing standards for acceptance at no cost to the department.

[ B. Effective date. All streets proposed for acceptance by the department after January 1, 2005, shall be accepted in accordance with these provisions, except as may be waived by the commissioner or his designee.

C. Transition. Prior to July 1, 2005, the department will allow the design of streets developed in accordance with either the former requirements (1996) or these requirements. Any street design initially submitted to the department for consideration after June 30, 2005, however, shall be in accordance with these requirements.

## **24 VAC 30-91-30. Local subdivision ordinances**

A. Precedence of local subdivision ordinance. Pursuant to § 33.1-229 of the Code of Virginia, new streets are established by the governing body of the locality in which they are located. Any requirements of the subdivision ordinance adopted by the governing body that are equal to or greater than these provisions shall become the department's requirements in that locality and govern unless the local governing body concurs with an exception to their higher standards.

B. Exemptions in local ordinances. The department does not recognize any provision of an ordinance adopted by the governing body that exempts the development of streets from these requirements based on its definition of the term subdivision. Consequently, any street proposed for addition to the secondary system of state highways maintained by the department shall comply with applicable requirements as

herein provided or, if greater than these provisions, the requirements of the local ordinance. ]

**[ ~~24 VAC 30-91-30~~ 24 VAC 30-91-40 ]. Continuity of public street system.**

The continuity of a publicly maintained street system is a prerequisite to the addition of any subdivision street into the secondary system of state highways. A street may only be accepted for state maintenance if it is the continuation of the network of public streets whose maintenance has been officially accepted by the department or, if appropriate, a city, town or county.

**[ ~~24 VAC 30-91-40. Large lot size subdivision.~~**

~~Notwithstanding any provision of an ordinance adopted by the governing body that exempts certain large lot size subdivisions from its definition of subdivision, any street proposed for addition to the secondary system of state highways shall comply with applicable requirements as herein provided. ]~~

**24 VAC 30-91-50. Service requirements.**

A. Service consideration. A street may only be accepted by the department for maintenance as part of the secondary system of state highways if it renders sufficient public service to justify expending public funds for its subsequent maintenance.

In the event the governing body requests the addition of a street before it meets these public service provisions, the resident engineer will review each request on an individual case basis and determine if the acceptance of a street prior to normal service requirements is justified. However, [ prior to deferring acceptance based solely on service requirements, ] the resident engineer shall confer with the Director of the Local Assistance Division [ ~~prior to deferring acceptance based solely on service requirements~~ or other designee appointed by the commissioner ].

[ ~~However,~~ ] The public service requirements of this subsection may be waived for cul-de-sac streets less than 0.25 miles in length when [ ~~required to~~ the acceptance of the street or streets will ] complete the acceptance of all [ ~~other~~ ] streets within the subject section of the subdivision.

B. Criteria. For the purpose of these requirements, public service may include, but is not necessarily limited to, streets meeting one or more of the following situations:

1. Serves three or more occupied units of varied proprietorship with a unit being a single-family residence, owner-occupied apartment, owner-occupied residence in a qualifying manufactured home park, a stand-alone business, or single business entity occupying an individual building, or other similar facility. However, streets providing service in settings similar to an apartment building setting will only be considered for acceptance if the street is well defined and appears to be a street rather than a travel way through a parking lot.
2. Constitutes a connecting link between other streets that qualify from the point of public service.

3. Provides an extension of a street to the subdivision boundary to facilitate the continuity of possible adjacent development, if required by local ordinance. Such streets shall normally incorporate an adequate means for vehicles to turn around and reverse direction [ ~~# greater than 0.04 miles in length~~ ].

4. Serves as access to schools, churches, public sanitary landfills, [ transfer stations, ] public recreational facilities, or similar facilities open to public use.

5. Serves at least 100 vehicles per day generated by an office building, industrial site, or other similar nonresidential land use in advance of the occupancy of three or more such units of varied proprietorship. Any addition under this provision shall be limited to the segment of a subdivision street that serves this minimum projected traffic and has been developed in compliance with these requirements.

6. Constitutes a part of the network of streets envisioned in the transportation plan or element of a county's comprehensive plan that, at the time of acceptance, serves an active traffic volume not less than 100 vehicles per day.

C. Apartment and retail shopping complexes. A through street that serves a shopping center or rental apartment building may be considered for maintenance as part of the secondary system of state highways if it is deemed by the department to provide a public service. However, internal streets [ in these complexes ] do not normally qualify for addition to the system because their operation and maintenance are considered to be a responsibility of the owner, who stands to profit, rather than the tenant or customer.

1. However, a street that serves as the principal access to rental apartment buildings may be considered to provide public service if unrestricted public use is permitted and maintenance continuity is practical.

2. Entrance streets and the internal traffic circulation system of shopping centers and apartment complexes qualify only if more than three property owners are served and the street is separated from the parking areas.

3. Streets serving manufactured home parks may only be considered if the residents of the park own the land occupied in fee simple.

D. Special exceptions. There may be other sets of circumstances that could constitute public service. Consequently, any [ ~~question~~ request for clarification ] regarding unclear situations should be [ ~~referred through~~ made in writing to ] the resident engineer [ ~~to the Director of the Local Assistance Division for resolution~~ ]. [ The resident engineer should then consult the Director of the Local Assistance Division or other designee appointed by the commissioner for resolution. ]

**24 VAC 30-91-60. Administrative procedure.**

A. Conceptual subdivision sketch. Prior to [ ~~preparation of plats or plans, or both,~~ the developer shall prepare a preliminary subdivision plat or conceptual plan of the entire development. The conceptual plat or plan shall provide sufficient information for VDOT to determine the functional classification of each street in the subdivision, depicting as a

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~~minimum, in conformance with the applicable provisions of the governing body's zoning and subdivision regulations: preparing detailed construction plans for review, the resident engineer shall be provided a preliminary plan of the entire development, prepared by the developer, that shows sufficient information for VDOT to review and concur with the functional classification proposed for each street in the subdivision. Any preliminary or conceptual plat, plan or sketch that conforms to the locality's zoning requirements or subdivision ordinance is acceptable if the required information is shown. The submittal should include: ]~~

1. The general location and configuration, including the terminus, of each street, including the traffic volume anticipated when the land served is fully developed in accordance with the land uses anticipated.
2. The location and area of each type of permitted land use within the subdivision.
3. The location of any proposed transportation facility, within the subdivision's boundaries, included in the comprehensive plan of the governing body.

~~[ 4. The proposed functional classification for each street in the subdivision.~~

~~[ 4. 5. ] Other available information pertinent to the intended development of the subdivision [ , including but not limited to any proposed phased development of streets pursuant to 24 VAC 30-91-70 (Phased development of subdivision streets) ].~~

~~The resident engineer [ shall provide written notice to ] will review the layout and functional classification of streets shown in the concept plan and notify [ the appropriate county official [ and in writing, as well as ] the developer, if applicable, [ regarding the approved functional classification, as defined in the Subdivision Street Design Guide, for each street in the subdivision of his concurrence or recommendations. Approval of the conceptual plan or subdivision sketch shall be considered concurrence only in the functional classifications and layout of the streets and is deemed to satisfy any requirement for notification to the county official ]. This approval [ shall or concurrence will ] be valid as long as the basic concept for the subdivision's development, as submitted for review [ , ] remains unchanged.~~

~~[ For subdivisions having more than 20 residential lots or a commercial or an industrial subdivision expected to generate more than 200 vehicles per day, a meeting of the developer, the planning staff of the locality in which the development is proposed, and the resident engineer is encouraged prior to the development of plans for submission. ]~~

B. Plan submission. Plats or plans, or both, together with other pertinent data as herein prescribed, shall be submitted to appropriate officials in the local government and to the responsible resident engineer in accordance with the practices of the local government for all proposed subdivisions whose streets are intended to be added to the secondary system of state highways maintained by the department. The resident engineer may, subject to the availability of staff and upon the request of a county, cooperate in the review of proposed subdivisions to be developed to these standards but not

initially intended for addition to the secondary system of state highways maintained by the department. [ VDOT may recover the costs for this service in accordance with 24 VAC 30-91-140 (Surety and fees). ]

C. Plan review. Upon receipt of the plats or plans, or both, the resident engineer will arrange for the appropriate review to determine compliance with all applicable requirements. The general procedure for this review is described in [ ~~24 VAC 30-91-280~~ 24 VAC 30-91-150 (Subdivision street development, plan review, and acceptance) ].

D. Plan approval. The resident engineer will advise the appropriate county official and the developer, if applicable, as to the results of the review.

1. If the street development proposed by the plats or plans, or both, is determined to be in compliance with these requirements, the resident engineer will provide written confirmation of this finding. This action signifies the resident engineer's approval of the street design shown on the plats or plans, as submitted. Any subsequent revision, additions, or deletions thereto shall require specific written approval of the resident engineer for each such change.

2. [ ~~Where the~~ If a ] revision of the submitted plats or plans is determined necessary, the resident engineer will list the required changes in a written response to the county official and the developer, if applicable. Upon completion of the specified revisions, the plats or plans will be resubmitted for review and approval by the resident engineer as prescribed in [ ~~24 VAC 30-91-280~~ 24 VAC 30-91-150 (Subdivision street development, plan review, and acceptance) ].

The department's approval of a [subdivision street] construction plan shall constitute its commitment to accept the streets depicted thereon when all applicable provisions of these requirements are satisfied and the streets have been constructed according to the approved construction plan and supporting specifications. However, during VDOT's inspection of construction, if a situation is discovered that was not addressed on the approved plan that could, in the opinion of the resident engineer, adversely affect public safety [ or the integrity of either the roadway or the adjacent property ], acceptance of the street shall be deferred until the situation is corrected.

The department's approval of a [subdivision street] construction plan shall expire after a period of three years if construction has not commenced, in which case the [subdivision street construction] plan shall be resubmitted for subsequent review and approval. [ This shall not affect the adequacy of the approved concept plan as depicted on a recorded final plat, as provided for under § 15.2-2241 of the Code of Virginia. ]

E. Street acceptance. Upon the satisfactory completion of construction of the subdivision street, the department will advise the local governing body regarding the street's readiness for acceptance and the governing body, in consultation with the resident engineer, will initiate its acceptance into the secondary system of state highways maintained by the department provided:

1. The developer dedicates the prescribed right-of-way to public use.
2. The street has been constructed in accordance with the applicable specifications, standards and the plats or plans approved by the department.
3. The street renders a public service as prescribed in 24 VAC 30-91-50 [(Service requirements)] or as may otherwise be approved under those provisions.
4. The street has been properly maintained since its completion.
5. The developer furnishes the surety and fees in accordance with [ ~~24 VAC 30-91-160~~ 24 VAC 30-91-140 (Surety and fees) ].
6. The governing body has executed all agreements prescribed by these requirements, unless specifically waived on an individual case basis by the Director of the Local Assistance Division [ , or other designee appointed by the commissioner ].
7. The governing body [ , by proper resolution, ] requests [ ~~by proper resolution that includes~~ ] the [ department to accept the street or streets for maintenance as part of the secondary system of state highways under its jurisdiction. The resolution shall include the governing body's ] guarantee of an unrestricted and unencumbered right-of-way as dedicated, [ ~~the department's acceptance of the street into the secondary system of state highways under its maintenance plus any necessary easements for fills, drainage, or sight distance~~ ].

Upon the department's determination that the requested addition is in compliance with the applicable provisions of these requirements, the governing body will be officially advised of the street's acceptance into the secondary system of state highways and the effective date of such action. This notification serves as the resident engineer's authority to begin maintenance thereon.

**[ 24 VAC 30-91-70. Phased development of subdivision streets.**

A. Policy. Certain subdivision streets that require four or more travel lanes to accommodate the projected traffic may be accepted by the department for maintenance after completion of the first two lanes to an acceptable, initial phase of construction, upon the request of the governing body. It is recognized that there is a distinction between those streets that benefit the overall transportation network and those that primarily serve the development of land and, therefore, the criteria for phased construction for each situation differs as described in subsection B of this section.

However, in all cases, the right-of-way required for the road at its complete stage of construction shall be dedicated and accepted as part of the initial street acceptance. In addition, the initial phase of construction shall be designed and constructed to facilitate construction of the remaining phase in a manner that will avoid the need to reconstruct the initial two lanes.

Consideration for the acceptance of any street under the provisions of this section shall be limited to the phased development of only the street's roadway. All other applicable requirements, e.g., public service, drainage easements, and administrative procedures, shall apply.

B. Criteria.

1. For streets included in the transportation element of the county's comprehensive plan that serve diverse areas of the region or county, no special agreement or acknowledgement is needed as a prerequisite to acceptance, provided:

- a. The street is part of a transportation corridor that was formally adopted as a part of the county's comprehensive transportation plan prior to the local governing body's approval of the plat or plan for the development of the adjacent land.
- b. The transportation corridor is a major thoroughfare planned primarily to move through traffic.
- c. When fully developed the street must satisfy the department's functional classification criteria as a major collector or higher.
- d. The street has a projected traffic volume of 8,000 vehicles per day or less for a period of 10 years following the date of the acceptance for maintenance by the department.

2. For all other streets, the local governing body's resolution requesting acceptance of the initial two lane section must include provisions that acknowledge:

- a. The local governing body agrees that all costs incurred in the street's complete construction, including right-of-way, engineering, utility adjustment, etc., shall be provided from funds other than those derived from state revenue sources administered by VDOT, except as may be expressly authorized by the department's Director of the Local Assistance Division.
- b. The local governing body agrees that it is their responsibility to ensure that the roadway is completed as needed to accommodate the traffic. However, the county also acknowledges that a determination that the street needs to be completed to its ultimate section will be made by the resident engineer or his designee once it is determined that the first two lanes will not sustain an acceptable level of service for the function classification of the roadway in accordance with the Highway Capacity Manual (24 VAC 30-91-160).

C. Procedures.

1. Plats or plans, or both, for the street's complete development, in accordance with all applicable provisions of these requirements, shall be submitted for approval.
2. The plats or plans shall also delineate the street's initial development as proposed pursuant to this section. In no case shall this design provide less than one-half of the roadway typical section required by the applicable requirements for the street's complete development.

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3. Unless waived by the resident engineer, a capacity analysis shall be submitted to document that an acceptable level of service will be maintained for the intended duration of the initial phase of development. In determining an acceptable level of service, the beneficial effect of the proposed street on the overall transportation network will be considered. The resident engineer or his designee may waive this requirement for a traffic capacity analysis.

4. A determination will be made by VDOT in consultation with the locality whether the street can be approved for phased development and which criterion in subsection B of this section applies.

5. Upon the resident engineer's determination that the proposal is in compliance with the applicable provisions of this section, the plans may be approved accordingly.

6. Upon completion of the street's initial phase in accordance with approved plans, its compliance with all other applicable provisions of this section, and the inclusion of the appropriate language in the resolution, the street may be accepted for maintenance by the department as part of the secondary system of state highways.

## **24 VAC 30-91-80. Connections to or work within streets maintained by the department.**

A. Connections to streets maintained by the department. A land use permit issued by the department is required for new connections of any kind to existing streets maintained by the department. Due to the wide variation in prevailing conditions, each location shall be evaluated individually to determine exact requirements. Therefore, it is incumbent upon the developer or his designee to apply for a land use permit at the appropriate time to ensure the desired completion of the development. Such application shall be made to the resident engineer and be consistent with the approved plats or plans for the subdivision or the document reviewed for the connection of a street that is to remain privately maintained.

B. Relocations, adjustments, and improvement of streets maintained by the department. All work performed within the existing right-of-way of streets maintained by the department, including pavement widening, the addition of turn lanes, realignments and relocations of existing streets, shall be coordinated with and approved by VDOT as follows:

1. All such work shall be accomplished pursuant to a land use permit issued by the department after the required right-of-way has been dedicated to public use or as otherwise required by the department.

2. All work, including the relocation, adjustment, and improvement of existing streets under VDOT jurisdiction shall be subject to the department's direction rather than these requirements. Such work should include overlaying and restriping the old and new portions of the roadway.

3. The relocation of streets maintained by the department shall only be accomplished with the consent of the local governing body.

4. Traffic should be maintained on streets under the department's jurisdiction until the new portion has been

accepted by the department for maintenance unless the department authorizes a closure of the road to traffic.

5. No street or roadway maintained by the department and actively used by the public shall be abandoned or vacated unless a new street serving the same citizens has been constructed and accepted for maintenance by the department.

6. Streets previously discontinued exist as a public way under the jurisdiction of the local governing body and should be abandoned or vacated prior to the development of land associated with such streets. ]

## **[ ~~24 VAC 30-91-79~~ 24 VAC 30-91-90 ]. Discretionary authority.**

The department's resident engineers are authorized considerable discretionary authority regarding the [ ~~development~~ design ] of subdivision streets functionally classified as "local." Such judgments should take into consideration the individual situation, but in no instance are the safety features, structural integrity, or traffic capacities prescribed by these requirements to be sacrificed. Meandering alignment and rolling grades are satisfactory, provided adequate stopping sight distances and reasonable alignment and gradients are provided to safely accommodate the projected traffic at the design speed.

## **[ ~~24 VAC 30-91-80. Entrance permits.~~**

~~An entrance permit is required by the general rules and regulations of the Commonwealth Transportation Board for any form of access to state maintained roads, including the connection of a subdivision street whether the street is intended for acceptance by the department or will remain the responsibility of others. Such a connection shall comply with applicable commercial entrance requirements of the department's Land Use Permit Manual (24 VAC 30-150) and Minimum Standards of Entrances to State Highways (24 VAC 30-71).~~

~~Due to the wide variation in prevailing conditions, each location shall be evaluated individually to determine exact requirements. Therefore, it is incumbent upon the developer or his designee to apply for any required entrance permit at the appropriate time to ensure the desired completion of the development. Such application shall be made to the resident engineer and be consistent with the approved plats or plans for the subdivision or the document reviewed for the connection of a street that is to remain privately maintained. ]~~

## **[ ~~24 VAC 30-91-90~~ 24 VAC 30-91-100 ]. Appeal to district administrator.**

The district administrator is authorized to consider and render a ruling on unresolved differences of opinion between the developer and the resident engineer that pertain to the interpretation and application of these requirements.

To obtain this review, the developer shall provide the district administrator, the resident engineer and the county official a written request for such action, describing any unresolved issue. After reviewing all pertinent information, the district administrator will advise the developer in writing regarding the decision of the appeal, with a copy to the county official and

the resident engineer. The developer may further appeal the district administrator's decision to the ~~[ commissioner or his commissioner's ]~~ designee. All correspondence requesting an appeal should include copies of all prior correspondence regarding the issue or issues with the county officials and department representatives.

**~~[ 24 VAC 30-91-100. Precedence of local subdivision ordinance.~~**

~~Pursuant to § 33.1-229 of the Code of Virginia, new streets are established by the governing body of the locality in which they are located. Any requirements of the subdivision ordinance adopted by the governing body that are equal to or greater than these requirements shall become the department's requirements in that locality and govern unless the local governing body concurs with an exception to their higher standards.~~

**~~24 VAC 30-91-110. Applicable requirements of other regulatory agencies.~~**

~~Should a subdivision street proposed for acceptance into the secondary system of state highways be subject to provisions of any regulatory agency pertaining to the maintenance, control, or operation of the completed street, the developer shall provide the resident engineer with a copy of such requirements at the time its addition is requested.~~

PART II.  
SPECIFIC PROVISIONS.

**~~[ 24 VAC 30-91-120 24 VAC 30-91-110 ]. Design [ and agreement ] requirements.~~**

A. [ General requirements. ] Most criteria addressing the design of new subdivision streets can be found in the Subdivision Street Design Guide (24 VAC 30-91-160). However, the following provisions are provided for guidance ~~[ concerning ]~~, particularly in regard to] features that require agreements or formal acknowledgements of the governing body before VDOT's acceptance of the street or streets within a subdivision.

When an agreement is required between the local governing body and the department as a prerequisite to the acceptance of a subdivision street, nothing in these requirements shall preclude the local governing body from entering into separate agreements with other entities to fulfill its responsibilities. However, if the provisions are intended to ensure the safety of the public using the street, the department reserves the right to approve the involvement of the other party or parties.

B. ~~[ New streets. 1. ]~~ Geometric requirements. Geometric requirements for new subdivision streets are established in the ~~[ Supplemental Subdivision Street ]~~ Design Guide ~~[ for Subdivision Streets of the Road Design Manual (24 VAC 30-91-160) ]~~. ~~[ In the event a reduced pavement width is proposed, the reduced roadway will only be considered at the request of the local governing body, which by formal resolution, shall express its commitment to require sufficient off-street parking to accommodate the land served. In certain circumstances the Subdivision Street Design Guide (24 VAC 30-91-160) allows reduced pavement widths for curb and gutter sections. Any such reduction must be specifically requested by the governing body in writing and be approved~~

by the resident engineer. Sufficient off-street parking must be provided by the local governing body as indicated in the Subdivision Street Design Guide (24 VAC 30-91-160) to accommodate any request for reduced pavement widths. However, no special request from the local governing body shall be required in the event the department has approved a design standard for use throughout that county that includes street width reductions for a specific type of subdivision, such as a Neotraditional subdivision.]

~~[ 2. C. ]~~ Turn lanes. Left or right turn lanes shall be provided at intersections when the department determines that projected turning movements warrant their installation. These facilities shall be designed in accordance with the ~~[ appropriate provisions of the department's Minimum Standards of Entrances to State Highways Subdivision Street Design Guide (24 VAC 30-91-160) ]~~ and, if necessary, additional right-of-way shall be provided to accommodate these facilities.

~~[ 3. Cul-de-sacs and turnarounds. An adequate turnaround facility shall be provided at the end of each cul-de-sac or stub street accepted to permit the safe and convenient maneuvering by service vehicles. Various configurations of turnarounds are illustrated in the Subdivision Street Design Guide; however, alternative configurations may be approved by the resident engineer. Additional right-of-way shall be provided as required by the design of the turnaround. Normally, any nontraveled way areas within the turnaround, such as an island, shall be included in the dedicated right-of-way of the facility.~~

~~For circular turnarounds, a well defined, identifiable street segment, equal to the normal lot width along the intersected street that serves the cul-de-sac or 50 feet, whichever is greater, shall extend from the intersected street to the turning area.~~

4. D. ] Pavement structure.

[ a. 1. ] Pavement design. The pavement structure for new subdivision streets shall be in accordance with the Pavement Design Guide (~~[ effective August 1, 2000 24 VAC 30-91-160 ]~~), including any prescribed underdrains. Prior to construction of the pavement sub-base and finish courses, the resident engineer shall approve the proposed pavement design.

[ b. 2. ] Special pavement surfaces. The resident engineer may approve special pavement surfaces, such as the use of stamped pavement or the use of paving blocks or bricks. However, if the pavement design is a type not addressed by the Pavement Design Guide (~~[ effective August 1, 2000 24 VAC 30-91-160 ]~~) or otherwise not in general use by the department, an agreement shall be provided by the governing body that addresses the future maintenance of such pavement.

[ c. 3. ] Pavement additions to existing streets. When an existing VDOT maintained roadway is to be widened to accommodate additional lanes or the addition of turn lanes, the necessary pavement design shall be obtained from the resident engineer and the entire surface of the roadway (old and new portions) shall be overlaid and re-stripped as required by the resident engineer.

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## [ E. Parking.

1. *Perpendicular and angle parking along subdivision streets is normally prohibited. However, perpendicular and angle parking along subdivision streets may be considered if the features along the street cause the street to readily appear to be a street rather than a travel way through a parking lot. In addition, additional pavement width may be necessary between the travel lanes and the parking spaces to allow a car to back from its normal parked position, orient itself for entering the travel lanes and stop without either encroaching into the travel lanes or having the driver's vision of oncoming traffic obscured by adjacent, parked vehicles.*

*Street designs that anticipate the restriction of on-street parking shall only be approved with the consent of the county official and the resident engineer.*

2. *Localities are encouraged to adopt local ordinances to appropriately address adequate off street parking in subdivisions. In the absence of local regulations that are deemed acceptable by the department, the following criteria shall apply for the design of subdivision streets:*

a. *A minimum of two off-street parking spaces per dwelling unit, exclusive of garage facilities associated with the unit, shall be provided in the proximity of the unit they are intended to serve. Additional off-street parking space shall be provided when the width of any residential curb and gutter roadway is proposed for reduction as permitted in the Subdivision Street Design Guide (24 VAC 30-91-160). Except as may be associated with corner dwellings, the availability of on-street parking along other streets will not normally be considered as additional off-street parking.*

b. *If parking bays are provided, they shall be located off the street's right-of-way and designed to prevent vehicles from backing into the adjacent subdivision street.*

c. *Entrances to parking bays shall be separated by at least 50 feet and designed in accordance with the appropriate provisions of the standards or Land Use Permit Manual.*

F. *Cul-de-sacs and turnarounds. An adequate turnaround facility shall be provided at the end of each cul-de-sac or stub street to permit the safe and convenient maneuvering by service vehicles. Various configurations of turnarounds are illustrated in the Subdivision Street Design Guide (24 VAC 30-91-160); however, alternative configurations may be approved by the resident engineer. Additional right-of-way shall be provided as required by the design of the turnaround. Normally, any nontraveled way areas within the turnaround, such as an island, shall be included in the dedicated right-of-way of the facility.*

*For circular turnarounds, a well-defined, identifiable street segment, equal to the normal lot width along the intersected street that serves the cul-de-sac or 50 feet, whichever is greater, shall extend from the intersected street to the turning area.*

G. *Curb and gutter. For the purpose of these requirements, the use of curb and gutter is an acceptable roadway design*

*alternative, rather than a requisite. However, when used, curb and gutter shall be designed in accordance with the Subdivision Street Design Guide (24 VAC 30-91-160) and only one curb and gutter design may be used along the length of a street.*

1. *Driveway entrance requirements. Without regard to the curb design used, the curb shall incorporate a driveway entrance apron, as illustrated in the Subdivision Street Design Guide (24 VAC 30-91-160), to provide a smooth transition from the gutter invert or roadway surface onto the driveway. However, exceptions may be granted by the resident engineer when roll top curb is used if requested by the local official.*

2. *Curb ramps. All streets that incorporate accessible routes for pedestrian use shall, without regard to the curb design used, include curb ramps at intersections for use by persons with disabilities and shall incorporate other applicable provisions of the Americans with Disabilities Act.*

H. *Private entrances. All private entrances shall be designed and constructed in accordance with the Subdivision Street Design Guide (24 VAC 30-91-160).*

I. *Pedestrian, bicycle, and shared use path facilities. The Commonwealth Transportation Board's "Policy for Integrating Bicycle and Pedestrian Accommodations" emphasizes accommodating pedestrian and bicycle traffic as an essential part of any VDOT financed transportation project. While separate pedestrian and bicycle facilities are not mandated for local subdivision streets, unless required by local ordinance, any street proposed for VDOT acceptance should accommodate the anticipated pedestrian and bicycle traffic. When separate pedestrian and bicycle facilities are deemed appropriate, they should be included in the initial construction of the street, prior to VDOT acceptance. These facilities are eligible for VDOT acceptance based on the criteria of this section.*

1. *Compliant facilities. Pedestrian and bicycle facilities, including shared use paths as defined under § 46.2-100 of the Code of Virginia, shall be accepted as part of subdivision streets, unless otherwise requested by the governing body, provided they are located fully within the dedicated right-of-way of the street and they are constructed in accordance with applicable criteria and standards of the department.*

a. *Sidewalk criteria. Sidewalks shall be constructed in accordance with the Subdivision Street Design Guide (24 VAC 30-91-160). However, sidewalks that meander vertically in comparison to the grade of the roadway may be considered noncompliant sidewalks.*

b. *Bicycle facility criteria. Bicycle facilities contiguous with the street shall be in accordance with the department's design and construction criteria set forth in the Road Design Manual (24 VAC 30-91-160).*

c. *Shared use path criteria. Shared use paths shall be constructed in accordance with the Road Design Manual (24 VAC 30-91-160) and closely follow the vertical alignment of the roadway without meandering on and off the right-of-way.*

2. Noncompliant sidewalk, bicycle, and shared use paths. Noncompliant sidewalk, bicycle and shared use paths that fail to meet requirements of the department's standards for construction, alignment, or placement within the dedicated right of the street shall be deemed to be noncompliant and not qualify for maintenance. However, such facilities may co-exist within the dedicated right-of-way of the street under a land use permit issued by the resident engineer to the local governing body responsible for having established the facility through its subdivision process.

Such permits will clearly specify the responsibility for maintenance of the facility and related activities to the extent the facility occupies the street's right-of-way. The permit applicant should be a county, incorporated town, or other entity that has perpetual maintenance capability. Noncompliant sidewalks and shared use paths may be constructed of bituminous concrete, hydraulic concrete, gravel, or other stabilizer convenient to the applicant.

~~G. J. ] Bridge [ and , ] drainage [ , and other grade separation ] structures. Bridges [ and , ] drainage [ , and other grade separation ] structures shall be designed and constructed in accordance with all [ applicable ] department criteria and standards. The resident engineer may require special review of the plans and construction inspection. [ In addition, pursuant to subsection D of this section, certain structures may require the execution of an agreement between the local governing body and the department as a prerequisite for the acceptance of the street.~~

The department will accept grade separation structures as part of new subdivision streets provided the structure is a drainage structure or is intended to separate the movement of registered motor vehicles. In addition, the department will accept grade separation structures intended to separate pedestrians or bicyclists or any combination thereof from traffic using the roadway, provided:

1. The structure is available for unrestricted public use;
2. The structure is accessible to pedestrian facilities, if any, situated along the street; and
3. The projected traffic volume of the street is not less than 4000 vpd or, if the structure otherwise serves as part of the principle pedestrian access to a school and a peak hour traffic volume of 450 vph is projected.

In all other instances, the grade separation structure shall be deemed to be a county controlled grade separation structure within the right-of-way of the street, in which case the street will only be accepted as part of the secondary system of state highways maintained by the department after the local governing body and the department have executed an agreement acceptable to the department that (i) acknowledges the department has no responsibility or liability due to the presence of the structure and (ii) assures the costs of inspection, maintenance, and future improvements to the structure are provided from sources other than those administered by the department.

In all cases, whether the structure is accepted as an integral part of the roadway for maintenance by the department or it remains a county controlled structure, the responsibility for

lighting, safety, and security of those using such facilities shall remain a responsibility of local government. ]

~~[ D. Crossings of dams. Except as otherwise provided in this subsection, subdivision streets that occupy embankments that create a dam may be eligible for acceptance into the secondary system of state highways subject to the following criteria:~~

~~1. Criteria.~~

~~a. The right of way across the dam is recorded as either an easement for public road purposes or is dedicated specifically to the governing body. Right of way that includes a dam and that is dedicated in the name of the Commonwealth or any of its agencies is not acceptable and roads through such right-of-way will not be accepted as a part of the secondary system of state highways.~~

~~b. An appropriate alternate roadway facility for public ingress and egress, with suitable provisions to assure its perpetual maintenance, is provided.~~

~~c. An engineer, licensed to practice in the Commonwealth of Virginia, certifies that the dam's hydraulic and structural design is in accordance with national engineering practice.~~

~~d. Applicable federal and state permits are secured prior to VDOT acceptance of the street.~~

~~e. Protection of the roadway from inundation shall be provided as herein prescribed by these requirements. Flow of water over the roadway is not acceptable as an emergency spillway.~~

~~f. VDOT maintenance responsibilities shall be limited to the roadway surface and related elements. The maintenance of the dam shall be the responsibility of the owner, other than VDOT, as established by § 33.1-176 of the Code of Virginia.~~

~~g. The governing body shall provide the department with an acceptable agreement, which acknowledges that the department's liability is limited to the maintenance of the roadway and its related elements and that the department has no responsibility or liability due to the presence of the dam.~~

~~2. Exceptions—waiver of agreement. For the purposes of this subsection, if the roadway does not share the embankment of the dam, even if the area between the embankments is filled in, the roadway will not be considered to occupy a dam, provided the impoundment includes an overflow facility sufficient to prevent the street from being inundated as the result of a 100-year storm.~~

~~Otherwise, the street will be considered to cross a dam if any part of the roadway embankment and that of the dam overlap, in which case the acceptance of the road for maintenance by the department will be subject to all provisions of subdivision 1 of this subsection.~~

K. Dams. The department will only consider accepting subdivision streets for maintenance that occupy dams when all of the following provisions are satisfied. For the purpose of this section, a roadway will be considered to occupy a dam if

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any part of the fill for the roadway and the fill for the dam overlap or if the area between the two embankments is filled in so that the downstream face of the dam is obscured or if a closed drainage facility from a dam extends under a roadway fill.

1. *Agreements with the governing body.* Except as exempt under subdivision 6 of this subsection, the governing body acknowledges by formal agreement the department's liability is limited to the maintenance of the roadway and that the department has no responsibility or liability due to the presence of the dam, the maintenance of which shall remain the responsibility of an owner, other than VDOT, as established by § 33.1-176 of the Code of Virginia.

2. *Design review.* An engineer, licensed to practice in the Commonwealth of Virginia, shall certify that the hydraulic and structural design of any dam, as described below, is in accordance with current national and state engineering practice and that all pertinent provisions of the Subdivision Street Design Guide (24 VAC 30-91-160) have been considered. Prior to approval of the roadway construction plans, the hydraulic and structural design of a proposed dam shall be reviewed by and meet the department's satisfaction if:

- a. A roadway is considered to occupy a dam; or
- b. A roadway is located below but sufficiently close to the dam that a catastrophic breach could endanger the roadway or the safety of those using the roadway.

3. *Right-of-way requirements.* The right-of-way of roads considered to occupy dams shall be recorded either as an easement for public road purposes or as a dedication specifically to the governing body. Right-of-way dedicated in the name of the Commonwealth or any of its agencies is not acceptable if it includes a dam and roads through such right-of-way will not be accepted as a part of the secondary system of state highways maintained by the department.

4. *Supplemental, alternative access.* To be considered for VDOT maintenance, roadways that occupy a dam must be supplemented by an appropriate alternative roadway facility for public ingress or egress, having suitable provisions that ensure perpetual maintenance.

5. *Permits.* All applicable federal and state permits associated with dams shall be secured and filed with the county prior to VDOT's acceptance of any street that occupies a dam.

6. *Dams exempt from agreements.* The acceptance of roadways that occupy dams shall be exempt from the requirements for an agreement with the governing body, as required by subdivision 1 of this subsection, if all of the following is satisfied:

- a. The dam is used to create a stormwater detention or retention facility;
- b. The maximum depth of the water retained by the impoundment at its 100-year storm flood elevation is not greater than four feet; and

c. The surface area of the impoundment at full flood is not greater than two acres and is beyond the right-of-way dedicated to public use.

[ ~~E. L.~~ ] Roadway drainage.

1. *Policy and procedures.* All drainage facilities shall be designed in accordance with the department's Drainage Manual (~~[ effective April 2002 24 VAC 30-91-160 ]~~) and supplemental directives. All drainage computations supporting a proposed drainage design shall be submitted to the department for review as part of the documents necessary for the approval of a construction plan.

2. *Stormwater management.* [~~Whereas~~] the department considers matters regarding stormwater management associated with the construction of new subdivision streets to be under the authority of the local governing body [~~Consequently, the department does not require stormwater management in the construction of subdivision streets~~, decisions regarding stormwater management in the construction of subdivision streets are deferred to the locality]. However, stormwater management, including the construction of detention or retention facilities, or both, is recognized as an available design alternative. Where the developer is required by regulations promulgated by an agency or governmental subdivision other than the department or the developer chooses to use stormwater management facilities in the design of a subdivision, the governing body shall, by formal agreement, and as a prerequisite for the transfer of jurisdiction over the street to the department, acknowledge that the department is [~~neither responsible nor liable for the stormwater detention facility~~ not responsible for the operation, maintenance, or liability of the stormwater management facility or facilities associated with the subdivision. However, in the event the governing body has executed a comprehensive, countywide agreement with the department addressing these matters, a specific agreement addressing stormwater management controls in the subdivision will not be required as a condition for street acceptance ].

Stormwater management controls for VDOT projects are designed in accordance with the VDOT Erosion and Sediment Control and Stormwater Management Program Specifications Manual (~~[ effective March 1, 2004 24 VAC 30-91-160 ]~~), the Virginia Erosion and Sediment Control Regulations, 4 VAC 50-30, and the Virginia Stormwater Management Regulations, 4 VAC 3-20. While [~~these controls may be necessary whenever a street maintained by VDOT is widened or relocated,~~] the department [~~cannot~~ does not] require [~~these controls to be used~~ them] in the development of new subdivision streets, because such activity is regulated by the local governments [~~rather than by VDOT~~]. However, developers and counties may find these controls useful in managing land development activity.

Devices and treatments intended to mitigate the impact of stormwater shall be placed off of the right-of-way and shall be designed to prevent the backup of water against the roadbed.

Where development activity results in increased runoff to the extent that adjustment of an outfall facility is required, such adjustment shall be at the developer's expense and be contained within an appropriate easement.

~~[ 3. Stormwater management impoundments. For the purposes of this subsection, a street proposed for acceptance as part of the secondary system maintained by the department will not be considered to cross a dam if the purpose of the impoundment is exclusively for managing stormwater runoff, in which case the aforementioned agreement shall not be required provided:~~

- ~~a. The maximum depth of the water retained at its flood elevation (100-year storm) is not greater than three feet;~~
- ~~b. The surface area of the impoundment at full flood is not greater than two acres;~~
- ~~c. The surface area of the impoundment at full flood is outside of the limits of the right-of-way dedicated to public use;~~
- ~~d. The materials retaining the impoundment are impervious and designed to prevent leakage that might otherwise undermine the adjacent roadway fill;~~
- ~~e. An emergency spillway is provided that will ensure the roadway will not be inundated as the result of a 100-year storm; and~~
- ~~f. The county executes or has executed an agreement acknowledging the department is not responsible for the operation, maintenance, or liability of stormwater management facilities established within the subdivision or countywide.~~

#### 4. 3. ] Drainage easements.

- a. An acceptable easement shall be provided from all drainage outfalls to a natural watercourse, as opposed to a swale. [(See 24 VAC 30-91-10 for definitions.)]

[ Editor's Note: Image of swale and watercourse deleted ]

b. The department normally accepts and maintains only that portion of a drainage system that falls within the limits of the dedicated right-of-way for a street. [ ~~However,~~ ] The department's responsibility to enter drainage easements outside of the dedicated right-of-way shall be limited to undertaking corrective measures to alleviate problems that may adversely affect the safe operation or integrity of the roadway.

c. In the event drainage to a natural watercourse is not accomplished or is interrupted, an acceptable agreement from the governing body [ ~~that acknowledges that the department is neither responsible nor liable for drainage from the roadway~~ ] may be considered as an alternative to providing an easement to a natural watercourse [ , provided the agreement acknowledges that the department is neither responsible nor liable for drainage from the roadway ].

#### [ M. Other design considerations.

1. **Guardrail.** Guardrail shall be used when required by the resident engineer consistent with the Road Design Manual (24 VAC 30-91-160). For placement considerations, see the Subdivision Street Design Guide (24 VAC 30-91-160).

2. **Landscaping and erosion control.** All disturbed areas within the dedicated right-of-way and easements of any subdivision street shall be restored with vegetation compatible with the surrounding area. Where there is visual evidence of erosion or siltation, acceptance of the street as part of the secondary system of state highways maintained by the department will be postponed until appropriate protective measures, in accordance with VDOT's construction practices, are taken. Except as otherwise approved by the resident engineer, planting of trees or shrubs on the right-of-way shall be in accordance with the Subdivision Street Design Guide (24 VAC 30-91-160).

3. **Lighting.** Roadway, security, or pedestrian lighting, when required by the governing body or desired by the developer, shall be installed in accordance with the Subdivision Street Design Guide (24 VAC 30-91-160). However, VDOT shall not be responsible for the maintenance or replacement of lighting fixtures or the provision of power for lighting.

#### 4. **Railroad crossings.**

a. Short-arm gates with flashing signals, flashing signals alone, or other protective devices as deemed appropriate by the department shall be provided at any at-grade crossing of an active railroad by a subdivision street.

b. Crossings of railroad right-of-way are subject to the requirements of the railroad. Subdivision streets to be accepted by the department for maintenance as part of the secondary system of state highways that cross railroad right-of-way will only be considered if the protective measures outlined under this section have been fully installed and an agreement between the railroad, the developer and the local governing body has been executed. Prior to execution, such agreements shall be presented to the department for consideration in consultation with the Department of Rail and Public Transportation.

5. **Utilities.** Local governments, the development community, and the utility community are encouraged to coordinate and consolidate their interests as part of the initial development plan.

a. **Underground utilities.** The department allows the placement of underground utilities within the dedicated right-of-way of streets, but normally restricts placement to areas outside of the travel lanes and desirably beyond pavement areas. However, if the governing body has established adequate requirements for the design, location, and construction of underground utilities within the right-of-way of subdivision streets, including provisions that ensure that adequate testing and inspection is performed to minimize future settlement, those requirements shall become the department's requirements and govern unless those requirements conflict with a requirement of the department.

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When location of the utilities outside of the pavement area is not practical and is endorsed by the local government through its requirements, such installations:

(1) Are acceptable within the shoulders along the street or within the parking area adjacent to curb and gutter roadways.

(2) May be acceptable beneath the travel lanes of the street when provisions are made to ensure adequate inspection and compaction tests and:

(a) Longitudinal installations and manholes are located outside of the normal travel lanes, or

(b) Longitudinal installations and manholes are placed in the center of an undivided roadway out of the wheel path.

However, manholes shall not be placed in sidewalk or shared use path facilities within five feet of curb ramps or within driveway entrances.

b. Open-cutting of hard-surfaced roadways. The department usually prohibits the open-cutting of hard-surfaced roads except in extenuating circumstances. Therefore, all underground utilities within the right-of-way, as determined necessary by good engineering practice to serve the complete development of adjacent properties, shall be installed during the street's initial construction and prior to the application of its final pavement surface course. This shall include extensions of all necessary cross-street connections or service lines to an appropriate location beyond the pavement and preferably the right-of-way line.

In the event it is necessary to open the street pavement to work on utilities after the surface has been placed, additional compaction tests and paving as necessary to restore the integrity and appearance of the roadway may be required at the discretion of the resident engineer.

c. Cross-street conduits. To facilitate the placement of future underground utilities, cross-street conduits are encouraged, with placement of such conduits occurring on each street at intersections and approximate every 1,000 feet along the length of a street.

d. Aboveground utilities. All aboveground utilities shall be installed behind the sidewalk or as close as possible to the limits of the street's right-of-way but shall not encroach on the sidewalk, the shared use path, or any clear zone.

To assure the unencumbered dedication of the right-of-way for subdivision street additions, easements or other interests within the platted right-of-way shall be quitclaimed of any prior rights therein. In exchange, a permit may be issued by the department for a utility to occupy the area involved. This permit will be processed by the resident engineer upon acceptance of the street into the secondary system of state highways maintained by the department. No inspection fee is required for permits so issued. However, the approval of the permit shall be contingent upon the utility's compliance with applicable provisions of the Land Use Permit Manual.

## ~~[ 24 VAC 30-91-130. Phased development of subdivision streets.~~

~~A. Policy. Certain subdivision streets that would require four or more travel lanes to accommodate the projected traffic may be accepted by the department for maintenance after completion of the first two lanes to an acceptable initial phase of construction, upon the request of the governing body. It is recognized that there is a distinction between those streets that benefit the overall transportation network and those that primarily serve the development of land and, therefore, the criteria for phased construction for each situation differs as described in subsection B of this section.~~

~~However, in all cases, the right of way required for the road at its complete stage of construction will be dedicated and accepted as part of the initial street acceptance. In addition, the initial phase of construction shall be designed and constructed to facilitate construction of the remaining phase in a manner that will avoid the need to reconstruct the initial two lanes.~~

~~Consideration for the acceptance of any street under the provisions of this section shall be limited to the phased development of only the street's roadway. All other applicable requirements, e.g., public service, drainage easements, and administrative procedures shall apply.~~

### ~~B. Criteria.~~

~~1. For streets included in the county's transportation element of its comprehensive plan that serve diverse areas of the region or county, no special agreement or acknowledgement is needed as a prerequisite to acceptance, provided:~~

~~a. The street is part of a transportation corridor that was formally adopted as a part of the county's comprehensive transportation plan prior to the local governing body's approval of the plat or plan for the development of the adjacent land.~~

~~b. The transportation corridor is a major thoroughfare planned primarily to move through traffic.~~

~~c. When fully developed the street must satisfy the department's functional classification criteria as a major collector or higher.~~

~~d. The street has a projected traffic volume of 8,000 vehicles per day or less for a period of 10 years following the date of the acceptance for maintenance by the department.~~

~~2. For all other streets, the local governing body's resolution requesting acceptance of the initial two lane section will include provisions that acknowledge:~~

~~a. The local governing body agrees that all costs incurred in the street's complete construction, including right-of-way, engineering, utility adjustment, etc., shall be provided from funds other than those derived from state revenue sources administered by VDOT, except as may be expressly authorized by the department's Director of the Local Assistance Division.~~

~~b. The local governing body agrees that it is their responsibility to ensure that the roadway is completed as needed to accommodate the traffic. However, the county also acknowledges that a determination that the street needs to be completed to its ultimate section will be made by the resident engineer or his designee once it is determined that the first two lanes will not sustain a minimum level of service of "D."~~

## ~~C. Procedures.~~

~~1. Plats or plans, or both, for the street's complete development, in accordance with all applicable provisions of these requirements, shall be submitted for approval.~~

~~2. The plats or plans shall also delineate the street's initial development as proposed pursuant to this section. In no case shall this design provide less than one-half of the roadways typical section required by the applicable requirements for the street's complete development.~~

~~3. A capacity analysis shall normally be submitted to document that an acceptable level of service will be maintained for the intended duration of the initial phase of development. In determining an acceptable level of service, the beneficial effect of the proposed street on the overall transportation network will be considered. The resident engineer or his designee may waive this requirement for a traffic capacity analysis.~~

~~4. A determination will be made by VDOT in consultation with the locality whether the street can be approved for phase development and which criterion in subsection B of this section applies.~~

~~5. Upon the resident engineer's determination that the proposal is in compliance with the applicable provisions of this section, the plans may be approved accordingly.~~

~~6. Upon completion of the street's initial phase in accordance with approved plans, its compliance with all other applicable provisions of this section and the inclusion of the appropriate language in the resolution, the street may be accepted into the secondary system of state highways. ]~~

## ~~24 VAC 30-91-140. Relocations, adjustments, and improvements to streets maintained by the department.~~

~~Relocations of streets currently maintained by the department shall be coordinated with and approved by VDOT as follows:~~

~~1. All such work shall be accomplished pursuant to a land use permit issued by the department after the required right-of-way has been dedicated to public use or as otherwise required by the department.~~

~~2. All work, including the relocation, adjustment, and improvement of existing streets under VDOT jurisdiction shall be subject to the department's direction rather than these requirements. Such work shall normally include overlaying and re-striping the old new portions of the roadway.~~

~~3. The relocation of streets maintained by the department shall only be accomplished with the consent of the local governing body.~~

~~4. Traffic shall normally be maintained on streets under the department's jurisdiction until the new portion has been accepted by the department for maintenance unless the department authorizes a closure of the road to traffic.~~

~~5. No street or roadway maintained by the department and actively used by the public shall be abandoned or vacated unless a new street serving the same citizens has been constructed and accepted for maintenance by the department.~~

~~6. Streets previously discontinued exist as a public way under the jurisdiction of the local governing body and should be abandoned or vacated prior to the development of land associated with such streets. ]~~

## ~~[ 24 VAC 30-91-150. Right-of-way, 24 VAC 30-91-120. Right-of-way width, spite strips, and encroachments. ]~~

~~A. [ Right-of-way ] width. A clear and unencumbered right-of-way shall be dedicated to public use for any subdivision street proposed for addition to the secondary system of state highways maintained by the department. [ However, in certain, rare extenuating circumstances involving a party beyond the influence of the developer, an easement for transportation purposes may be approved by the resident engineer in lieu of dedicated right-of-way. In all other cases, any easement that might interfere with the public's unencumbered use of the street shall be quitclaimed in exchange for a land use permit, as outlined in 24 VAC 30-91-110 M 5 (Design and agreement requirements - Utilities. ]~~

~~The width of right-of-way shall be as indicated in the [ Supplemental ] Subdivision Street Design Guide [ 24 VAC 30-91-160) ] and shall be sufficient to include all essential elements of the roadway [ intended to be maintained by the department ], including [ the safe pedestrian, bicycle, or shared use path facilities and ] clear zone [ and pedestrian/bicycle facilities intended to be maintained by the department ]. However, supplemental easements may be used to accommodate sight distance requirements and slopes for cuts and fills. The right-of-way [ line shall be not less than three feet behind any roadway facility to be maintained by the department requirements are defined in the Subdivision Street Design Guide (24 VAC 30-91-160) ].~~

~~When an existing state maintained road is widened, the additional right-of-way should be dedicated as follows:~~

~~1. If the existing right-of-way consists of a prescriptive easement, to the degree that the developer controls the land, the right-of-way shall be dedicated to public use from the centerline of the alignment.~~

~~2. If the existing right-of-way is dedicated to public use, the additional right-of-way shall be dedicated to public use.~~

~~3. If the existing right-of-way is titled in the name of the department or the Commonwealth, the additional right-of-way shall be deeded to the department or to the Commonwealth, consistent with the title of the existing right-of-way.~~

~~[ B. Utilities. Local governments, the development community, and the utility community are encouraged to coordinate and~~

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~~consolidate their interests as part of the initial development plan.~~

~~To assure the unencumbered dedication of the right-of-way for subdivision street additions, easements or other interests within the platted right-of-way shall be quitclaimed of any prior rights therein. In exchange, a permit may be issued by the department for a utility to occupy the area involved. This permit will be processed by the resident engineer upon acceptance of the street into the secondary system of state highways maintained by the department. No inspection fee is required for permits so issued. However, the approval of the permit shall be contingent upon the utility's compliance with applicable provisions of the Land Use Permit Manual (24 VAC 30-150).~~

~~1. Underground utilities. The department allows the placement of underground utilities within the dedicated right-of-way of streets.~~

~~Underground utilities should normally be located outside of the travel lanes and desirably beyond the pavement. However, if the governing body has established adequate requirements for the design, location, and construction of underground utilities within the right-of-way of subdivision streets, including provisions that ensure that adequate testing and inspection is performed to minimize future settlement, those requirements shall become the department's requirements and govern unless those requirements conflict with a requirement of the department.~~

~~When location of the utilities outside of the pavement area is not practical and is endorsed by the local government through its requirements, such installations:~~

~~a. Are acceptable within the parking area and the shoulders along the street.~~

~~b. May be acceptable beneath the travel lanes of the street when provisions are made to ensure adequate inspection and compaction tests and~~

~~(1) Longitudinal installations and manholes are located outside of the normal travel lanes, or~~

~~(2) Longitudinal installations and manholes are placed in the center of an undivided roadway out of the wheel path.~~

~~2. Open cutting of hard surfaced roadways. The department usually prohibits the open-cutting of hard-surfaced roads except in extenuating circumstances. Therefore, all underground utilities within the right-of-way, as determined necessary by good engineering practice to serve the complete development of adjacent properties, shall be installed during the street's initial construction and prior to the application of its final pavement surface course. This shall include extensions of all necessary cross-street connections or service lines to an appropriate location beyond the pavement and preferably the right-of-way line.~~

~~In the event it is necessary to open the street pavement to work on utilities after the surface has been placed, additional compaction tests and paving as necessary to restore the integrity and appearance of the roadway may be required at the discretion of the resident engineer.~~

~~3. Cross-street conduits. To facilitate the placement of future underground utilities, cross-street conduits are encouraged with placement of such conduits occurring on each street at intersections and approximate every 1,000 feet along the length of a street.~~

~~4. Above ground utilities. All above ground utilities shall be installed behind the sidewalk or as close as possible to the limits of the street's right-of-way.~~

~~G. B. ] "Spite strips." Plans that include a reserved or "spite" strip that prohibits otherwise lawful vehicular access to a street from the adjacent properties, whether within or outside the subdivision, will not be approved.~~

~~[ D. Extrinsic structures and encroachments C. Encroachments ] within the right-of-way. Recording of a plat causes the fee title interest of areas dedicated to public use to transfer to the local governing body. Therefore, objects installed within the right-of-way for purposes other than transportation may be considered an unlawful encroachment in the right-of-way and prevent the right-of-way from being considered clear and unencumbered.~~

~~Posts, walls, signs, or similar ornamental devices that do not interfere with roadway capacity or encroach into [ the safe a ] clear zone or interfere with prescribed sight distance requirements may be permitted within the right-of-way. However, specific authorization by the resident engineer or as authorized under the Land Use Permit Manual [ (24 VAC 30-150) ] is a requisite for these devices or any other encroachment located within the right-of-way. For the purposes of this subsection, mailboxes installed on breakaway posts may occupy the right-of-way without permit. Otherwise [ such ] encroachments that do not [ encroach into fall within ] the safe clear zone may be allowed [ under within the right-of-way pursuant to ] a land use permit issued by the resident engineer [ or other designee ].~~

~~[ The department will accept grade separation structures as part of new subdivision streets if the structure is not considered to be an extrinsic structure and is intended to separate the movement of pedestrians or cyclists from traffic using the roadway provided:~~

~~1. The structure is available and unrestricted to public use;~~

~~2. The structure is accessible to pedestrian facilities, if any, situated along the street; and~~

~~3. The projected traffic volume of the street is not less than 4000 vpd or, if the facility provides the principle pedestrian access to a school, a peak hour traffic volume of 450 vph is projected.~~

~~In all other instances where an extrinsic structure exists within the right of way of the street, the street will only be accepted as part of the secondary system of state highways maintained by the department if the local governing body and the department have executed an agreement acceptable to the department that acknowledges the department has no responsibility or liability due to the presence of the structure and assures the costs of inspection, maintenance, and future improvements to the structure are provided from sources other than those administered by the department.~~

~~In all cases, the responsibility for lighting, safety, and security of those using such facilities shall remain a responsibility of local government. ]~~

**[ 24 VAC 30-91-130. Neotraditional developments.**

Streets maintained with public transportation funds should be able to safely accommodate the effective and efficient movement of those expected to use those streets. Consequently, the design of streets intended for maintenance by the department within neotraditional or other unique developments also must comply with all applicable provisions of these requirements and the department's applicable design criteria.

The Subdivision Street Design Guide (24 VAC 30-91-160) offers additional guidance on neotraditional developments and acceptable unique features typically seen in these type developments. The utilization of many neotraditional concepts and traffic calming features can normally be accomplished within the flexibility available within VDOT's subdivision street design criteria, and specific requests for exceptions when requests cannot be accommodated should be in writing to the resident engineer. ]

**[ ~~24 VAC 30-91-160~~ 24 VAC 30-91-140 ]. Surety and fees.**

A. [Policy.] Except as otherwise provided herein, the developer shall provide surety to guarantee the satisfactory performance of the street, a maintenance fee to offset the department's maintenance costs, and an administrative cost recovery fee to recover the department's costs associated with the review of subdivision plans, the inspection of new subdivision streets, and the administrative processing of the acceptance of new streets as determined in this section. All surety and fees collected under this section shall be based on the date of the local governing body's request and the aggregate mileage of new subdivision streets in that request, rounded up to the next tenth. In the event of extenuating circumstances beyond the developers control, the commissioner or his designee may waive all or a portion of any of the surety and fees.

**B. Surety.**

1. Type of surety and expiration. [~~The developer shall furnish~~] An acceptable surety, in accordance with this section, [shall be provided by the developer] to guarantee the satisfactory performance of the street for a period of one year from the date of its acceptance into the secondary system of state highways. In the event the developer fails to provide surety [~~and development~~ or any of the] fees [described in this section] within the 30-day period following the local governing body's request for the department to accept the maintenance of a street, the department's previous final inspection of the street shall be considered void and a new inspection shall be required. [~~The~~] Surety may be in the form of a performance bond, cash deposit, certified check, irrevocable letter of credit, third party escrow account, or other form mutually satisfactory to the department and the developer. Under no circumstances shall the department or any agency of the Commonwealth be named the escrow agent nor shall funds deposited with the department as surety be subject to the payment of interest.

**2. Alternatives to surety.**

a. In jurisdictions where the staff of the governing body administers a comprehensive subdivision construction inspection program that has been approved by the department, the surety may be waived upon certification by the governing body that the proposed addition has been constructed in accordance with approved plans and specifications.

b. If requested by the developer and subject to availability of departmental personnel, VDOT may perform the construction inspection of subdivision streets proposed to be added to the secondary system of state highways. In such cases, the developer shall bear all costs incurred by the department and the surety shall be waived.

3. Amount of surety. Surety shall be calculated at the rate of \$2,000 per lane per tenth mile of street, or portion thereof, to be accepted by the department for maintenance as part of the secondary system of state highways.

**C. Maintenance fee.**

A maintenance fee [~~will~~, provided by the developer, shall] be required for the acceptance of any street as part of the secondary system of state highways. The maintenance fee shall be calculated at the rate of \$150 per lane per tenth mile or portion thereof.

**D. Administrative cost recovery fee.**

1. Application of the administrative cost recovery fee. To recover a portion of the department's direct costs associated with the review of subdivision plans, the inspection of new subdivision streets, and the administrative processing of the acceptance of new streets, an administrative cost recovery fee shall be required from the developer at the time the streets are accepted by the department. The amount of this cost recovery fee shall be based on the following:

a. For streets shown on subdivision construction plans approved prior to (the effective date of the regulation):

(1) No cost recovery fee will be collected for street additions requested by the local government before July 1, 2005; and

(2) The cost recovery fee structure described in subdivision 1 c of this subsection shall apply until July 1, 2007, after which the department's prevailing cost recovery fee structure will apply.

b. For streets shown on subdivision construction plans approved after the effective date of the regulation, the department's cost recovery fee structure in effect at the time of construction plan approval shall apply and be fixed for a period of three years from the date of said approval, after which the prevailing cost recovery fee structure shall apply.

c. The administrative cost recovery fee shall be computed at a base rate of \$250 per lane, without regard to street length, plus \$100 per lane per tenth mile, or portion thereof. However, in the event the surety for new streets is waived under the provisions of subdivision A 2 of this

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section, the administrative cost recovery fee shall be reduced 50%.

2. Alternatives to the administrative cost recovery fee. As an alternative to the administrative cost recovery fee, the department may use one of the following approaches to recover its direct costs:

a. For any subdivision, at the developer's request, the department may establish an account for the purpose of tracking these costs and billing the developer not more often than every 30 days;

b. For large, complex, multi-use developments, the department, at its option, may establish an account for the purpose of tracking these costs and billing the developer not more often than every 30 days. However, the cost recovery fee assessed under this provision shall not be greater than two times the prevailing cost recovery fee structure; or

c. If requested to provide plan review or inspection services or both for subdivision streets that are not intended for maintenance by the department, the department may establish an account for the purpose of tracking these costs and billing the developer not more often than every 30 days.

3. Administrative cost recovery fee, annual adjustments. The department shall have the option of adjusting the annual cost recovery fee, in which case it shall compile information regarding its costs for the review of subdivision plans, the inspection of new subdivision streets, and the administrative processing of the acceptance of new streets during the previous fiscal year and report this information to the commissioner by January 1 of each year. The commissioner may adjust the administrative cost recovery fee by not more than 25% of the fee structure in effect on July 1 of the previous calendar year but not greater than the department's average direct cost as established in the report.

If the commissioner deems that a change in the cost recovery fee structure is warranted, implementation of the change shall be made as follows:

a. Notice of the adjusted fee structure, including the report on which it is based or information about where the report may be viewed, will be published in the Virginia Register of Regulations in April of that year, and

b. The adjusted fee structure shall become effective on July 1 of that year.

## **[ 24 VAC 30-91-170. Pedestrian and bicycle facilities.**

~~A. Pedestrian and bicycle facilities may be accepted as part of subdivision streets when constructed in accordance with applicable criteria and standards when located within the dedicated right-of-way.~~

~~However, the department's responsibility for maintaining pedestrian facilities, including combined bicycle pedestrian facilities separated from the roadway, shall normally be limited to the replacement of the facility. Routine ordinary~~

~~maintenance of such facilities (e.g., removal of snow and leaves) shall normally be the responsibility of others.~~

~~B. Sidewalk criteria. Sidewalks shall be constructed in accordance with the Subdivision Street Design Guide. However, sidewalks that meanders vertically in comparison to the grade of the roadway may be considered noncompliant sidewalks.~~

~~C. Bicycle facility criteria. Bicycle facilities contiguous with the portion of the street intended for motor vehicles shall be in accordance with the department's design and construction criteria set forth in the Road Design Manual (effective July 1, 1998).~~

~~D. Multi-use pedestrian and bicycle trail criteria. Multi-use pedestrian and bicycle trails that are separated from the roadway pavement may be accepted for maintenance as part of the street if constructed in accordance with the Road Design Manual (effective July 1, 1998) and provided they closely follow the vertical alignment of the roadway without meandering on and off the right-of-way.~~

~~E. Noncompliant sidewalk and noncompliant multi-use pedestrian and bicycle trails. Noncompliant sidewalk and multi-use pedestrian and bicycle trails will not be accepted for maintenance, but may be located on the dedicated right-of-way under a permit issued by the department to the local governing body.~~

~~Such permits will clearly specify the responsibility for maintenance of the facility and related activities to the extent the facility occupies the street's right of way. The permit applicant shall normally be a county, incorporated town, or other entity that has perpetual maintenance capability. Noncompliant sidewalks and trails may be constructed of bituminous concrete, hydraulic concrete, gravel, or other stabilizer convenient to the applicant.~~

## **24 VAC 30-91-180. Guardrail.**

~~A guardrail shall be used when required by the resident engineer consistent with the Road Design Manual (effective July 1, 1998).~~

## **24 VAC 30-91-190. Curb and gutter.**

~~A. For the purpose of these requirements, the use of a curb and gutter is an acceptable alternative, rather than a requisite, for the acceptance of subdivision streets. However, when used, curb and gutter shall be designed in accordance with the Subdivision Street Design Guide and only one curb and gutter design may be used along the length of a street.~~

~~B. Driveway entrance requirements. Without regard to the curb design used, the curb shall incorporate a driveway entrance apron, as illustrated in the Subdivision Street Design Guide to provide a smooth transition from the gutter invert or roadway surface onto the driveway. However, exceptions may be granted by the resident engineer when roll top curb is used if requested by the local official.~~

~~C. Curb cut ramps. All streets that incorporate accessible routes for pedestrian use, such as existing or proposed sidewalks, shall, without regard to the curb design used, include curb cut ramps at intersections for use by persons~~

~~with mobility impairments and other applicable provisions of the Americans with Disabilities Act.~~

## **~~24 VAC 30-91-200. Neotraditional developments.~~**

~~Streets maintained with public transportation funds should be able to safely accommodate the effective and efficient movement of those classes of motor vehicles expected to utilize those streets. Consequently, the design of streets intended for maintenance by the department within neotraditional or other unique developments also must comply with all applicable provisions of these requirements and the department's applicable design criteria.~~

~~The Subdivision Street Design Guide offers additional guidance on neotraditional developments and acceptable unique features typically seen in these type developments. The utilization of many neotraditional concepts and traffic calming features can normally be accomplished within the flexibility available within VDOT's subdivision street design criteria, and specific requests for exceptions when requests cannot be accommodated should be in writing to the resident engineer.~~

~~All plans that include neotraditional characteristics or traffic calming measures should have those features clearly identified on the plans for review and approval by the resident engineer in consultation with other disciplines within the department as deemed necessary, as a prerequisite of plan approval, construction, or acceptance of the street as part of the secondary system of state highways maintained by the department.~~

## **~~24 VAC 30-91-210. Railroad crossing.~~**

~~Railroad crossings will only be accepted by the department for maintenance pursuant to an agreement with the rail company that, before being executed by the railroad and the developer or the governing body, has been reviewed and approved by the department in consultation with the Department of Rail and Public Transportation. Such agreements shall be fully executed before the initiation of procedures for the acceptance of the street as part of the secondary system of state highways maintained by the department.~~

~~All at-grade railroad crossings to be maintained by the department shall be protected with short arm gates with flashing signals, flashing signals alone, or other protective devices deemed appropriate by the department.~~

## **~~24 VAC 30-91-220. Private entrances.~~**

~~All private entrances shall be designed and constructed in accordance with the applicable standard of the department's Minimum Standards of Entrances to State Highways (24 VAC 30-71). All entrance pipe culverts shall be sized to accommodate the runoff expected from a 10-year frequency storm. On streets with curb and gutter, the appropriate entrance gutter, as prescribed by 24 VAC 30-91-190, shall be provided.~~

## **~~24 VAC 30-91-230. Parking.~~**

~~A. Perpendicular and angle parking along subdivision streets shall normally be prohibited. However, perpendicular and angle parking along subdivision streets may be considered~~

~~provided features along the street cause the street to readily appear to be a street rather than a travel way through a parking lot. In addition, additional pavement width may be necessary between the travel lanes and the parking spaces to allow a car to back from its normal parked position, orient itself for entering the travel lanes and stop without either encroaching into the travel lanes or having the driver's vision of oncoming traffic obscured by adjacent, parked vehicles.~~

~~Street designs that anticipate the restriction of on-street parking shall only be approved with the consent of the county official and the resident engineer.~~

~~B. In the absence of local regulations that are deemed acceptable by the department, the following criteria shall apply for the design of subdivision streets:~~

~~1. A minimum of two off-street parking spaces per dwelling unit, exclusive of garage facilities associated with the unit, shall be provided in the proximity of the unit they are intended to serve. Additional off-street parking space shall be provided when the width of any residential curb and gutter roadway is proposed for reduction as permitted in the Subdivision Street Design Guide. Except as may be associated with corner dwellings, the availability of on-street parking along other streets will not normally be considered as additional off-street parking.~~

~~2. If parking bays are provided, they shall be located off the street's right of way and designed to prevent vehicles from backing into the adjacent subdivision street.~~

~~3. Entrances to parking bays shall be separated by at least 50 feet and designed in accordance with the appropriate provisions of the standards or Land Use Permit Manual (24 VAC 30-150).~~

## **~~24 VAC 30-91-240. Landscaping.~~**

~~All disturbed areas within the dedicated right-of-way and easements of any subdivision street shall be restored with vegetation compatible with the surrounding area. No street will be accepted as part of the secondary system of state highways maintained by the department where there is visual evidence of erosion or siltation unless appropriate protective measures, in accordance with VDOT's construction practices, have been taken. Except as otherwise approved by the resident engineer, planting of trees or shrubs on the right-of-way shall be in accordance with the Subdivision Street Design Guide.~~

## **~~24 VAC 30-91-250. Lighting.~~**

~~Roadway, security, or pedestrian lighting, when required by the governing body or desired by the developer, shall be installed in accordance with the Subdivision Street Design Guide. However, VDOT shall not be responsible for the maintenance or replacement of lighting fixtures or the provision of power for lighting.~~

## **~~24 VAC 30-91-260. Noise abatement.~~**

~~Where applicable, the governing body and the developer are reminded of the board's adoption, on August 18, 1988, of the State Noise Abatement Policy (24 VAC 30-80), which applies~~

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~~to nonfederal aid highway construction and improvement projects.~~

## **24 VAC 30-91-270. Effective date and transition.**

~~These requirements are effective 30 days from publication of the final regulation in The Virginia Register of Regulations. However, the department will consider approval of streets designed in accordance with either the former requirements (1996) or with these requirements during the six month period following the effective date of these requirements. Any street design initially submitted for approval after that period shall be in accordance with these requirements. ]~~

### PART III. REFERENCE SECTION.

## **[ 24 VAC 30-91-280 24 VAC 30-91-150]. Subdivision street development, plan review, and acceptance.**

A. The county-state partnership governing VDOT acceptance of new streets for maintenance. Section 33.1-229 of the Code of Virginia (a Byrd Act provision) creates the authority under which local governments establish new roads as part of the secondary system of state highways. Sections 15.2-2240 and 15.2-2241 of the Code of Virginia establish the authority of local subdivision ordinances and the authority of counties to set the standards for new streets within their territories.

VDOT's participation in the development and acceptance of subdivision streets for maintenance is a cooperative commitment of the Commonwealth Transportation Board.

VDOT's concurrence with or approval of a construction plan represents VDOT's commitment to accept the streets [ ~~depicted upon their satisfactory construction shown on the plan when satisfactorily constructed~~ ] and [ ~~the satisfaction of~~ ] all other requirements governing the [ department's ] acceptance of streets [ ~~upon the county's~~ ] request for the acceptance of or transfer of [ the maintenance and operational ] jurisdiction over the street, as outlined in these requirements.

Pursuant to these principles:

1. Local government controls land development activity and establishes new streets, the relocation of existing streets, and the criteria governing the development of such streets.

2. VDOT establishes the minimum standards that must be satisfied for new subdivision streets to be considered for maintenance by the department as part of the secondary system of state highways under its jurisdiction.

[ ~~3. The department's resident engineer or designee represents VDOT to the localities served by the residency office listed in 24 VAC 30-91-290. Within each locality, VDOT is represented by a resident engineer or comparable designee. ]~~

[ ~~The department's Subdivision Street Design Guide sets out design parameters deemed appropriate for most land development scenarios. However, the business of land development is fluid and the department is prepared to consider innovative transportation approaches associated with a proposed land development approach that are consistent~~

~~with the geometric requirements of the Subdivision Street Design Guide in consultation with local government officials. ]~~

B. Street development and acceptance of maintenance process.

1. Concept and construction plan approval phase. The proposed construction plan shall be considered incomplete in the absence of a preliminary pavement design based on the Pavement Design Guide ( [ effective August 1, 2000 24 VAC 30-91-160 ] ) and the presumed values therein.

2. Construction phase. Upon approval of the construction plan and prior to construction, the resident engineer should advise the developer regarding inspection of the construction phases and the scheduling of those inspections. VDOT approval of each of the following phases of construction is recommended.

a. Installation of any enclosed drainage system before it is covered.

b. Installation of any enclosed utility placements within the right-of-way before being covered.

c. Construction of the cuts and fills, including field density tests, before placement of roadbed base materials.

d. A final pavement design, based on actual soil characteristics and certified tests, shall be completed and approved before the pavement structure is placed.

e. Placement of base materials, including stone depths, consistent with the approved pavement design, prior to placement of the paving course or courses, followed by field density and moisture tests and the placement of a paving course as soon as possible.

f. Construction of pavement, including depth and density, upon completion as part of the final inspection.

3. Street acceptance process. In the absence of any other formal acceptance, the governing body's resolution requesting the department to accept a street for maintenance as part of the secondary system of state highways completes the dedication [ ~~of a street for public purposes~~ ] and is deemed to constitute the governing body's acceptance of the street ].

4. Post acceptance phase.

## **[ 24 VAC 30-91-290 24 VAC 30-91-160]. Listing of documents (publications) incorporated by reference.**

Information pertaining to the availability and cost of any of these publications should be directed to the address indicated below the specific document. Requests for documents available from the department may be obtained from the department's division and representative indicated; however, department documents may be available over the Internet at [www.Virginiadot.org](http://www.Virginiadot.org).

1. Drainage Manual, effective April 2002.  
Location and Design Division (VDOT)  
Location and Design Engineer  
1401 E. Broad Street  
Richmond, Virginia 23219

2. *Land Use Permit Manual, 24 VAC 30-150, effective November 15, 1983.*

Local Assistance Division (VDOT)  
Director of the Local Assistance Division  
1401 E. Broad Street  
Richmond, Virginia 23219

~~[ 3. *Minimum Standards of Entrances to State Highways, 24 VAC 30-71, effective December 3, 2003.*~~

~~Mobility Management Division (VDOT)  
Director of Mobility Management  
1401 E. Broad Street  
Richmond, Virginia 23219 ]~~

[ 4. 3. ] *Pavement Design Guide for Subdivision and Secondary Roads in Virginia, effective August 1, 2000.*

Materials Division (VDOT)  
State Materials Engineer  
1401 E. Broad Street  
Richmond, Virginia 23219

[ 5. 4. ] *Road and Bridge Specifications, effective 2002.*

Construction Division (VDOT)  
State Construction Engineer  
1401 E. Broad Street  
Richmond, Virginia 23219

[ 6. 5. ] *Road Design Manual, effective [ July 1, 1998 January 1, 2005 ].*

Location and Design Division (VDOT)  
Location and Design Engineer  
1401 E. Broad Street  
Richmond, Virginia 23219

6. *Subdivision Street Design Guide (Appendix B: Road Design Manual, effective January 1, 2005)*

Location and Design Division (VDOT)  
Location and Design Engineer  
1401 E. Broad Street  
Richmond, Virginia 23219 ]

7. *Road and Bridge Standards, effective February 1, 2001.*

Location and Design Division (VDOT)  
Location and Design Engineer  
1401 E. Broad Street  
Richmond, Virginia 23219

8. *Standard Specifications for Highway Bridges, effective 1996.*

American Association of State Highway and Transportation Officials  
North Capital Street, Suite 225  
Washington, DC 20001

VDOT Modifications to document above

Structure and Bridge Division (VDOT)  
Structure and Bridge Engineer  
1401 E. Broad Street  
Richmond, Virginia 23219

9. *Virginia Erosion and Sediment Control Handbook, effective 1992.*

Division of Soil and Water Conservation with The Virginia Erosion and Sediment Control Law and Regulations  
Division of Soil and Water Conservation

Governor Street, Suite 206  
Richmond, Virginia 23219

10. *Highway Capacity Manual, effective 2000.*

Transportation Research Board  
Keck Center of the National Academies  
Transportation Research Board  
500 Fifth Street, NW  
Washington, DC 20001  
Attn: TRB Publications Sales & Affiliate Services

11. *VDOT Erosion and Sediment Control and Stormwater Management Program Specifications Manual (effective March 1, 2004).*

Location and Design Division (VDOT)  
Location and Design Engineer  
1401 E. Broad Street  
Richmond, Virginia 23219

[ 12. *Policy for Integrating Bicycle and Pedestrian Accommodations - Commonwealth Transportation Board (effective March 18, 2004.) Note: This policy reference is included in the regulation only for informational purposes and is not considered a regulatory provision. Applicable elements of this policy are stated in the regulation itself. ]*

VA.R. Doc. No. R03-156; Filed April 14, 2004, 10:50 a.m.



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# FAST-TRACK REGULATIONS

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Section 2.2-4012.1 of the Code of Virginia provides an exemption from certain provisions of the Administrative Process Act for agency regulations deemed by the Governor to be noncontroversial. To use this process, Governor's concurrence is required and advance notice must be provided to certain legislative committees. Fast-track regulations will become effective on the date noted in the regulatory action if no objections to using the process are filed in accordance with § 2.2-4012.1.

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## TITLE 12. HEALTH

### STATE BOARD OF HEALTH

**Title of Regulation:** 12 VAC 5-410. Rules and Regulations for the Licensure of Hospitals (amending 12 VAC 5-410-440; adding 12 VAC 5-410-441 through 12 VAC 5-410-447).

**Statutory Authority:** § 32.1-127 of the Code of Virginia.

**Public Hearing Date:** N/A -- Public comments may be submitted until January 28, 2005.

(See Calendar of Events section for additional information)

**Effective Date:** February 14, 2005.

**Agency Contact:** Carrie Eddy, Senior Policy Analyst, Department of Health, Center for Quality Health Care Services, 3600 West Broad Street, Suite 216, Richmond, VA 23230, telephone (804) 367-2157, FAX (804) 864-2149, or e-mail carrie.eddy@vdh.virginia.gov.

**Basis:** The regulation is promulgated under the authority of § 32.1-127 of the Code of Virginia, which grants the Board of Health the legal authority to promulgate regulations "in substantial conformity to the standards of health, hygiene, sanitation, construction, and safety as is established and recognized by medical and health care professionals and by specialists in the matters of public health and safety."

**Purpose:** In December 2003, the department was contacted by the Virginia Breastfeeding Task Force and informed that the current time standard (24 hours) for the storage of breast milk is in conflict with the current national recommendations of practice, i.e., 48 hours. Because of this conflict, hospitals providing newborn services are at risk of violating state regulatory standards when providing the quality of care expected for newborns and their mothers.

Currently 12 VAC 5-410-440, contains multiple standards specific to pregnant women and the delivery of their infants. As might be expected, this can have a negative impact as it unintentionally increases chances for an "out of compliance" condition during a licensure inspection, through no fault of the licensee. Breaking the one section into six additional sections, with related section titles, will make it easier to quickly and easily locate specific requirements. In addition, reformatting this section will assist with the planned revision to the entire hospital regulation.

**Rationale for Using Fast-Track Process:** The intent of this amendment is to ease the current burden on lactating mothers and hospitals. In addition, the changes are not medically complex to implement and will reduce costs to mothers and hospitals. As an interim measure, the department has issued variance letters allowing hospitals providing newborn services to store breast milk for up to 48 hours. Therefore, the department does not expect this proposed change to be controversial.

The reformatting changes to 12 VAC 5-410-440 are technical in nature and do not change the intent of any of the current standards and, therefore, are not considered to be controversial.

**Substance:** The proposed amendment updates two hospital regulatory time standards for storing breast milk from within 24 hours consumption or disposal to 48 hours consumption or disposal, unless the milk is frozen. In addition, the more medically accurate term "aseptic" replaces the archaic term "sterile." The changes as a result of reformatting 12 VAC 5-410-440 are technical in nature and do not change the intent of any of the current standards.

**Issues:** The department learned that the current standard of 24 hours "consume or dispose, unless frozen" was proving too burdensome for lactating mothers attempting to provide their hospitalized infants with breast milk and for hospitals charged with tracking the use of the milk. By allowing a 48-hour standard, hospitals still meet best practices for quality care without overburdening lactating mothers with outdated and archaic state requirements. The changes as a result of reformatting 12 VAC 5-410-440 are technical in nature and do not change the intent of any of the current standards.

There are no disadvantages to the public or the Commonwealth.

**Department of Planning and Budget's Economic Impact Analysis:** The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

**Summary of the proposed regulation.** The proposed regulations will increase the duration of time that hospitals can store breast milk prior to consumption or disposal from 24 hours to 48 hours, unless the milk is frozen. The proposed changes will also reorganize the regulations.

**Estimated economic impact.** One of the proposed changes will allow hospitals to store breast milk up to 48 hours for consumption before it is disposed or frozen. Thus, the hospitals will be able to store breast milk for an additional 24-hour period. According to the department, the Virginia Breastfeeding Task Force pointed out that the current national standards for storage of breast milk is 48 hours. In particular, Human Milk Banking Association of North America states, "The recommended 48 hours of refrigerated storage is within a bacteriologically safe range and is conservative enough to

cover variables in home refrigeration, time and temperature, collection techniques, hospital transport, and hospital exposure to multiple caregivers.<sup>1</sup> This recommendation is based on five studies that looked at the effects of refrigeration on storage for varying times from 24 hours to 8 days and found no appreciable bacterial growth over the storage times analyzed. The most recent of these studies is by Pardou et al.<sup>2</sup> which states that "The data also suggests that refrigeration is better than freezing for storage up to 8 days as far as antimicrobial properties are concerned." In short, the weight of empirical evidence seems to support that the health benefits from the nutritional and immunological qualities of unfrozen human breast milk would exceed the health risks from deteriorating bacteriological properties within the first 48 hours.

The economic costs to hospitals associated with an additional 24-hour storage time, if chosen, are expected to be negligible. Furthermore, given the fact that hospitals are already issued variances allowing them to store breast milk up to 48 hours, no significant economic costs are expected upon promulgation of the proposed standard.

Finally, the proposed reorganization of the regulation into six separate sections is not expected to create any significant economic effects, but may improve the clarity of the regulations and make it easier to locate specific requirements.

Businesses and entities affected. The proposed regulations apply to 63 hospitals providing obstetric and newborn services.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. No significant effect on employment is expected.

Effects on the use and value of private property. No significant effect on the use and value of private property is expected.

Department of Planning and Budget's Economic Impact Analysis: The agency concurs substantially with the analysis performed by DPB.

Summary:

*This proposed amendment changes the storage of breast milk by hospitals, or at home for hospital use, from 24 hours consumption or disposal to 48 hours consumption or disposal, unless the milk is frozen. In addition, the amendment reformats a portion of 12 VAC 5-410-440 into six new sections.*

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<sup>1</sup> Recommendations for Collection Storage and Handling of a Mother's Milk for Her Own Infant in the Hospital Setting, 1999 Edition, Human Milk Banking Association of North America.

<sup>2</sup> Pardou, A., E. Serruys, F. Mascart-Lemone, M. Dramaix, H.L. Vis, 1994, "Human Milk Banking: Influence of Storage Process and of Bacterial Contamination on Some Milk Constituents," *Biology of the Neonate*, No. 65, pp. 302-309.

## **12 VAC 5-410-440. Obstetric and newborn services general requirements.**

A. Hospitals with licensed obstetric and newborn services in operation prior to ~~the effective date of this chapter~~ August 10, 1995, or revisions to thereof shall comply with all of the requirements of this section ~~within 12 months of the effective date of this chapter~~, with the exception of specified sections of ~~subdivision C-5 of this section~~ 12 VAC 5-410-442. Hospitals that establish and organize obstetric and newborn services after ~~the effective date of this chapter~~ August 10, 1995, shall comply with all requirements of this section and 12 VAC 5-410-441 through 12 VAC 5-410-447 before licensure approval is granted.

B. A hospital with organized obstetric and newborn services shall comply with the following general requirements:

1. ~~Administrative management.~~ The governing body of the hospital or the chief executive officer shall appoint an administrative manager for the obstetric and newborn services. The administrative manager may serve as an administrator of another hospital service but must be available to the obstetric and newborn services. The chief executive officer shall designate, in writing, an individual to act in the administrative manager's behalf during a temporary absence of the administrative manager.

2. ~~Services plan.~~ The hospital is responsible for the development, periodic review and revision of a service management plan. The plan must include provisions to assure that the hospital complies with all state and federal regulations and guidelines applicable to obstetric and ~~neonatal~~ newborn care as well as the policies and procedures for obstetric and newborn care adopted by the hospital's governing body and medical staff. The plan is to be developed and maintained as follows:

a. The plan shall be developed in cooperation with the medical directors and nursing staffs assigned to each of the services.

b. The plan shall include the protocol, required by § 32.1-127 of the Code of Virginia, for the admission or transfer of any pregnant woman who presents in labor.

c. The plan shall be the responsibility of the administrative manager who is to assure that the plan is developed, that it complies with state and federal requirements and the hospital's policies and procedures, and that it is periodically reviewed and revised.

d. A copy of the plan shall be readily available at each nursing station within the obstetric and newborn services for staff reference.

e. A copy of the plan shall be made available, upon request, to the ~~hospital state~~ licensing inspector for review.

3. ~~Support services.~~ The hospital shall provide the following services in support of the obstetric and newborn services units:

a. Clinical laboratory services and blood bank services shall be available in the hospital on a 24-hour basis.

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Laboratory and blood bank personnel shall be available on-site or on-call on a 24-hour basis. The blood bank shall have group O Rh negative blood available at all times and be able to provide correctly matched blood in 45 minutes from request. The hospital's laboratory and blood bank personnel must be capable of performing the following tests with less than 1.0 ml of blood within one hour of request or less if specified:

- (1) Blood group and Rh type determination/cross matching
- (2) Arterial blood gases within 20 minutes
- (3) Blood glucose within 20 minutes
- (4) Complete blood count
- (5) Total protein
- (6) Total bilirubin
- (7) Direct Coombs test
- (8) Electrolytes
- (9) Blood urea nitrogen
- (10) Clotting profile (may require more than one cc of blood)

b. Portable radiological services for basic radiologic studies in each labor room, delivery room, and nursery shall be available on call on a 24-hour basis.

c. In addition to the requirements specified in 12 VAC 5-410-240 of this chapter, anesthesia service personnel shall be available on-site or on-call to begin anesthesia within 30 minutes of notification.

**~~G. 12 VAC 5-410-441. Obstetric service requirements are as follows: ; medical direction; physician consultation and coverage; nurse staffing and coverage; policies and procedures.~~**

~~1. Medical direction.~~ a. A. The governing body shall appoint a physician as medical director of the organized obstetric service who meets the qualifications specified in the medical staff bylaws.

~~b. 1.~~ If the medical director is not a board certified obstetrician or board eligible in obstetrics, the hospital shall have a written agreement with one or more board-certified or board-eligible obstetricians to provide consultation on a 24-hour basis. Consultation may be by telephone.

~~e. 2.~~ The duties and responsibilities of the medical director of obstetric services shall include but not be limited to:

- ~~(1)~~ a. The general supervision of the quality of care provided patients admitted to the service;
- ~~(2)~~ b. The establishment of criteria for admission to the service;
- ~~(3)~~ c. The adherence to standards of professional practices and policies and procedures adopted by the medical staff and governing body;

~~(4)~~ d. The development of recommendations to the medical staff on standards of professional practice and staff privileges;

~~(5)~~ e. The identification of clinical conditions and medical or surgical procedures that require physician consultation; and

~~(6)~~ f. Arranging conferences, at least quarterly, to review obstetrical surgical procedures, complications and infant and maternal mortality and morbidity. Infant mortality and morbidity shall be discussed jointly between the obstetric and newborn service staffs.

~~2. Physician consultation and coverage.~~

~~a. B.~~ A physician with obstetrical privileges capable of arriving on-site within 30 minutes of notification shall be on a 24-hour on-call duty roster.

~~b. C.~~ A physician with obstetrical privileges shall be accessible for patient treatment within 10 minutes during the administration of an oxytocic agent to an antepartum patient.

~~e. D.~~ A physician or a certified nurse-midwife, under the supervision of a physician with obstetrical privileges, shall be in attendance for each delivery. Physician supervision of the nurse-midwife shall be in compliance with the regulations of the Boards of Nursing and Medicine.

~~d. E.~~ A physician shall be in attendance during all high-risk deliveries. High-risk deliveries shall be defined by the obstetric service medical staff.

~~e. F.~~ A physician or a nurse skilled in neonatal cardiopulmonary resuscitation (CPR) shall be available in the hospital at all times.

~~f. G.~~ A current roster of physicians, with a delineation of their obstetrical, newborn, pediatric, medical and surgical staff privileges, shall be posted at each nurses' station in the obstetric suite and in the emergency room.

~~g. H.~~ A copy of the 24-hour on-call duty schedule, including the list of on-call consulting physicians, shall be posted at each nurses' station in the obstetric suite and in the emergency room.

~~3. Nursing staff and coverage.~~

~~a. I.~~ An occupied unit of the obstetrics service shall be supervised by a registered nurse 24 hours a day.

~~b. J.~~ If the postpartum unit is organized as a separate nursing unit, staffing shall be based on a formula of one nursing personnel for every six to eight obstetric patients. Staffing shall include at least one registered nurse for the unit for each duty shift.

~~e. K.~~ If the postpartum and general care newborn units are organized as combined rooming-in or modified rooming-in units, staffing shall be based on a formula of one nursing personnel for every four mother-baby units. The rooming-in units shall be staffed at all times with no less than two nursing personnel each shift. At least one of the two nursing personnel on each shift shall be a registered nurse.

~~d.~~ L. A registered nurse shall be in attendance at all deliveries. The nurse shall be available on-site to monitor the mother's general condition and that of the fetus during labor, at least one hour after delivery, and longer if complications occur.

~~e.~~ M. Nurse staffing of the labor and delivery unit shall be scheduled to ensure that the total number of nursing personnel available on each shift is equal to one half of the average number of deliveries in the hospital during a 24-hour period.

~~f.~~ N. At least one of the personnel assigned to each shift on the obstetrics unit shall be a registered nurse. At no time when the unit is occupied shall the nursing staff on any shift be less than two staff members.

~~g.~~ O. Patients placed under analgesia or anesthesia during labor or delivery shall be under continuous observation by a registered nurse or a licensed practical nurse for at least one hour after delivery.

~~h.~~ P. To ensure adequate nursing staff for labor, delivery, and postpartum units during busy or crisis periods, duty schedules shall be developed in accordance with the following nurse/patient ratios:

- ~~(1)~~ 1. 1:1 to 2 Antepartum testing
- ~~(2)~~ 2. 1:2 Laboring patients
- ~~(3)~~ 3. 1:1 Patients in second stage of labor
- ~~(4)~~ 4. 1:1 Ill patients with complications
- ~~(5)~~ 5. 1:2 Oxytocin induction or augmentation of labor
- ~~(6)~~ 6. 1:2 Coverage of epidural anesthesia
- ~~(7)~~ 7. 1:1 Circulation for cesarean delivery
- ~~(8)~~ 8. 1:6 to 8 Antepartum/postpartum patients without complications
- ~~(9)~~ 9. 1:2 Postoperative recovery
- ~~(10)~~ 10. 1:3 Patients with complications, but in stable condition
- ~~(11)~~ 11. 1:4 Mother-newborn care

~~i.~~ Q. Student nurses, licensed practical nurses and nursing aides who assist in the nursing care of obstetric patients shall be under the supervision of a registered nurse.

~~j.~~ R. At least one registered nurse trained in obstetric and neonatal care shall be assigned to the care of mothers and infants at all times.

~~k.~~ S. At least one member of the nursing staff on each shift who is skilled in cardiopulmonary resuscitation of the newborn must be immediately available to the delivery suite.

~~l.~~ T. All nursing personnel assigned to the obstetric service shall have orientation to the obstetrical unit.

#### ~~4. Policies and procedures.~~

~~a. General policies and procedures.~~ U. The governing body shall adopt written policies and procedures for the management of obstetric patients approved by the medical and nursing staff assigned to the service.

1. The policies and procedures shall include, but not be limited to, the following:

~~(1)~~ a. Criteria for the identification and referral of high-risk obstetric patients;

~~(2)~~ b. The types of birthing alternatives, if offered, by the hospital;

~~(3)~~ c. The monitoring of patients during antepartum, labor, delivery, recovery and postpartum periods with or without the use of electronic equipment;

~~(4)~~ d. The use of equipment and personnel required for high-risk deliveries, including multiple births;

~~(5)~~ e. The presence of family members or chosen companions during labor, delivery, recovery, and postpartum periods;

~~(6)~~ f. The reporting, to the Department of Health, of all congenital defects;

~~(7)~~ g. The care of patients during labor and delivery to include the administration of Rh O(D) immunoglobulin to Rh negative mothers who have met eligibility criteria. Administration of RH O(D) immunoglobulin shall be documented in the patient's medical record;

~~(8)~~ h. The provision of family planning information, to each obstetric patient at time of discharge, in accordance with § 32.1-134 of the Code of Virginia;

~~(9)~~ i. The use of specially trained paramedical and nursing personnel by the obstetrics and newborn service units;

~~(10)~~ j. A protocol for hospital personnel to use to assist them in obtaining public health, nutrition, genetic and social services for patients who need those services;

~~(11)~~ k. The use of anesthesia with obstetric patients;

~~(12)~~ l. The use of radiological and electronic services, including safety precautions, for obstetric patients;

~~(13)~~ m. The management of mothers who utilize breast milk with their newborns. Breast milk shall be collected in ~~sterile aseptic~~ containers, dated, stored under refrigeration and consumed or disposed of within 24 48 hours of collection if the breast milk has not been frozen. This policy pertains to breast milk collected while in the hospital or at home for hospital use;

~~(14)~~ n. Staff capability to perform cesarean sections within 30 minutes of notice;

~~(15)~~ o. Emergency resuscitation procedures for mothers and infants;

~~(16)~~ p. The treatment of volume shock in mothers;

~~(17)~~ q. Training of hospital staff in discharge planning for identified substance abusing, postpartum women and their infants; *and*

~~(18)~~ r. Written discharge planning for identified substance abusing, postpartum women and their infants. The discharge plans shall include appropriate referral sources

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available in the community or locality for mother and infants such as:

- ~~(a)~~ (1) Substance abuse treatment services; and
- ~~(b)~~ (2) Comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 USC § 1471 et seq.
- (3) The discharge planning process shall be coordinated by a health care professional and shall include, to the extent possible:
  - (a) The father of the infant; and
  - (b) Any family members who may participate in the follow-up care of the mother or infant.

The discharge plan shall be discussed with the mother and documented in the medical record.

~~b. Policies and procedures for the use of the labor, delivery and recovery rooms/labor, delivery, recovery and postpartum rooms.~~ 2. The obstetric service shall adopt written policies and procedures for the use of the labor, delivery and recovery rooms (LDR)/Labor, delivery, recovery and postpartum rooms (LDRP) that include, but are not limited to the following:

- ~~(1)~~ a. The philosophy, goals and objectives for the use of the LDR/LDRP rooms;
- ~~(2)~~ b. Criteria for patient eligibility to use the LDR/LDRP rooms;
- ~~(3)~~ c. Identification of high-risk conditions which disqualify patients from use of the LDR/LDRP rooms;
- ~~(4)~~ d. Patient care in LDR/LDRP rooms, including but not limited to, the following:
  - ~~(a)~~ (1) Defining vital signs, the intervals at which they shall be taken, and requirements for documentation; and
  - ~~(b)~~ (2) Observing, monitoring, and assessing the patient by a registered nurse, certified nurse midwife, or physician;
- ~~(5)~~ e. The types of analgesia and anesthesia to be used in LDR/LDRP rooms;
- ~~(6)~~ f. Specifications of conditions of labor or delivery requiring transfer of the patient from LDR/LDRP rooms to the delivery room;
- ~~(7)~~ g. Specification of conditions requiring the transfer of the mother to the postpartum unit or the newborn to the nursery;
- ~~(8)~~ h. Criteria for early or routine discharge of the mother and newborn;
- ~~(9)~~ i. The completion of medical records;
- ~~(10)~~ j. The presence of family members or chosen companions in the delivery room or operating room in the event that the patient is transferred to the delivery room or operating room;

~~(11)~~ k. The number of visitors allowed in the LDR/LDRP room, and their relationship to the mother; *and*

~~(12)~~ l. Infection control, including, but not limited to, gowning and attire to be worn by persons in the LDR/LDRP room, upon leaving it, and upon returning.

## **5. 12 VAC 5-410-442. Obstetric service design and equipment criteria.**

A. In addition to complying with Article 5 of this part, a hospital shall comply with the following requirements of this section for the physical design of obstetric service facilities. Existing hospitals with licensed obstetric and newborn services in operation prior to the effective date of the regulations or revisions thereof, shall comply with all of the regulations of this section with the exception of the minimum dimension and square footage requirements for labor rooms and LDR/LDRP rooms provided for in subdivisions ~~e, f, and i of this subdivision B 5, 6 and 9 of this section~~. Existing hospitals with an obstetric service may not decrease the dimensions of the labor rooms and the LDR/LDRP rooms from what was granted approval at the time the service was licensed.

B. Labor rooms and LDR/LDRP rooms that are renovated or constructed after the effective date of this chapter shall conform with all of the room dimensions specified in this section-:

- ~~a-~~ 1. The space and arrangement of a hospital building or a section of the hospital designated as the obstetric unit (antepartum and postpartum) shall be designed to assure the separation of obstetric patients from other patients with the exception of clean gynecological patients. Clean gynecological patients shall be defined in approved written hospital policy.
- ~~b-~~ 2. The hospital shall identify specific rooms and beds as obstetric rooms and beds. Adjacent rooms and beds may be used for clean gynecological cases.
- ~~e-~~ 3. Labor, delivery, recovery and labor, delivery, recovery and postpartum rooms shall be physically separate from emergency and operating rooms.
- ~~e-~~ 4. The obstetric nursing unit shall meet the requirements of 12 VAC 5-410-750 A ~~of this chapter~~, except for the following:
  - ~~(1)~~ a. A handwashing lavatory must be provided in each patient room;
  - ~~(2)~~ b. The soiled workroom and janitors' closet in the obstetric nursing unit shall only be shared with the newborn services unit; *and*
  - ~~(3)~~ c. All bathing facilities shall be showers or tub units with showers.
- ~~e-~~ 5. Labor rooms shall be single-bed or two bed rooms with a minimum clear area of 180 square feet for each bed.
- ~~f-~~ 6. In hospitals having only one delivery room, two labor rooms shall be provided. One labor room shall be large enough to function as an emergency delivery room with a minimum of 300 square feet (27.87 sq. m). Each room shall have at least two oxygen and two wall-mount suction

outlets. Hospitals must equip a labor room with the same equipment as a delivery room if it is to be used as a delivery room. Each labor room shall contain a handwashing lavatory. Each labor room shall have access to a toilet room. One toilet room may serve two labor rooms. At least one shower shall be provided for labor room patients. A water closet shall be accessible to the shower without patients having to enter a corridor or general area.

~~g.~~ 7. The delivery room shall have a minimum clear area of 300 square feet (27.87 sq. m) exclusive of fixed and movable cabinets and shelves. The minimum dimensions shall be 16'0" (4.88 m) in any direction between two walls. Separate resuscitation facilities (electrical outlets, oxygen, suction, and compressed air) shall be provided for newborn infants.

~~h.~~ 8. The recovery room shall contain a minimum of two beds, charting facilities located to permit staff to have visual control of all beds, facilities for medicine dispensing, handwashing facilities, a clinical sink with a bedpan flushing device, and storage for supplies and equipment.

~~i.~~ 9. Hospitals that include birthing LDR/LDRP rooms in their obstetrical program shall designate room(s) within the labor suite for this purpose. Birthing LDR/LDRP rooms shall be designed to prohibit unrelated traffic through the labor and delivery suite and to be readily accessible to delivery rooms and operating rooms. Birthing LDR/LDRP rooms shall meet the requirements of labor rooms which may be used as emergency delivery rooms as specified in 12 VAC 5-410-830 D of this chapter. The minimum dimensions shall be 16'0" (4.88 m) clear between walls or fixed cabinets or shelving and shall have a clear area of 300 square feet (27.87 sq. m). Each LDR/LDRP room shall have a private water closet, shower, and handwashing lavatory.

~~j.~~ 10. When specified in this subsection, service areas shall be located in individual rooms. Alcoves or other open spaces that do not interfere with traffic may be used unless individual rooms are specified. Service areas, except the soiled workroom and the janitors' closet, may be shared within the obstetrical unit. If shared, service areas shall be arranged to avoid direct traffic between the delivery and operating rooms. The following service areas shall be provided:

- ~~(1)~~ a. A control station that is located to permit visual surveillance of all traffic that enters the labor and delivery suite;
- ~~(2)~~ b. A supervisor's office or station;
- ~~(3)~~ c. Sterilizing facilities with high speed autoclaves conveniently located to serve all delivery rooms. If provisions have been made for the replacement of sterile instruments during a delivery, sterilizing facilities will not be required;
- ~~(4)~~ d. A drug distribution station equipped for storage, preparation, and dispensing of medication;
- ~~(5)~~ e. At least two scrub stations located near the entrance to each delivery room. Two scrub stations may serve two delivery rooms if the stations are located adjacent to the entrance to each delivery room. Scrub

facilities shall be arranged to minimize any incidental splatter on nearby personnel or supply carts;

~~(6)~~ f. A soiled workroom for the exclusive use of the labor and delivery room personnel. The workroom shall contain a clinical sink or equivalent flushing type fixture, a work counter, a handwashing lavatory, a waste receptacle and a linen receptacle;

~~(7)~~ g. Fluid waste disposal facilities conveniently located to the delivery rooms. A clinical sink or equivalent equipment in a soiled workroom or soiled holding room may meet this requirement;

~~(8)~~ h. A clean workroom that contains a work counter, handwashing lavatory, and space for clean and sterile supplies;

~~(9)~~ i. Anesthesia storage facilities. Unless official hospital board action, in writing, prohibits use of flammable anesthetics, a separate room shall be provided for storage of flammable gases in accordance with the requirements detailed in NFPA 99 and NFPA 70;

~~(10)~~ j. An anesthesia workroom for cleaning, testing, and storing anesthesia equipment. The workroom shall contain a work counter and sink;

~~(11)~~ k. A space for reserve storage of nitrous oxide and oxygen cylinders;

~~(12) Equipment~~ l. Storage rooms for equipment and supplies used in the labor and delivery suite;

~~(13) m.~~ Staff's clothing change areas. ~~Clothing change areas shall be provided~~ for personnel working within the labor and delivery suite. The areas shall contain lockers, showers, toilets, handwashing lavatories, and space for donning scrub suits and boots;

~~(14) n.~~ Lounge and toilet facilities for obstetrical staff. ~~A nurses' toilet room shall be provided near the labor rooms and recovery room(s);~~

~~(15) o.~~ A janitors' closet. ~~A closet containing a floor receptor or service sink and storage for housekeeping supplies and equipment shall be provided for the labor and delivery suite to.~~ *The closet may be shared only with the newborn services unit; and*

~~(16) p.~~ A stretcher storage area. ~~This area shall be that is out of direct line of traffic.~~

~~6.~~ C. Equipment requirements- *shall include:*

- ~~a.~~ 1. Delivery rooms, LDR/LDRP rooms, and nurseries shall be equipped to provide emergency resuscitation for mothers and infants.
- ~~b.~~ 2. Equipment and supplies shall be assigned for exclusive use in the obstetric and newborn units.
- ~~c.~~ 3. The same equipment and supplies required for the labor room and delivery room shall be available for use in the LDR/LDRP rooms during periods of labor, delivery, and recovery.

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d. 4. Sterilizing equipment shall be available in the obstetric unit or in a central sterilizing department. Flash sterilizing equipment or sterile supplies and instruments shall be provided in the obstetric unit.

e. 5. Daily monitoring is required of the stock of necessary equipment in the labor, delivery, and recovery rooms (LDR) and labor, delivery, recovery and postpartum (LDRP) rooms and nursery.

f. 6. The hospital shall provide the following equipment in the labor, delivery and recovery rooms and, except where noted, in the LDR/LDRP rooms:

(1) a. Labor rooms.

- (a) (1) A labor or birthing bed with adjustable side rails
- (b) (2) Adjustable lighting adequate for the examination of patients
- (c) (3) An emergency signal and intercommunication system
- (d) (4) A sphygmomanometer, stethoscope and fetoscope or doppler
- (e) (5) Fetal monitoring equipment with internal and external attachments
- (f) (6) Mechanical infusion equipment
- (g) (7) Wall-mounted oxygen and suction outlets
- (h) (8) Storage equipment
- (i) (9) Sterile equipment for emergency delivery to include at least one clamp and suction bulb-
- (j) (10) Neonatal resuscitation cart.

(2) b. Delivery rooms.

- (a) (1) A delivery room table that allows variation in positions for delivery. This equipment is not required for the LDR/LDRP rooms
- (b) (2) Adequate lighting for vaginal deliveries or cesarean deliveries
- (c) (3) Sterile instruments, equipment, and supplies to include sterile uterine packs for vaginal deliveries or cesarean deliveries, episiotomies or laceration repairs, postpartum sterilizations and cesarean hysterectomies
- (d) (4) Continuous in-wall oxygen source and suction outlets for both mother and infant
- (e) (5) Equipment for inhalation and regional anesthesia. This equipment is not required for LDR/LDRP rooms
- (f) (6) A heated, temperature-controlled infant examination and resuscitation unit
- (g) (7) An emergency call system
- (h) (8) Plastic pharyngeal airways (~~adult and newborn size~~), *adult and newborn sizes*

(i) (9) Laryngoscope and endotracheal tubes (~~adult and newborn size~~), *adult and newborn sizes*

(j) (10) A self-inflating bag with manometer and adult and newborn masks that can deliver 100% oxygen

(k) (11) Separate cardiopulmonary crash carts for mothers and infants

(l) (12) Sphygmomanometer

(m) (13) Cardiac monitor. This equipment is not required for the LDR/LDRP rooms

(n) (14) Gavage tubes

(o) (15) Umbilical vessel catheterization trays. This equipment is not required for LDR/LDRP rooms

(p) (16) Equipment that provides a source of continuous suction for aspiration of the pharynx and stomach

(q) (17) Stethoscope

(r) (18) Fetoscope

(s) (19) Intravenous solutions and equipment

(t) (20) Wall clock with a second hand

(u) (21) Heated bassinets equipped with oxygen and transport incubator

(v) (22) Neonatal resuscitation cart

(3) c. Recovery rooms.

(a) (1) Beds with side rails

(b) (2) Adequate lighting

(c) (3) Bedside stands, overbed tables, or fixed shelving

(d) (4) An emergency call signal

(e) (5) Equipment necessary for a complete physical examination

(f) (6) Accessible oxygen and suction equipment

**D. 12 VAC 5-410-443. Newborn service requirements are as follows: ; designation of newborn service levels, service levels.**

~~1. Designation of newborn service levels.~~

a. A. If a hospital intends to provide newborn services, it shall make application to the department requesting approval for a level of newborn service as specified in ~~subdivision 2 of this subsection B of this section~~. Application shall be made at least 60 days prior to the desired date of approval. Approval is required to be renewed annually. Newborn service level approval shall be based upon the hospital's certification and the department's verification that the hospital meets the requirements of this ~~chapter section~~ for the level requested.

b. 1. No approval for a general level newborn service designation will be granted without a Certificate of Public Need (COPN) or without documentation by the applicant that it provided general level newborn services prior to July

1, 1992, or that the provision of general level newborn services was found to be exempt from Certificate of Public Need review pursuant to § 32.1-102.11 of the Code of Virginia.

2. No approval for a newborn service level designation higher than general level will be granted without a Certificate of Public Need or without documentation by the applicant that it provided a newborn service level higher than general level prior to July 1, 1992, or that the provision of a newborn service level higher than general level was found to be exempt from Certificate of Public Need review pursuant to § 32.1-102.11 of the Code of Virginia.

## 2. Service levels.

a. B. A hospital's newborn service shall be designated as a general level, intermediate level, specialty level, or subspecialty level newborn service. The newborn service levels are designated as follows:

(1) 1. A general level newborn service shall provide care to newborns of low risk as specified within the service's medical protocol. A general level newborn nursery shall have the capability to care for newborns who weigh at least 2000 grams at birth or who have completed 34 weeks gestation. Risk assessment shall be provided to identify all high-risk neonates and ensure appropriate consultation. A general level newborn nursery shall have the equipment and staff capabilities to immediately stabilize a sick newborn prior to transporting the newborn to an appropriate higher level nursery. The equipment and staff to receive convalescing neonates from higher level nurseries shall also be provided.

(2) 2. An intermediate level newborn service shall provide care as specified within the service's medical protocol to moderately ill neonates or stable-growing low birthweight neonates who require only a weight increase to be ready for discharge. In addition to the capabilities required of the general level newborn nursery, the intermediate level nursery shall have the equipment and staff capabilities to provide controlled temperature environments for each neonate, the insertion and maintenance of umbilical arterial lines, hood oxygen to 40%, continuous monitoring of blood oxygen, and assisted ventilation of a neonate in preparation for transport utilizing a mechanical ventilator or an ambu bag.

(3) 3. A specialty level newborn service shall provide intensive care to high-risk neonates with neonatal illnesses as specified in the service's medical protocol. In addition to the capabilities required of the lower level nurseries, the specialty level nursery shall have the equipment and staff capabilities to provide the following: maintenance of central arterial umbilical catheters or peripheral arterial lines with constant pressure monitoring, insertion and maintenance of chest tubes for drainage, administration of total parenteral nutrition (TPN), the maintenance of pressor medications, the administration of surfactant and respiratory support to include the maintenance of hood oxygen, continuous positive airway pressure (CPAP), and neonatal mechanical ventilation beyond the immediate stabilization period.

(4) 4. A subspecialty level newborn service shall provide intensive care for high-risk, critically ill neonates with complex neonatal illnesses. The subspecialty level newborn service shall provide, in-house, a full range of pediatric medical and surgical subspecialists to care for critically ill neonates. The pediatric subspecialists required as members of the hospital's staff are those subspecialists required of a Subspecialty Perinatal Center as referenced within the 1993 edition of *Toward Improving the Outcome of Pregnancy*, March of Dimes Birth Defects Foundation, Appendix 6, Pages 114 and 115. Rarely, the availability of highly technical expertise and specialized physicians at another subspecialty center will indicate consultation and possibly transfer. The subspecialty level nursery shall have the capability to care for neonates born in its facility as well as those referred from lower level nurseries. The subspecialty level nursery shall have all of the technical capabilities required of the lower level nurseries as well as the equipment and staff capabilities to maintain a neonate on prostaglandin E1 (PgE1) and the ability to perform echocardiography evaluations.

b. C. The hospital shall establish a written medical protocol, approved by the governing body, that specifies all neonatal conditions routinely managed by the newborn service as well as protocols for those medical conditions which require consultation and may necessitate transfer to a higher level of newborn service.

c. D. Physician consultation shall occur between physicians at the birth hospital and at the referral hospital to which the newborn may be referred.

d. E. The physician at the birth hospital shall document in the newborn's medical record any physician's consultation and any agreement to manage the newborn at the birth hospital or to stabilize and then transfer the newborn according to the hospital's collaboration agreement. In the event of disagreement, the attending physician at the birth hospital shall be responsible for the management and care of the newborn and shall document the consultation and results of consultation in the newborn's medical record.

## **3. 12 VAC 5-410-444. Newborn service medical direction; physician consultation and coverage; nursing direction, nurse staffing and coverage; policies and procedures.**

a. A. The governing body shall appoint a physician as medical director of the organized newborn service who meets the qualifications specified in the medical staff bylaws. In addition, the medical director must meet the qualifications specified in ~~this chapter~~ for the medical direction of the highest level of newborn service provided by the hospital.

b. 1. If a hospital offers only general level newborn services, the medical director shall be a physician qualified to provide normal newborn care, including the ability to immediately resuscitate and stabilize a sick newborn for transfer to a higher level of service.

c. 2. If a hospital offers intermediate level newborn services, the medical director shall be a board-certified or board-eligible pediatrician with training and experience in the care of preterm neonates, including stabilization and ventilation management.

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d. 3. If a hospital offers specialty level newborn services, the medical director shall be a board-certified or board-eligible neonatologist.

e. 4. If a hospital offers subspecialty level newborn services, the medical director shall be a board-certified or board-eligible neonatologist.

f. B. The duties and responsibilities of the medical directors of all levels of newborn service shall include, but not be limited to the:

~~(1)~~ 1. General supervision of the quality of care provided patients admitted to the service;

~~(2)~~ 2. Establishment of criteria for admission to the service;

~~(3)~~ 3. Adherence of the service to standards of professional practices, policies and procedures, the medical protocol, and the hospital's collaboration agreements adopted by the medical staff and governing body applicable to the service;

~~(4)~~ 4. Development of recommendations to the medical staff on standards of professional practice and staff privileges applicable to the service;

~~(5)~~ 5. Identification of clinical conditions and medical and surgical procedures that require physician consultation;

~~(6)~~ 6. Conducting conferences, at least quarterly, to review routine and emergency surgical procedures, complications and infant and maternal mortality and morbidity. Infant mortality and morbidity shall be discussed with the obstetric service staff; and

~~(7)~~ 7. Active participation in the service's quality assurance program.

#### ~~4. Physician consultation and coverage.~~

a. C. The hospital shall provide the following physician consultation and coverage in the general level newborn nursery service and all higher level nursery services unless unique requirements are specifically imposed ~~within this chapter~~ for the higher level nursery services:

~~(1)~~ D. A physician with pediatric privileges capable of arriving on-site within 30 minutes of notification shall be on the 24-hour on-call duty roster;

~~(2)~~ E. A physician or nurse skilled in neonatal cardiopulmonary resuscitation (CPR) shall be available in the hospital at all times .

~~(3)~~ F. A current roster of physicians, with a delineation of their newborn, pediatric, medical and surgical privileges shall be posted at each nurses' station in the newborn service unit.

~~(4)~~ G. A copy of the 24-hour on-call duty schedule, including a list of on-call consulting physicians, shall be posted at each nurses' station in the newborn service unit.

~~(5)~~ H. If the medical director is not a board-certified or board-eligible pediatrician, the hospital shall have a written agreement with one or more board-certified or board-eligible pediatricians to be available to provide consultation on a 24-hour basis. Consultation may be by telephone.

~~(6)~~ I. If a hospital does not have a neonatologist on staff who is available on a 24-hour basis, it shall have a written agreement with another hospital to provide consultation, at least by telephone, on a 24-hour basis, by a board-certified or board-eligible neonatologist. The consultant shall be available to advise on the development of a protocol for the care and transport of sick newborns.

b. J. The physician consultation and coverage for the intermediate level newborn nursery service shall be the same as the general level newborn service with the following ~~exception~~ exceptions:

~~(1)~~ 1. Subdivision 4 a ~~(1)~~ of this subsection C 1 of this section shall not apply.

~~(2)~~ 2. Physician coverage shall be provided on a 24-hour on-call basis by a board-certified or board-eligible pediatrician or pediatricians capable of arriving on-site within 30 minutes of notification.

e. K. The physician consultation and coverage for the specialty level and the subspecialty level newborn services shall be the same as for the lower level newborn services with the following exceptions:

~~(1)~~ 1. Subdivision 4 a ~~(1)~~ of this subsection C 1 of this section shall not apply.

~~(2)~~ 2. In-house physician consultation and coverage shall be provided 24 hours a day by a:

~~(i)~~ a. a Board-certified or board-eligible neonatologist; ~~or~~

~~(ii)~~ b. a Board-certified or board-eligible pediatrician; ~~or~~

~~(iii)~~ c. a Second year or higher level pediatric resident; or

~~(iv)~~ d. a Neonatal nurse practitioner.

~~(3)~~ 3. Whenever in-house coverage is provided as stated in ~~clause ii, iii, or iv of subdivision above (2) 2 b, c, or d of this subsection~~, a board-certified or board-eligible neonatologist shall be on-call and available to be on-site within 20 minutes of request.

#### ~~3. Nursing direction, staff and coverage.~~

a. L. The nursing direction, staff and coverage required for the general level newborn service shall be as follows:

~~(1)~~ 1. The neonatal nursing program shall be under the direction of a registered nurse.

~~(2)~~ 2. The nursing director's responsibilities shall include, but not be limited to:

~~(a)~~ a. Directing neonatal nursing services;

~~(b)~~ b. Guiding the development and implementation of neonatal nursing policies and procedures;

~~(c)~~ c. Collaborating with the medical staff; and

~~(d)~~ d. Consulting with referral hospitals with which a hospital has transfer agreements applicable to the service or services.

~~(3)~~ 3. Each occupied unit of the newborn service shall be under the direct supervision of a registered nurse 24 hours

a day. The registered nurse shall have documented competence in neonatal nursing appropriate to the level of service provided.

~~(4)~~ 4. If a general level newborn nursery is organized as a separate nursing unit, staffing shall be based on a formula of a minimum of one nursing personnel to every eight newborns. Staffing shall include at least one registered nurse for the unit for each duty shift to provide direct supervision for nursing care.

~~(5)~~ 5. If the postpartum and general level newborn units are organized as combined rooming-in or modified rooming-in units, staffing shall be based on a formula of one nursing personnel for every four mother-baby units. The rooming-in units shall always be staffed with no less than two nursing personnel assigned to each shift. One of the two nursing personnel shall be a registered nurse to provide direct supervision of nursing care.

~~(6)~~ 6. When infants are present in the nursery, at least one nursing personnel trained in the care of newborn infants, with duties restricted to the care of the infants, shall be assigned to the nursery at all times. This nursing personnel is in addition to the registered nurse who is required to provide supervision.

~~(7)~~ 7. To ensure adequate nursing staff for the nursery for normal newborns, duty schedules shall be developed and actual shift staffing shall occur according to the following minimum nurse to patient ratios:

~~(a)~~ a. 1:4 Recently born infants and those needing close observation

~~(b)~~ b. 1:8 Newborns needing only routine care

~~(c)~~ c. 1:4 Mother-newborn routine care

~~(8)~~ 8. Student nurses, licensed practical nurses and nursing aides who assist in the nursing care of newborn infants shall be under the direct supervision of a registered nurse.

~~(9)~~ 9. At least one nurse on each shift who is skilled in neonatal cardiopulmonary resuscitation must be immediately available to the nursery.

~~(10)~~ 10. All nursing personnel assigned to the newborn service shall have orientation to the nursery which includes, including orientation to patient care appropriate for the service level provided.

~~b.~~ M. The nursing direction, staff and coverage required of the intermediate level newborn service shall be the same as required of the general level newborn service with the following exceptions:

~~(1)~~ 1. To ensure adequate nursing staff for the nursery, duty schedules shall be developed and actual shift staffing shall occur according to a ratio of at least one nurse to four neonates.

~~(2)~~ 2. All registered nurses assigned to the newborn service shall be trained in neonatal cardiopulmonary resuscitation (CPR).

~~e.~~ N. The nursing direction, staff and coverage for the specialty level newborn service shall be the same as the lower level newborn service levels with the following exceptions:

~~(1)~~ 1. The newborn nursery service shall have a nurse manager. The nurse manager shall be a registered nurse with advanced training and experience in the nursing management of high-risk neonates and their families. The responsibilities of the nurse manager shall include, but not be limited to:

~~(a)~~ a. Daily management of the nursery;

~~(b)~~ b. Supervision and evaluation of nursing personnel assigned to the nursery;

~~(c)~~ c. Assuring nursing coverage 24 hours a day; and

~~(d)~~ d. Implementing nursing policies and procedures at the service level.

~~(2)~~ 2. All registered nurses shall have advanced training and experience in the management of neonatal patients, including specialized care technology and ventilator care for neonates. Only registered nurses with this advanced training and experience shall be assigned to care for neonates on ventilators.

~~(3)~~ 3. To ensure adequate nursing staff for the nursery, duty schedules shall be developed and actual shift staffing shall occur according to a ratio of at least one nurse to three patients for neonates requiring specialty level care. For those neonates who have been assessed as no longer needing specialty level care, nurse to patient ratios shall be according to the neonate's appropriate level of service.

~~e.~~ O. The nursing direction, staff and coverage for the subspecialty level newborn service shall be the same as all lower levels of newborn services with the following exceptions:

~~(1)~~ 1. A neonatal clinical nurse specialist shall be assigned to the nursery, duties and responsibilities shall include staff consultation, collaboration, and teaching.

~~(2)~~ 2. All registered nurses shall have advanced training and experience, beyond what is required of nurses in the lower level nurseries, in the management of high-risk neonates, including the care of unstable neonates with multisystem problems.

~~(3)~~ 3. To ensure adequate nursing staff for the nursery, duty schedules shall be developed and actual shift staffing shall occur according to the following minimum nurse to patient ratios for neonates requiring subspecialty level care:

~~(a)~~ a. 1:2 Neonates requiring subspecialty level care; and

~~(b)~~ b. 1:1 Neonates requiring multisystem support.

For those neonates who have been assessed as no longer needing subspecialty level care, nurse to patient ratios shall be according to the neonate's appropriate level of service.

~~(4)~~ 4. All nursing patient care shall be provided by registered nurses assigned to the subspecialty level nursery.

~~6. Policies and procedures.~~

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a- P. The governing body shall adopt written policies and procedures approved by the medical and nursing staff of the service, for the medical care of newborns

b- Q. The policies and procedures for the general level nursery and all higher levels of newborn services shall include, but not be limited to:

(1) 1. Medical criteria for the identification of high-risk neonatal patients.

(2) 2. Protocols for the management of all neonatal medical conditions that are routinely managed by the service as well as protocols for the stabilization and transfer of neonates that require a higher level of newborn service. These protocols shall be maintained in the nursery in addition to the telephone numbers of each nursery and the names of each referral newborn service medical director.

~~(3) Hospital~~ 3. Written collaboration agreements with other hospitals that provide with higher levels of newborn services not available in the referring hospital. A hospital may enter into more than one collaboration agreement. The collaboration agreements shall specifically identify those medical conditions which that require consultation and may necessitate a neonatal transfer as well as the interim treatment required prior to transfer. Nothing in the regulation shall require a birth hospital to enter into a collaboration agreement with a referral hospital that disagrees with the medical, consultation and transfer protocols adopted by the birth hospital. All neonatal transfers shall conform with Section 1867 of the Social Security Act, its amendments in force to date and implementing regulations. At the time of any transfer, the medical treatment at the referral hospital shall outweigh the risks to the neonate from effecting affecting the transfer. The collaboration agreements shall include, but not be limited to:

- (a) a. Criteria for neonatal transfer to the referral nursery;
- (b) b. Procedures for neonatal transport;
- (c) c. Back transfer criteria which provides for the return of the neonate to the referring hospital when medically appropriate;
- (d) d. Annual review by both parties of all cases of neonatal transfer;
- (e) e. Annual review by both parties of the collaboration agreements; and
- (f) f. Annual evaluation by both parties of the collaboration agreement and modification of the agreement, as necessary, as indicated by the evaluation results.

(4) 4. Establishment and maintenance of an ongoing, documented quality assurance program by the service which that utilizes a multidisciplinary team of health practitioners and administrators for review and is integrated with the hospital's overall quality assurance program.

- (a) a. The quality assurance program shall include:
  - (i) (1) Problem identification;
  - (ii) (2) Action plans;

(iii) (3) Evaluation; and

(iv) (4) Follow-up.

(b) b. The quality assurance program shall include an annual review of the following:

- (i) (1) Neonatal transfer cases;
- (ii) (2) Management of in-house neonatal cases; and
- (iii) (3) Staff in-house inservice programs.

(c) c. Outcome statistics, including morbidity, mortality, and the appropriateness of neonatal transfers, shall be compiled in a standardized manner and reviewed quarterly by a multidisciplinary committee.

(5) 5. Immediate resuscitation and stabilization of the sick neonate in accordance with current cardiopulmonary resuscitation (CPR) standards of the American Heart Association and the American Academy of Pediatrics.

(6) 6. Care of newborns after delivery to include the following:

- (a) a. Care of eyes, skin and umbilical cord and the provision of a single parenteral dose of Vitamin K-1, water soluble, as a prophylaxis against hemorrhagic disorder;
- (b) b. Maintenance of the newborn's airway, respiration, and body temperature; and
- (c) c. Assessment of the newborn and recording of the one-minute and five-minute Apgar scores.

(7) 7. Performance of prophylaxis against ophthalmia neonatorum by the administration of a 1.0% solution of silver nitrate aqueous solution, erythromycin, or tetracycline ointment or solution. This process is to be performed within one hour of delivery with documentation entered in the newborn's medical record. The process may be performed in the nursery.

(8) 8. Clamping or tying of the umbilical cord and, when indicated, collecting a sample of cord blood.

(9) 9. Performance of Rh type and Coombs' test for every newborn born to a Rh negative mother and performing major blood grouping and Coombs' tests when indicated for every newborn born to an O blood group mother or a mother with a family history of blood incompatibility. If such qualitative tests are performed, the results shall be documented in the newborn's medical record.

(10) 10. Identification and treatment of hyperbilirubinemia and hypoglycemia.

(11) 11. Identification of each newborn, prior to leaving the delivery room, with two identification bands fastened on the newborn and one identification band fastened on the mother. The newborn's medical record shall accompany the infant from the delivery room.

(12) 12. Newborn transport, within the hospital, of all newborns who are either premature or compromised by using a heated bassinet equipped with oxygen, a transport incubator or other similar equipment.

~~(13)~~ 13. Registered nurse or physician assessment of a newborn within one hour after delivery and documentation of the assessment in the newborn's medical record. Assessment in the delivery area is permitted if the hospital permits a newborn and its mother to remain together during the immediate post-delivery period.

~~(14)~~ 14. Delineation of how infants are to be monitored during stays with their mothers and under what circumstances infants must be taken to the nursery immediately after delivery and not allowed to remain with their mothers.

~~(15)~~ 15. Physician examination of the newborn consistent with guidelines of the American Academy of Pediatrics. A high-risk newborn shall be examined upon admission to the nursery.

~~(16)~~ 16. Ensuring that every bassinet and incubator in the nursery bears the identification of the newborn's last name, sex, date and time of birth, the mother's last name, and the attending physician's name.

~~(17)~~ 17. The management of mothers who utilize breast milk with their newborns. Breast milk shall be collected in ~~sterile aseptic~~ containers, dated, stored under refrigeration and consumed or disposed of within ~~24 48~~ hours of collection if the breast milk has not been frozen. This policy pertains to breast milk collected while in the hospital or at home for hospital use.

~~(18)~~ 18. Preparation and use of formula including, but not limited to:

~~(a)~~ a. The distribution of feeding units immediately after assembly;

~~(b)~~ b. The use of prepared formula only within the time period designated on the package; and

~~(c)~~ c. The use of presterilized formula only, except in the case of facility-defined emergencies.

~~(19)~~ 19. Screening newborns for risk factors associated with hearing impairment as required in §§ 32.1-64.1 and 32.1-64.2 of the Code of Virginia and in accordance with the regulations of the Board of Health governing the Virginia Hearing Impairment Identification and Monitoring System (12 VAC 5-80-~~40 et seq.~~).

~~(20)~~ 20. Screening and treatment of genetic, metabolic, and other diseases identifiable in the newborn period as specified in § 32.1-65 of the Code of Virginia and in accordance with the Regulations Governing the Newborn Screening and Treatment Program (12 VAC 5-70-~~40 et seq.~~).

~~(21)~~ 21. Reporting to the Department of Health all required reportable congenital defects.

~~(22)~~ 22. Visitor contact with the newborn, including newborns delivered by cesarean section, and premature, sick, congenitally malformed, and dying newborns.

~~(23)~~ 23. Completion of birth certificates.

~~(24)~~ 24. Discharge planning appropriate for the needs of the patient for at-risk infants. The Virginia High Priority Infant

Tracking Program Enrollment Form should be used as part of the discharge planning.

~~e.~~ R. The additional policies and procedures required for the intermediate level newborn service shall include, but not be limited to:

~~(1)~~ 1. Insertion and maintenance of peripheral intravenous lines and use of pediatric infusion pumps that are accurate to plus or minus one milliliter an hour;

~~(2)~~ 2. Insertion and maintenance of umbilical arterial lines and the use of pediatric infusion pumps accurate to plus or minus one milliliter an hour;

~~(3)~~ 3. Use of heated, humidified, and blended supplemental oxygen by hood with a recording of oxygen levels every hour using a calibrated constant oxygen analyzer. The policy shall address consultation with a higher level nursery identified in the collaboration agreement when oxygen levels exceed 40% and remain at 40% or greater for a period of four hours or more;

~~(4)~~ 4. Administration of nasogastric or orogastric feedings;

~~(5)~~ 5. Use of saturation monitor (pulse oximeter or equivalent) for any newborn requiring supplemental oxygen;

~~(6)~~ 6. Use of assisted ventilation in preparation for transport;

~~(7)~~ 7. Initiation of PgE1 prior to transport; and

~~(8)~~ 8. Administration of blood components and a policy for provision of partial and total exchange transfusions.

~~e.~~ S. The additional policies and procedures required for the specialty level newborn service shall include, but not be limited to:

~~(1)~~ 1. Provision of ongoing assisted ventilation;

~~(2)~~ 2. Administration of surfactant;

~~(3)~~ 3. Preparation and administration of total parenteral nutrition (TPN);

~~(4)~~ 4. Initiation and maintenance of pressor medications;

~~(5)~~ 5. Provision for developmental follow up;

~~(6)~~ 6. Insertion and maintenance of central umbilical arterial catheters or peripheral arterial lines with constant pressure monitoring;

~~(7)~~ 7. Placement of chest tubes with water seal on an emergency basis;

~~(8)~~ 8. Use of heated, humidified, and blended supplemental oxygen by hood with a recording of oxygen levels every hour using a calibrated constant oxygen analyzer;

~~(9)~~ 9. Administration and maintenance of CPAP including the requirement for in-house physician coverage;

~~(10)~~ 10. Daily availability of appropriate drug peak and trough assays on one milliliter or less of blood;

~~(11)~~ 11. Cardioversion capability specific for newborns; and

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(12) 12. Provision for ophthalmology consult and requirements regarding the examination of high-risk newborns.

e- 7. The additional policies and procedures required for the subspecialty level newborn service shall include, but not be limited to:

- (1) 1. Provision for returning patients to the operating room within 30 minutes, if indicated;
- (2) 2. Provision for echocardiography evaluation;
- (3) 3. Provision for patient treatment on an extracorporeal membrane oxygenator (ECMO) or a written collaboration agreement with a hospital with this capability;
- (4) 4. Provision for maintenance of central venous pressure monitoring; and
- (5) 5. Provision for the maintenance of neonates on prostaglandin E1 (PGE1).

**7. 12 VAC 5-410-445. Newborn service design and equipment criteria.**

A. In addition to complying with 12 VAC 5-410-430 and 12 VAC 5-410-790, a hospital shall comply with the following physical design criteria for its newborn services:

a- 1. The *general level nursery* design criteria ~~required for the general level nursery~~ are:

(1) a. The newborn nursery shall be located adjacent to the obstetric nursing unit. The nursery must have adequate lighting and ventilation and be equipped to prevent direct drafts on infants. The temperature and humidity in the nursery shall be maintained at a level best suited for the protection of newborns as determined by the medical and nursing staff of the newborn service and as recommended by the American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) in the most current edition of Guidelines for Perinatal Care.

(2) b. The nursery shall be designed to preclude unrelated traffic. Connecting nurseries shall have the capability to close the doors for infection control purposes.

(3) c. Each nursery shall contain the following:

(a) (1) One handwashing lavatory for every eight bassinets. Lavatories shall be equipped with wrist, knee or foot controls, soap dispenser and paper towel dispenser;

(b) (2) A nurses' emergency calling system that meets the requirements of 12 VAC 5-410-1130 D of ~~this chapter~~; and

(c) (3) Glazed observation windows to permit infants to be viewed from public areas, from workrooms, and between adjacent nurseries.

(4) d. There shall be a minimum of 24 square feet of floor area for each bassinet, exclusive of nonpatient areas, and

a minimum of three feet (91 cm) between bassinets in the newborn nursery.

(5) e. Each nursery shall contain no more than 16 infant stations in open bassinets, self-contained incubators, open radiant heat infant care systems, or combination thereof. When a rooming-in program is used, the total number of bassinets provided in the general level nursery may be appropriately reduced but the nursery may not be omitted. A hospital designed for 16 infant stations or less shall provide two rooms with eight infant stations so that a room is available to permit cohorting in the case of infection.

(6) f. A special care area for infants requiring close observation or stabilization, such as those with low birth weight, is required in hospitals having 25 or more postpartum beds that do not have higher level nurseries. The minimum floor area for each infant station shall be 40 square feet (3.72 sq. m).

(7) g. Each nursery shall be served by a connecting workroom. The workroom shall contain gowning facilities at the entrance for staff and personnel, work space with counter, refrigerator, storage space and handwashing lavatory which meets the requirements of 12 VAC 5-410-1090. One workroom may serve more than one nursery.

(8) h. The examination and treatment room shall contain a work counter, storage, handwashing lavatory and charting facilities. This may be part of the workroom.

(9) i. A closet for the use of the housekeeping staff in maintaining the nurseries shall be provided. It shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(10) j. Lighting and wall finishes shall be sufficient to permit easy detection of jaundice and cyanosis. Shadow-free illumination with at least 100 foot candle intensity at the infant's level using fluorescent lamps with proper diffusers to prevent glare is required.

(11) k. All incubators and electrical appliances used in nurseries shall be free from electrical hazards and approved by Underwriters Laboratories.

(12) l. One grounded duplex electrical outlet shall be provided for every bassinet.

(13) m. Task illumination and selected electrical outlets shall be on the hospital's emergency electrical system. In new construction, one outlet for each bassinet shall be on the hospital's emergency electrical system. Emergency electrical outlets shall be clearly marked. Outlets shall be checked at least monthly for safety and grounding.

(14) n. An incubator shall be available and maintained for every 10, or fraction thereof, bassinets.

(15) o. Bassinets shall be equipped to allow for medical examinations of newborn infants and for storing necessary supplies and equipment. Bassinets shall be provided in a number to exceed obstetric beds by 25% at the minimum, to accommodate multiple births, extended stays, and fluctuating patient loads. Bassinets are to be

separated by a minimum of three feet measuring from the edge of one bassinet to the edge of the adjacent bassinet.

~~(16)~~ p. The hospital shall provide isolation facilities ~~which that~~ follow universal precautions in accordance with its approved policies and procedures and the most recent editions of the Guidelines for Perinatal Care (AAP/ACOG) and the Control of Communicable Diseases in Man (American Public Health Association).

~~b-~~ 2. The *intermediate level nursery* design criteria ~~required for the intermediate level nursery~~ are:

(1) a. There shall be efficient and controlled access to the nursery from the labor and delivery area, the emergency room or other referral entry areas. The nursery shall be designed to preclude unrelated traffic.

~~(2)~~ b. Lighting and wall finishes shall be sufficient to permit easy detection of jaundice and cyanosis. Shadow-free illumination with at least 100 foot candle intensity at the infant's level using fluorescent lamps with proper diffusers to prevent glare is required. The level of general lighting shall be adjustable to simulate day-night patterns and to satisfy diagnostic and procedural requirements.

~~(3)~~ c. The temperature, humidity, and ventilation in the nursery shall be maintained at levels best suited for the protection of newborns as determined by the medical and nursing staff of the newborn service and as recommended by the American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) in the most current edition of Guidelines for Perinatal Care. The nursery must be equipped to prevent direct drafts on neonates.

(4) d. Each nursery shall contain the following:

~~(a)~~ (1) One handwashing lavatory for at least every four patient stations. Lavatories shall be equipped with wrist, knee or foot controls, soap dispenser and paper towel dispenser; and

~~(b)~~ (2) A nurses' emergency calling system that meets the requirements of 12 VAC 5-410-1130.

~~(5)~~ e. Each nursery shall be served by a connecting workroom. The workroom shall contain gowning facilities at the entrance for staff and personnel, work space with counter, refrigerator, storage space and handwashing lavatory which meets the requirements of 12 VAC 5-410-1090 B of this chapter. One workroom may serve more than one nursery.

~~(6)~~ f. A closet for the use of the housekeeping staff in maintaining the nursery shall be provided. It shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.

~~(7)~~ g. All incubators and electrical appliances used in nurseries shall be free from electrical hazards and approved by Underwriters Laboratories.

~~(8)~~ h. Outlets shall be checked at least monthly for safety and grounding.

~~(9)~~ i. The hospital shall provide isolation facilities ~~which that~~ follow universal precautions in accordance with its approved policies and procedures and the most recent editions of the Guidelines for Perinatal Care (AAP/ACOG) and the Control of Communicable Diseases in Man (American Public Health Association). Connecting nurseries shall have the capability to close the doors for infection control purposes.

~~(10)~~ j. All electrical outlets shall be connected to both regular and auxiliary power.

~~(11)~~ k. An additional outlet wired to accommodate a portable x-ray machine shall be available in each nursery.

~~(12)~~ l. The minimum floor area for each infant station in a nursery constructed or renovated after August 10, 1995, shall be 50 square feet (4.66 sq m) with a minimum of four feet between infant stations and aisles at least five feet wide.

~~(13)~~ m. At least eight electrical outlets, two oxygen outlets, two compressed air outlets and two suction outlets shall be provided for each infant station.

~~e-~~ 3. The *specialty level and subspecialty level nurseries* design criteria ~~required for both specialty level and subspecialty level nurseries~~ are:

~~(1)~~ a. The requirement of ~~12 VAC 5-410-440 D 7 b (1-11) 12 VAC 5-410-445 A 2 a through k~~ shall apply;

~~(2)~~ b. Nurseries constructed or renovated after August 10, 1995, shall have a minimum floor area for each infant station of 80 square feet with at least six feet between incubators or overhead warmers, and aisles at least eight feet wide.

~~(3)~~ c. Each infant station shall have a least 12 electrical outlets, two oxygen outlets, two compressed air outlets and two suction outlets.

## ~~8. Equipment requirements.~~

~~a-~~ B. The hospital shall provide the following equipment in the general level nursery and all higher level nurseries, unless additional equipment requirements are imposed for the higher level nurseries:

~~(1)~~ 1. Resuscitation equipment as specified for the delivery room in ~~this chapter 12 VAC 5-410-442 C 6 b~~ shall be available in the nursery at all times;

~~(2)~~ 2. Equipment for the delivery of 100% oxygen concentration, properly heated, blended, and humidified, with the ability to measure oxygen delivery in fractional inspired concentration (FI02). The oxygen analyzer shall be calibrated every eight hours and serviced according to the manufacturer's recommendations by a member of the hospital's respiratory therapy department or other responsible personnel trained to perform the task;

~~(3)~~ 3. Saturation monitor (pulse oximeter or equivalent);

~~(4)~~ 4. Equipment for monitoring blood glucose;

~~(5)~~ 5. Infant scales;

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- ~~(6)~~ 6. Intravenous therapy equipment;
- ~~(7)~~ 7. Equipment and supplies for the insertion of umbilical arterial and venous catheters;
- ~~(8)~~ 8. Open bassinets, self-contained incubators, open radiant heat infant care system or any combination thereof appropriate to the service level;
- ~~(9)~~ 9. Equipment for stabilization of a sick infant prior to transfer that includes a radiant heat source capable of maintaining an infant's body temperature at 99°F;
- ~~(10)~~ 10. Equipment for insertion of a thoracotomy tube; and
- ~~(11)~~ 11. Equipment for proper administration and maintenance of phototherapy.

~~b.~~ C. The additional equipment required for the intermediate level newborn service and for any higher service level is:

- ~~(1)~~ 1. Pediatric infusion pumps accurate to plus or minus 1 milliliter (ml) per hour;
- ~~(2)~~ 2. On-site supply of PgE1;
- ~~(3)~~ 3. Equipment for 24-hour cardiorespiratory monitoring for neonatal use available for every incubator or radiant warmer;
- ~~(4)~~ 4. Saturation monitor (pulse oximeter or equivalent) available for every infant given supplemental oxygen;
- ~~(5)~~ 5. Portable x-ray machine; and
- ~~(6)~~ 6. If a mechanical ventilator is selected to provide assisted ventilation prior to transport, it shall be approved for the use of neonates.

~~c.~~ D. The additional equipment required for the specialty level newborn service and a higher newborn service is as follows:

- ~~(1)~~ 1. Equipment for 24-hour cardiorespiratory monitoring with central blood pressure capability for each neonate with an arterial line;
- ~~(2)~~ 2. Equipment necessary for ongoing assisted ventilation approved for neonatal use with on-line capabilities for monitoring airway pressure and ventilation performance;
- ~~(3)~~ 3. Equipment and supplies necessary for insertion and maintenance of chest tube for drainage;
- ~~(4)~~ 4. On-site supply of surfactant;
- ~~(5)~~ 5. Computed axial tomography equipment (CAT) or magnetic resonance imaging equipment (MRI);
- ~~(6)~~ 6. Equipment necessary for initiation and maintenance of continuous positive airway pressure (CPAP) with ability to constantly measure delineated pressures and including alarm for abnormal pressure (i.e., vent with PAP mode); and
- ~~(7)~~ 7. Cardioversion unit with appropriate neonatal paddles and ability to deliver appropriate small watt discharges.

~~d.~~ E. The hospital shall document that it has the appropriate equipment necessary for any of the neonatal surgical and special procedures it provides that are specified in its medical

protocol and that are required for the specialty level newborn service.

~~e.~~ F. The additional equipment requirements for the subspecialty level newborn service are:

- ~~(1)~~ 1. Equipment for emergency gastrointestinal, genitourinary, central nervous system, and sonographic studies available 24 hours a day;
- ~~(2)~~ 2. Pediatric cardiac catheterization equipment;
- ~~(3)~~ 3. Portable echocardiography equipment; and
- ~~(4)~~ 4. Computed axial tomography equipment (CAT) and magnetic resonance imaging equipment (MRI).

~~f.~~ G. The hospital shall document that it has the appropriate equipment necessary for any of the neonatal surgical and special procedures it provides that are specified in the medical protocol and are required for the subspecialty level newborn service.

## **9-12 VAC 5-410-446. Newborn support services and other resources.**

~~a.~~ A. The support services and other resources required for the general level newborn service and all higher levels of newborn services shall be as follows:

- ~~(1)~~ 1. Clinical laboratory services and blood bank services available in the hospital on a 24-hour basis. Laboratory and blood bank personnel available on-site or on-call on a 24-hour basis;
- ~~(2)~~ 2. Group O Rh negative blood available from the blood bank at all times and the blood bank's ability to provide correctly matched blood within 45 minutes of request;
- ~~(3)~~ 3. Hospital laboratory and blood bank personnel capability to perform the following tests with less than 1.0 ml of blood within one hour or less of request if specified: (i) blood group and Rh type determination/cross-matching, (ii) arterial blood gases within 20 minutes, (iii) blood glucose within 20 minutes, (iv) complete blood count, (v) total protein and albumin, (vi) total and direct bilirubin, (vii) direct Coombs' test, (viii) electrolytes, (ix) blood urea nitrogen, (x) clotting profile (may require more than one ml of blood); and
- ~~(4)~~ 4. Portable radiological services for basic radiologic studies in the nursery available on-call, within 30 minutes of request, on a 24-hour basis.

~~b.~~ B. The additional support services and resources required of the intermediate level newborn service shall be as follows:

- ~~(1)~~ 1. A respiratory therapist in-house 24 hours a day. The therapist shall have orientation to the neonatal nursery ~~which includes~~ , *including* orientation to the appropriate level of care. The therapist shall have documented competence in neonatal respiratory care;
- ~~(2)~~ 2. A radiology technician in-house 24 hours a day;
- ~~(3)~~ 3. An ultrasound technician available on-call 24 hours a day;
- ~~(4)~~ 4. A laboratory technician in-house 24 hours a day;

~~(5)~~ 5. A blood bank technician available on call within 30 minutes of request;

~~(6)~~ 6. A licensed physical therapist or certified occupational therapist available for consultation;

~~(7)~~ 7. A registered dietitian with documented competence in neonatal nutrition available for consultation;

~~(8)~~ 8. A biomedical technician, available to the nursery, responsible for the maintenance and safe functioning of specialized medical equipment;

~~(9)~~ 9. Microvolume assays for xanthines and aminoglycosides available within 12 hours of request;

~~(10)~~ 10. Blood gases to be performed on 0.25 ml or less heparinized blood within 20 minutes of request;

~~(11)~~ 11. Blood components available within two hours of request; and

~~(12)~~ 12. Portable chest x-ray within 20 minutes of request.

e. C. The specialty level support services and resources that are required in addition to the requirements for the lower level nurseries are as follows:

~~(1)~~ 1. A blood bank technician in-house 24 hours a day;

~~(2)~~ 2. A pharmacist with documented competence in neonatal pharmacology on staff;

~~(3)~~ 3. A licensed physical therapist or certified occupational therapist with documented competence in neonatal care;

~~(4)~~ 4. A medical social worker as a participating member of the service;

~~(5)~~ 5. An ultrasound technician on-call 24 hours a day; and

~~(6)~~ 6. A registered dietitian with documented competence in neonatal nutrition as a participating member of the service.

d. D. The subspecialty level support services and resources that are required in addition to the requirements of the lower level nurseries are as follows:

~~(1)~~ 1. A radiologist with documented competence in the interpretation of pediatric and neonatal films readily available for providing pediatric and neonatal x-ray procedures and ultrasound interpretation;

~~(2)~~ 2. A developmental pediatrician on staff;

~~(3)~~ 3. A cardiothoracic surgeon with documented competence in pediatric surgical procedures on staff and on-call 24 hours a day;

~~(4)~~ 4. A pediatric surgeon on staff and on-call 24 hours a day;

~~(5)~~ 5. An anesthesiologist with documented competence in neonatal anesthesiology on-call 24 hours a day;

~~(6)~~ 6. The following pediatric subspecialists on staff available to be on-site within 30 minutes of request 24 hours a day:

~~(a)~~ a. Cardiology;

~~(b)~~ b. Endocrinology;

~~(c)~~ c. Gastroenterology;

~~(d)~~ d. Genetics;

~~(e)~~ e. Hematology;

~~(f)~~ f. Immunology;

~~(g)~~ g. Infectious diseases;

~~(h)~~ h. Metabolism;

~~(i)~~ i. Nephrology;

~~(j)~~ j. Neurology;

~~(k)~~ k. Nutrition;

~~(l)~~ l. Pharmacology; and

~~(m)~~ m. Pulmonology;

~~(7)~~ 7. The following pediatric surgical subspecialists on staff available to be on-site within 30 minutes of request 24 hours a day:

~~(a)~~ a. Neurosurgeon;

~~(b)~~ b. Ophthalmologist;

~~(c)~~ c. Orthopedic surgeon;

~~(d)~~ d. Otolaryngologic surgeon; and

~~(e)~~ e. Urologic surgeon;

~~(8)~~ 8. An echocardiography technician on staff;

~~(9)~~ 9. An American College of Medical Genetics certified or eligible genetics counselor on staff;

~~(10)~~ 10. In-house 24-hour capability for microchemistries;

~~(11)~~ 11. Hospital resources to provide for the medical follow up of discharged, high-risk neonates that incorporate a parent education program that includes, but is not limited to, the following:

~~(a)~~ a. Pediatric cardiopulmonary resuscitation training;

~~(b)~~ b. Home cardiopulmonary monitoring;

~~(c)~~ c. Home oxygen monitoring; and

~~(d)~~ d. Lactation instruction;

~~(12)~~ 12. Hospital resources to provide comprehensive, neonatal continuing education to health professionals external to the hospital;

~~(13)~~ 13. A referral network for cardiovascular surgical consultation; and

~~(14)~~ 14. The operation of a neonatal transport system on a 24-hour basis. Transports shall be initiated within 30 minutes of request. The neonatal transport system shall operate in accordance with the most current editions of the Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients published by the American Academy of Pediatrics and the Neonatal Transport Standards and Guidelines published by the National Association of Neonatal Nurses.

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## **E. 12 VAC 5-410-447. Combined obstetric and clean gynecological service; infection control.**

A. A hospital may combine obstetric and clean gynecological services. The hospital shall define clean gynecological cases in written hospital policy. A combined obstetric and clean gynecologic service shall be organized under written policies and procedures. The policies and procedures shall be approved by the medical and nursing staff of these services and adopted by the governing body and shall include, but not limited to the following requirements:

1. Cesarean section and obstetrically related surgery, other than vaginal delivery, shall be carried out in designated operating or delivery rooms. Vaginal deliveries may be performed in designated delivery or operating rooms that are used solely for obstetric or clean gynecologic procedures.
  2. Clean gynecological cases may be admitted to the postpartum nursing unit of the obstetric service according to procedures determined by the obstetrics and gynecologic staff and the hospital's infection control committee.
  3. Only members of the medical staff with approved privileges shall admit and care for patients in the combined service area. These admissions shall be subject to the medical staff bylaws.
  4. Hospitals with a combined service shall limit admission to the service to those patients allowed by policies adopted by the obstetric and gynecological medical staff and the hospital's infection control committee.
  5. Unoccupied beds shall be reserved daily in a combined service ready for use by obstetric patients.
  6. Patients admitted to the combined service may be taken to radiology or other hospital departments for diagnostic procedures, before or after surgery, if it is not evident that these procedures may be hazardous to the patients or to other patients on the combined service.
  7. Patients may receive postpartum or immediate postoperative care in the general recovery room prior to being returned to the combined service area if the following conditions prevail:
    - a. The recovery room or intensive care unit is a separate unit adjacent to or part of the general surgical operating suite or delivery suite; *and*
    - b. The recovery room is under the direct supervision of the chairman of the anesthesiology department of the hospital.
- In separate obstetric recovery rooms, supervision shall be provided by the obstetrician in charge or by physicians approved by the medical staff of the combined service.
8. Nursing care of all patients shall be supervised by a registered nurse.
  9. Nursing care of both obstetrical and gynecological patients may be given by the same nursing personnel.

10. Visitor regulations applicable to visitors of obstetric patients shall also apply to visitors of other patients admitted to the combined service.

~~F. B.~~ In addition to the infection control requirements specified in 12 VAC 5-410-490 ~~of this chapter~~, the hospital's infection control committee, in cooperation with the obstetric and newborn medical and nursing staff, shall establish written policies and procedures for infection control within the obstetric and newborn services. The policies and procedures shall be adopted by the governing body and shall include, but not be limited to, the following:

1. The establishment of criteria for determining infection-related maternal and newborn morbidity;
2. Written criteria for the isolation or segregation of mothers and newborns, in accordance with Guidelines for Perinatal Care (American Academy of Pediatrics/American College of Obstetricians and Gynecologists) and Control of Communicable Diseases in Man (American Public Health Association) to include at least the following categories:
  - a. Birth prior to admission to the facility;
  - b. Birth within the facility but prior to admission to the labor and delivery area;
  - c. Readmission to the service after transfer or discharge;
  - d. Presence of infection;
  - e. Elevated temperature; and
  - f. Presence of rash, diarrhea, or discharging skin lesions;
3. Written policies and procedures for the isolation of patients in accordance with Guidelines for Perinatal Care (AAP/ACOG) and Control of Communicable Diseases in Man (American Public Health Association) including, but not limited to, the following:
  - a. Ensuring that a physician orders and documents in the patient's medical record the placement of a mother or newborn in isolation;
  - b. Ensuring that at least one labor room is available for use by a patient requiring isolation;
  - c. Provisions for the isolation of a mother and newborn together (rooming-in) or separately; and
  - d. Policies and procedures for assigning nursing personnel to care for patients in isolation;
4. Control of traffic, including personnel and visitors. Policies and procedures shall be established in the event that personnel from other services must work in the obstetric and newborn services or personnel from the obstetric and newborn services must work on other services. Appropriate clothing changes and handwashing shall be required of any individual prior to assuming temporary assignments or substitution from any other area or service in the hospital;
5. Determination of the health status of personnel, and control of personnel with symptoms of communicable infectious disease;

6. Review of cleaning procedures, agents, and schedules in use in the obstetric and newborn services. Incubators or bassinets shall be cleaned with detergent and disinfectant registered by the U.S. Environmental Protection Agency each time a newborn occupying it is discharged or at least every seven days;

7. Techniques of patient care, including handwashing and the use of protective clothing such as gowns, masks, and gloves; *and*

8. Infection control in the nursery, including, but not limited to, the following:

a. Closing of the nursery immediately in the event of an epidemic, as determined by the infection control director in consultation with the medical director and the Department of Health;

b. Assigning a newborn to a clean incubator or bassinet at least every seven days;

c. Using an impervious cover that completely covers the surface of the scale pan if newborns are weighed on a common scale, and changing the cover after each newborn is weighed;

d. Gowning in isolation cases; *and*

e. Requiring ~~that~~ nursery personnel wear clean scrub attire in the nursery when they are handling infants. Appropriate cover garments shall be worn over scrub attire when personnel are holding infants. Personnel shall wash their hands after contact with each patient and upon entering or leaving the nursery.

VA.R. Doc. No. R05-64; Filed November 8, 2004, 2:36 p.m.

## DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

**Title of Regulation:** 12 VAC 30-70. Methods and Standards for Establishing Payment Rates Inpatient Hospital Care (amending 12 VAC 30-70-331).

**Statutory Authority:** §§ 32.1-324 and 32.1-325 of the Code of Virginia.

**Public Hearing Date:** N/A -- Public comments may be submitted until January 28, 2005.

(See Calendar of Events section for additional information)

**Effective Date:** July 1, 2005.

**Agency Contact:** Victoria P. Simmons or Brian M. McCormick, Regulatory Coordinators, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-7959, FAX (804) 786-1680, or e-mail Vicki.simmons@dmas.virginia.gov or Brian.McCormick@dmas.virginia.gov.

**Basis:** Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia authorizes the Director of DMAS to administer and amend the Plan for

Medical Assistance according to the board's requirements. The Medicaid authority as established by § 1902 (a) of the Social Security Act [42 USC § 1396a] provides governing authority for payments for services.

**Purpose:** The purpose of the regulatory change is to set the private inpatient hospital adjustment factor at 0.75. This regulatory action is initiated at the direction of the Governor and General Assembly found in Item 326 XX of the 2004 Appropriation Act. This regulatory change is intended to increase inpatient hospital reimbursement to private (Type Two) hospitals in order to promote access to Medicaid services. Private (Type Two) hospitals have complained that the discount taken by the Medicaid program should be eliminated and costs should be reimbursed. This regulatory change lowers the discount taken, but does not eliminate the discount altogether.

**Rationale for Using Fast-Track Process:** This regulatory action will implement a more provider-favorable reimbursement policy than currently in place for private (Type Two) inpatient hospitals. Since this action will serve to increase reimbursements relative to the current rate methodology, objections by providers and their advocate groups are not anticipated. The agency is using the fast-track process in order to complete the needed regulatory changes far enough in advance of the 2006 rate year to provide predictability to the provider community and for state budget purposes.

**Substance:** 12 VAC 30-70-331 will be amended to eliminate the formula used to determine the adjustment factor, and to set the adjustment factor to 0.75. Under the current regulations, the adjustment factor for private (Type Two) hospitals is the ratio of Medicaid payments to Medicaid allowable costs in a determined base year. For the 2005 rate year, the calculated adjustment factor is approximately 0.72. Therefore, under the current formula, the Medicaid program has taken a 28% discount off of the providers' base year costs in determining the payment rates for the 2005 rate year. Under normal circumstances, the adjustment factor is calculated only in years for which the inpatient reimbursement system is rebased, which by regulation occurs at least every three years. When the system is not undergoing a rebasing, the adjustment factor remains at the level determined in the most recent rebasing, with hospital rates adjusted for inflation in the out years of a rebasing.

Setting the adjustment factor to 0.75 will eliminate any calculation of the adjustment factor and will reduce the discount taken to 25% (currently 28%). This change is being made to meet the directive of the Governor and General Assembly in the 2004 Appropriation Act. This change will be effective beginning with the 2006 rate year with the new adjustment factor applied to the current base year in use for the 2005 rates. The 2005 rates and DRG weights represent the first year of the most recent rebasing. DMAS is not rebasing the rates and weights again but rather is applying the new adjustment factor to the existing base year calculations. Under current regulations, DMAS is not required to rebase again until the 2008 rate year.

**Issues:** The primary advantage to this regulatory change will be increased reimbursements to private (Type Two) inpatient

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## Fast-Track Regulations

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hospitals for their Medicaid business. This should serve to maintain access to Medicaid services for the eligible population.

The primary disadvantage to the Commonwealth will be increased expenditures in the Medicaid program relative to the current methodology.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. Pursuant to Chapter 4, Item 326 XX of the 2004 Acts of the Assembly, the proposed change will set the adjustment factor used in the fee-for-service reimbursement methodology for private inpatient hospital services at 75% of base year costs.

Estimated economic impact. These regulations establish the reimbursement methodology for operating costs incurred by hospitals for providing Medicaid fee-for-service inpatient hospital services. The reimbursement rates are determined using data from a base year, which is the most recent year for which data is available to calculate rates for future years. Base rates are calculated for each hospital utilizing statewide average rates adjusted by the wage index to take into account hospital-specific labor cost differences. Then, the rate is adjusted by the application of an adjustment factor. The base rate is recalculated at least every three years using more recent data, a process generally referred to as rebasing. For the typical two years subsequent to a rebasing (and prior to the next rebasing), the base rate is adjusted for inflation according to regulations.

The proposed change will amend the adjustment factor used in the methodology. The adjustment factor is a tool used to artificially adjust reimbursement rates. It was first implemented in 1996 when the inpatient hospital methodology was revised. Prior to the 1996 revision, the rates were based on average/median costs and did not explicitly take into account the severity of the illness treated (although patient severity would have been inherent in the costs used to calculate the per diems). While the new methodology was being developed, an adjustment factor was made part of the methodology to ensure the budget neutrality of the methodology change. Effective July 1, 1996, the adjustment factor was 0.6247 meaning that the reimbursement rate was approximately 38% lower than the statewide average operating costs of serving Medicaid patients. Currently, the regulations define the adjustment factor as the ratio of total operating payments to total Medicaid allowable costs. The most recent adjustment factor is 0.7194, which was calculated

using cost report data for provider years ending in state fiscal year 2002 and would be effective for fiscal years 2005 – 2007.

Pursuant to the statutory changes, the proposed regulations will replace the calculation of the adjustment factor for private hospitals as the ratio of two numbers with an exact numerical figure of 0.75. The new adjustment factor will be effective on July 1, 2005. The last rebasing was done for rates effective July 1, 2004 (SFY 2005). DMAS has indicated that there are no plans to rebase the rates again until SFY 2008 (rates to be effective July 1, 2007), which corresponds to the regular three-year rebasing cycle. Thus, setting the adjustment factor to 0.75 will increase the base rates by approximately 4.26% for two years (FY 2006 and FY 2007).

The estimation of the likely effect beyond FY 2007 requires knowledge of what the adjustment factor would have been under the existing methodology for the rebasing scheduled for FY 2008. That, in turn, requires the data for reimbursements and operating costs for a more recent base year, which has not yet ended. Therefore, no data is currently available, nor will it be available in any time frame that would allow us to estimate the adjustment factor under the existing methodology for FY 2008 and beyond for this regulatory action.

The estimated fiscal effect of the 4.26% increase in the base payment rates to private hospitals is \$18.3 million annually for fiscal years 2006 and 2007 (including both the FFS and Managed Care program effects). One half of the increased reimbursement is going to come out of state funds and the other half through federal matching funds. These federal matching funds are additional money being injected into the state and are likely to produce benefits through the multiplier process.

The increased reimbursement rates will reduce private hospitals' average operating losses from serving Medicaid patients from 28% to 25% based on data from SFY 2002 cost reports. The effect of this increase in payments to hospitals on access to health care and on provision of services to Medicaid recipients is not expected to be significant. The hospitals' profit margin from serving Medicaid recipients is already in negative territory and the proposed increase will not change that. So, we will not see a swing from a negative profit margin to a positive profit margin, which would, in competitive markets, affect a firm's decision on whether to participate in the Medicaid program. However, because of certain institutional and regulatory arrangements, the hospital industry participating in the Medicaid program is far from competitive.

For example, hospitals are obligated to accept patients at the emergency rooms regardless of whether they participate in the Medicaid program. Instead of providing uncompensated care at emergency rooms for Medicaid patients, they are better off participating in the program and providing these services at a discount. Also, certificate of public need (COPN) requirements make entry into the inpatient hospital industry difficult, thus, providing an umbrella for incumbents against competition. Protected under the COPN, hospitals are able to shift their losses from the Medicaid program on to privately paying patients. There is no available information on how much discount the hospitals are willing to accept to avoid uncompensated care at emergency rooms and on their ability

and willingness to shift Medicaid losses to private patients. Without this information, it is not possible to accurately assess the effects (if any) of the 4.26% increase in payments on Medicaid recipients' access to health care and on the quality of care provided. It is likely, however, that the increased reimbursements will not have any significant affect on access to and quality of care, but merely improve private hospitals' profit margin.

**Businesses and entities affected.** The proposed regulations will affect Medicaid inpatient hospital payments to 112 private hospitals.

**Localities particularly affected.** The proposed regulations apply throughout the Commonwealth.

**Projected impact on employment.** The effect of the proposed changes on employment cannot be reliably assessed, as there is no information on what the hospitals would have done if the increase had not been provided. For example, if hospitals had continued to shift their Medicaid losses to private payers, there would be no change in their labor demand. On the other hand, if hospitals had discontinued their participation in the Medicaid program, there would have been a reduction in their demand for labor. The likely scenario, however, seems to be one in which hospitals would have continued to participate in the Medicaid program, in which case, no significant employment effect can be attributed to the proposed change.

**Effects on the use and value of private property.** Similarly, the effect of the proposed changes on the use and value of private property cannot be reliably assessed, as there is no information on what hospitals would have done if the payment increase were not provided. The likely effect of the proposed change will be to improve private hospitals' stream of future revenues and increase their asset values.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Department of Medical Assistance Services has reviewed the Economic Impact Analysis prepared by the Virginia Department of Planning and Budget and is in agreement with the overall conclusions of the report. However, the department believes that the fiscal impact of the regulatory change should not be held constant from SFY 2006 to SFY 2007. Rather, it should be increased by some inflationary percentage for 2007, as hospital rates are routinely adjusted for inflation each year, and the fiscal impact of increasing the adjustment factor would also be affected by any inflation applied to hospital rates.

Summary:

*Pursuant to Item 326 XX of Chapter 4 of the 2004 Acts of Assembly, the proposed amendment sets the adjustment factor used in the fee-for-service reimbursement methodology for private inpatient hospitals at 75% of base year costs beginning with the 2006 rate year (SFY 2006) on July 1, 2005.*

**12 VAC 30-70-331. Statewide operating rate per case.**

A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12 VAC 30-70-361, times the inflation values

specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor shall be determined separately for Type One and Type Two hospitals ~~and shall be the ratio of the following two numbers:~~

1. For Type One hospitals the adjustment factor shall be a calculated percentage that causes the Type One hospital statewide operating rate per case to equal the Type Two hospital statewide operating rate per case;

2. *Effective July 1, 2005*, for Type Two hospitals the adjustment factor shall be ~~the ratio of the following two numbers: .7500.~~

~~a. The numerator of the factor is the aggregate total Medicaid operating payments to affected hospitals in hospital fiscal years ending in the base year.~~

~~b. The denominator of the factor is the aggregate total Medicaid allowable operating cost as determined from settled cost reports from the same hospitals in the same year.~~

VA.R. Doc. No. R05-62; Filed November 4, 2004, 2:14 p.m.



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# EMERGENCY REGULATIONS

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## TITLE 8. EDUCATION

### STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

Titles of Regulations: 8 VAC 40-30. Regulation Governing Certification of Certain Institutions to Confer Degrees and Certificates (REPEALED).

**8 VAC 40-31. Regulation Governing Certification of Certain Institutions to Confer Degrees and Certificates (adding 8 VAC 40-31-10 through 8 VAC 40-31-320).**

Statutory Authority: § 23-276.3 of the Code of Virginia and Chapter 991 of the 2004 Acts of Assembly.

Effective Dates: November 8, 2004, through November 7, 2005.

Agency Contact: Rick Patterson, Assistant Director Private and Out of State Post Secondary Education, State Council of Higher Education for Virginia, James Monroe Building, 101 N. 14th Street, 9th Floor, Richmond, VA 23219, telephone (804) 225-2604, FAX (804) 225-2604, or e-mail rickpatterson@schev.edu.

Preamble:

*This emergency regulatory action is necessary pursuant to § 2.2-4011 A of the Administrative Process Act. The regulation is not otherwise exempt under the provisions of § 2.2-4006.*

*This action repeals 8 VAC 40-30 and promulgates emergency regulations 8 VAC 40-31 in order to implement changes required by Chapter 991 of the 2004 Acts of Assembly. The primary purpose of these changes is to incorporate nondegree proprietary schools into SCHEV current policy of self-certification.*

**PART I.**

**DEFINITIONS, PROHIBITIONS, ADVERTISING.**

**8 VAC 40-31-10. Definitions.**

*The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:*

*"Academic credit" means the measure of the total time commitment an average student is expected to devote to learning per week of study. Generally, one unit of credit represents a total of three hours per week of in-class and out-of-class work (Carnegie Unit of Credit). In this context, an hour is defined as 50 minutes. Emerging delivery methodologies may necessitate determining a unit of undergraduate credit with non-time based methods. These courses shall use demonstration of competency, demonstration of proficiency, or fulfillment of learning outcomes to insure these courses are equivalent to traditionally delivered courses.*

*"Academic-vocational" refers to a noncollege degree school that offers degree and nondegree credit courses.*

*"Agent" means a person who is employed by any institution of higher education or noncollege degree school, whether such*

*institution or school is located within or outside this Commonwealth, to act as an agent, solicitor, procurer, broker or independent contractor to procure students or enrollees for any such institution or school by solicitation in any form at any place in this Commonwealth other than the office or principal location of such institution or school.*

*"Accreditation" means a process of external quality review used by higher education to scrutinize colleges, universities and educational programs for quality assurance and quality improvement. This term applies to those accrediting organizations recognized by the United States Department of Education.*

*"Adjunct faculty" is defined as professional staff members of businesses, industries and other agencies and organizations who are appointed by institutions and schools on a part-time basis to carry out instructional, research or public service functions.*

*"Administrative capability" means a branch (i) maintains or has access to all records and accounts; (ii) designates a named site director; (iii) maintains a local mailing address; and (iv) the course offering at the branch consists of a large number of unit subjects which comprise a program of education or a set curriculum large enough to allow pursuit on a continuing basis.*

*"Branch" means an additional location, operated by an institution with an approved existing site. A branch campus must have administrative capability exclusive of the main campus and adequate resources to ensure that the objectives of its programs can be met.*

*"Certification" means the process of securing authorization to operate an institution of higher education and/or degree program in the Commonwealth of Virginia.*

*"Change of ownership" refers to the change in power within a school. Change of ownership may include, but is not limited to, the following situations: (i) sale of the school; (ii) merger of two or more schools if one of the institutions is nonexempt; or (iii) change from profit to non-profit or collective.*

*"CIP code number" means the six-digit Classification of Instructional Programs number assigned to each discipline specialty.*

*"Contact hour" means the basic unit of attendance for computing full-time equivalent student (FTES). It is a period of not less than 50 minutes of scheduled instruction and/or examination.*

*"College" means any institution of higher education that offers degree programs.*

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

*"Course for degree credit" means a single course whose credits are applicable to the requirements for earning a degree, diploma, or certificate.*

*"Course registration materials" means any official documents provided to students for the purpose of formal enrollment into the institution, a specific program, or a certain course(s).*

"Degree" means any earned award at the associate, baccalaureate, master's, first professional, or doctoral level which represents satisfactory completion of the requirements of a program or course of study or instruction beyond the secondary school level and includes certificates and specialist degrees when such awards represent a level of educational attainment above that of the associate degree level.

"Degree program" means a curriculum or course of study that leads to a degree in a discipline or interdisciplinary specialty and normally is identified by a six-digit CIP code number.

"Diploma" or "certificate" means an award which represents a level of educational attainment at or below the associate degree level and which is given for successful completion of a curriculum comprised of two or more courses and applies only to those awards given for coursework offered within Virginia by institutions of higher education which are appropriately approved to offer, either within the Commonwealth or outside the Commonwealth, degrees at the associate, baccalaureate, graduate, or professional level.

"Existing institution" or "existing postsecondary school" means any postsecondary school that (i) has been in operation in Virginia for 2 (two) or more calendar years as of July 1, 2004, and has been certified to operate continuously during that period, or; (ii) has been approved to operate as a postsecondary school in another state, is accredited by an accrediting agency recognized by the United States Department of Education, and is certified to operate in Virginia.

"Full-time faculty" means a person whose: (i) employment is based upon an official contract, appointment, or agreement with an institution; (ii) principal employment is with that institution; and (iii) major assignments are in teaching and research. A full-time administrator who teaches classes incidental to administrative duties is not a full-time faculty member.

"Gross tuition collected" means all fees collected or received on either a cash or accrual accounting method basis for all instructional programs or courses, except for nonrefundable registration and application fees and charges for materials, supplies, and books which have been purchased by, and are the property of, the student.

"In-state institution" means an institution of higher education that is formed, chartered or established within Virginia. For the purposes of certification as a degree-granting institution, an institution incorporated outside Virginia shall be considered a Virginia institution if (i) it is incorporated in a state in which it has no instructional campus, and (ii) it produces clear and convincing evidence that its main or principal campus is located in Virginia.

"Institution of higher education" or "institution" means any person, firm, corporation, association, agency, institute, trust, or other entity of any nature whatsoever offering education beyond the secondary school level which has received certification from the Council and: (i) offers courses or programs of study or instruction which lead to, or which may reasonably be understood to be applicable to, a degree; or (ii) operates a facility as a college or university or other entity of whatever kind which offers degrees or other indicia of level of

educational attainment beyond the secondary school level; or (iii) uses the term "college" or "university," or words of like meaning, in its name or in any manner in connection with its academic affairs or business.

"Instructional faculty" means a person employed by an institution of higher education that is engaged in instructional, research, or related activities.

"Multistate compact" means any agreement involving two or more states to offer jointly postsecondary educational opportunities, pursuant to policies and procedures set forth by such agreement and approved by Council.

"Noncollege degree school" means any postsecondary school that offers courses or programs of study that do not lead to an associate or higher level degree. Such schools may be academic-vocational or vocational.

"New institution" or "new postsecondary school" means any postsecondary school that seeks certification and has been in operation in Virginia for less than 2 (two) calendar years as of July 1, 2004, and has not operated in nor has been approved to operate as a postsecondary institution in another state.

"Out-of-state institution" means an institution of higher education that is formed, chartered or established outside Virginia.

"Part-time faculty" means a person whose: (i) annual employment is based upon an official contract, appointment, or agreement with an institution; (ii) principal employment is with an entity other than that institution; and (iii) teaching assignments include at least one course during at least two terms within the academic year.

"Postsecondary education" is the provision of formal instructional programs with a curriculum designed primarily for students who have completed the requirements for a high school diploma or equivalent. This includes programs of an academic, vocational, and continuing professional education purpose, and excludes avocational and adult basic education programs.

"Postsecondary education activities" means researching, funding designing, and/or conducting instructional programs, classes, or research opportunities, designed primarily for students who have completed the requirements for a high school diploma or its equivalent.

"Postsecondary school" or "school" means formal instructional programs with a curriculum designed primarily for students who have completed the requirements for a high school diploma or its equivalent. Such schools include programs of academic, vocational, and continuing professional education, and exclude avocational and adult basic education programs. For the purposes of this chapter, a "postsecondary school" shall be classified as either an institution of higher education as defined in this section or a noncollege degree school, as defined in this section.

"Program" means a curriculum or course of study in a discipline or interdisciplinary area that leads to a degree, certificate, or diploma.

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"Program area" means a general group of disciplines in which one or more degree programs, certificates, or diplomas may be offered.

"Program of study" means a curriculum of two or more courses that is intended or understood to lead to a degree, diploma, or certificate. It may include all or some of the courses required for completion of a degree program.

"Proprietary" means a privately owned and managed, for-profit institution of higher education or noncollege degree school.

"Site" means a location in Virginia where a postsecondary school (i) offers one or more courses on an established schedule and (ii) enrolls two or more persons who are not members of the same household. A site may or may not be a branch, and it does not have to have administrative capability.

"Surety instrument" means a surety bond or a clean irrevocable letter of credit, issued by a surety company or banking institution, authorized to transact business in Virginia, adequate to provide refunds to students for the unearned non-Title IV portion of tuition and fees for any given semester, quarter or term and to cover the administrative cost associated with filing a claim against the instrument.

"Teach-out agreement" means the process whereby a school undertakes to fulfill its educational and contractual obligations to currently enrolled students.

"Telecommunications activity" means any course offered by a postsecondary school or consortium of postsecondary schools where the primary mode of delivery to a site is television, videocassette or disc, film, radio, computer, or other telecommunications devices.

"University" means any institution offering programs leading to degrees or degree credit beyond the baccalaureate level.

"Vocational school" refers to a school that does not offer courses for degree credit.

## **8 VAC 40-31-20. Prohibited acts.**

A. Except as in accordance with this chapter, no person, or other entity shall sell, barter, or exchange for any consideration, or attempt to sell, barter, or exchange for any consideration, any degree, degree credit, diploma, or certificate.

B. No person, or other entity shall use, or attempt to use, in connection with any business, trade, profession, or occupation any degree or certification of degree or degree credit, including but not limited to a transcript of coursework, which has knowingly been fraudulently issued, obtained, forged, or materially altered.

C. Unless exempted from the provisions of this chapter pursuant to § 23-276.2 of the Code of Virginia, no person, firm, or institution may represent that credits earned at or granted by that person, firm, or institution are applicable for credit toward a degree, except under such conditions and in a manner specified and approved by the Council in accordance with this chapter.

D. Without prior certification, no person or other entity subject to the provisions of this chapter shall use in any manner,

within the Commonwealth of Virginia, the term "college" or "university" or abbreviations or words of similar meaning in its name or in any manner in connection with its academic affairs or business or in any literature, catalog, pamphlet, or descriptive materials.

1. This subsection shall not apply to any person or other entity that (i) used the term "college" or "university" openly and conspicuously in its title within the Commonwealth prior to July 1, 1970; (ii) was granted authority to operate in Virginia by the Council between July 1, 1970, and July 1, 2002, and maintains valid authority to so operate in Virginia after July 1, 2002; (iii) was exempted from the provisions of Chapter 21 (§ 23-265 et seq.) of this title, as such law was in effect prior to July 1, 2002; or (iv) was authorized by the Council to use a name prior to a request for certification.

2. For only as long as the provisions of Item 158 D of Chapter 912 of the 1996 Acts of Assembly shall be in effect, this subsection shall not apply to individual proprietorships, associations, co-partnerships or corporations which use the words "college" or "university" in their training programs solely for their employees or customers, which do not offer degree-granting programs, and whose name includes the word "college" or "university" in a context from which it clearly appears that such entity is not an educational institution.

E. Council may refuse to certify institution names and terms, which have the potential to mislead the general public about the institution's affiliation or association with any state-supported institution of higher education in Virginia. Terms such as, but not limited to, "public university", "public college," or "community college" may be protected from use by private institutions of higher education.

## **8 VAC 40-31-30. Advertisements, announcements, and other promotional materials.**

A. A school certified to operate by the Council in accordance with this chapter shall include in any print and electronic catalogs, and course registration materials that; (i) the Council has certified the institution to operate in Virginia, (ii) a complete address of the main campus and all branch locations within Virginia.

B. An out-of-state school shall state in its course registration materials distributed in Virginia that:

1. Each course or degree, diploma, or certificate program offered in Virginia is approved by the governing board of the institution;

2. The appropriate state agency, if any, in the state where the main campus of the institution is located has granted whatever approval may be necessary for the institution to:

a. Offer courses or degree, diploma, or certificate programs at the level for which credit is being awarded for those courses or programs in Virginia;

b. Offer courses or degree programs outside its state;

c. Offer each course or degree, diploma, or certificate program being offered in Virginia; and

d. Any credit earned for coursework offered by the institution in Virginia can be transferred to the institution's principal location outside Virginia as part of an existing degree, diploma, or certificate program offered by the institution.

C. No advertisement, announcement, or any other material produced by or on behalf of a postsecondary school shall in any way indicate that the institution is supervised, recommended, endorsed, or accredited by the Commonwealth of Virginia, by the State Council of Higher Education, or by any other state agency in Virginia.

## PART II. EXEMPTIONS.

### **8 VAC 40-31-40. State-supported institutions.**

This chapter shall not apply to the institutions named in § 23-9.5 of the Code of Virginia, including their branches, divisions, or colleges, or to any state-supported institution of higher education that may be established in the future.

### **8 VAC 40-31-50. Religious institutions.**

A. The Council shall exempt from the provisions of Chapter 21 (§ 23-276.1 et seq.) of Title 23 of the Code of Virginia, any institution of higher education whose primary purpose is to provide religious training or theological education, provided that the institution:

1. Awards only degrees, diplomas, or certificates (i) whose titles indicate the institution's primary purpose plainly upon their face and (ii) which state that the institution is excluded from the requirement of state certification; and

2. States plainly in its catalogs and other publications that (i) the institution's primary purpose is to provide religious training or theological education, (ii) the institution's degrees, diplomas, or certificates are so titled and worded, and (iii) the institution is exempt from the requirement of state certification.

3. The title of each degree, diploma, or certificate awarded by an institution which claims an exemption under the provisions of this section must reflect that the institution's primary purpose is religious education.

a. The titles of religious degrees that may be awarded include, but are not limited to, (i) Bachelor of Christian Education, (ii) Master of Divinity, and (iii) Doctor of Sacred Theology.

b. The titles of secular degrees that may not be awarded in any discipline, including religion, Christian education, and biblical studies, include, but are not limited to, (i) Associate of Arts, (ii) Associate of Science, (iii) Associate of Applied Science, (iv) Associate of Occupational Science, (v) Bachelor of Arts, (vi) Bachelor of Science, (vii) Master of Arts, (viii) Master of Science, (ix) Doctor of Philosophy, and (x) Doctor of Education.

B. Exemptions granted after July 1, 2002 will be for a maximum of five years. Institutions wishing to maintain an exempt status, must reapply to Council at least six months prior to the expiration of the exemption period. Exempt institutions shall not make claims of "approval" "endorsement"

or other such terms by the Council in any of their promotional materials. Exempt institutions shall clearly state in their catalogs and promotional materials that they are exempt from the requirements of state regulation and oversight.

C. An institution that awards secular degrees in addition to religious degrees, certificates or diplomas, as defined in subsections A and B of 8 VAC 40-31-50, must comply with the provisions for certification for all non-religious degree programs.

D. Each institution requesting full or partial exemption must apply on forms provided by and in a manner prescribed by the Council.

E. The Council, on its own motion, may initiate formal or informal inquiries to confirm that this chapter is not applicable to a religious institution if the Council has reason to believe that the institution may be in violation of the provisions of this section.

1. Any institution which claims an exemption under subsection A of this section on the basis that its primary purpose is to provide religious training or theological education shall be entitled to a rebuttable presumption of the truth of that claim.

2. It shall be the Council's responsibility to show that an institution is not exempt under subsection A of this section.

3. The Council assumes no jurisdiction or right to regulate religious beliefs under this chapter.

F. An institution whose claim for exemption under subsection A of this section is denied by the Council shall have the opportunity to appeal the Council's action in accordance with 8 VAC 40-31-70.

### **8 VAC 40-31-60. Institutions, programs, degrees, diplomas, & certificates exempt by council action.**

A. The following activities or programs offered by institutions, otherwise subject to this chapter shall be exempt from its provisions:

1. Any school subject to the provisions of Chapter 16 (§ 22.1-319 et seq.) of Title 22.1 of the Code of Virginia.

2. Any honorary degree conferred or awarded by an institution, as long as the degree (i) does not represent the satisfactory completion of all or any part of the requirements of a program or course of study and (ii) is normally regarded as one which is intended to be commemorative in nature in recognition of an individual's contributions to society. Such degree must state on its face that it is honorary in nature.

3. Any postsecondary educational course or program of study offered by an institution of higher education at a United States military post or reservation when that course or program is open only to military post personnel, their dependents or civilians employed by that military post or reservation.

a. Military personnel or civilians employed at one military post or reservation may take courses or programs of study at another military post or reservation without affecting the exemption from this chapter.

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b. This exemption shall not apply to an institution that offers a course or program of study at a military post or reservation if:

(1) Civilians who are not employed by the military post or reservation are enrolled in the course or program at that site.

(2) The appropriate military official at the military post or reservation submits a written request to the executive director of the Council that the institution be subject to this chapter.

(3) The postsecondary educational course or program of study offered at the military post or reservation is operated by an institution that is not already certified in Virginia and is operated as a branch campus having administrative capability within Virginia.

4. Any nursing education program offered by an institution to the extent that the program is regulated by the Virginia Board of Nursing.

a. The Virginia Board of Nursing is the state agency which is authorized to license registered nurses and to approve nursing programs with regard to the adequacy of the curriculum and resources for preparing students to take the licensing examination.

b. To offer a degree in nursing, an institution must have obtained prior Council certification.

5. A professional program for professional or occupational training offered by an institution to the extent that the program is subject to approval by a regulatory board pursuant to Title 54.1 of the Code of Virginia.

6. Any course or program of study given by or approved by any professional body, fraternal organization, civic club, or benevolent order principally for professional education or advancement or similar purpose and for which no degree or degree credit is awarded.

7. Courses or programs offered through approved multistate compacts, including but not limited to, the Southern Regional Education Board's Electronic Campus; and

8. Those courses offered and delivered by a postsecondary school solely on a contractual basis for which no individual is charged tuition and for which there is no advertising for open enrollment;

9. Any school, institute or course of instruction offered by any trade association or any nonprofit affiliate of a trade association on subjects related to the trade, business or profession represented by such association;

10. Any public or private high school accredited or recognized by the Board of Education that has offered or may offer one or more courses cited in this chapter, if any tuition, fees and charges made by the school are collected as may be permitted by Title 22.1, in the case of a public school, or pursuant to regulations prescribed by the relevant governing body of such private school; or

11. Tutorial instruction delivered and designed to supplement regular classes for students enrolled in any

public or private school or to prepare an individual for an examination for professional practice or higher education.

B. Notwithstanding the exemptions provided in this section, an institution of higher education may seek certification for an otherwise exempt activity or program.

## **8 VAC 40-31-70. Denial of exemption; appeal of action.**

If the Council denies a request for exemption the executive director shall ensure that the institution is afforded an opportunity to be heard. The procedures set forth in 8 VAC 40-31-220 of this chapter, shall apply.

### PART III.

#### ROLE OF THE COUNCIL AND STAFF.

## **8 VAC 40-31-80. Role of the council.**

A. Pursuant to § 23-276.9 of the Code of Virginia, the Council may establish fees for services and the methods for collecting such fees.

B. Pursuant to § 23-276.3 (E) of the Code of Virginia and unless otherwise indicated, the Council delegates authority for administering the requirements of § 23-276.1 through § 23-276.12 of the Code of Virginia and this chapter to the executive director.

C. Pursuant to § 23-276.3 of the Code of Virginia, the Council shall adopt certification criteria for the operation of postsecondary schools in Virginia.

D. Only the Council may refuse to grant certification, or revoke or suspend certification. In these instances, the Council will be responsible for ensuring due process and compliance with the Administrative Process Act (§ 2.2-4000 et seq.)

## **8 VAC 40-31-90. Role of the executive director.**

A. In addition to other administrative responsibilities vested in the executive director of the Council, the executive director shall carry out the following administrative responsibilities relative to this chapter:

1. Authorize certification to operate for postsecondary schools that meet the certification criteria.

2. Authorize the use of the term "college" or "university" in an institution's name.

3. Authorize religious exemptions.

4. Pursuant to § 23-276.7 of the Code of Virginia, authorize emergency action in the event an institution has received an adverse action by the United States Department of Education or by its accrediting agency which threatens a disruption of the operation of the institution and exposes students to a loss of course or degree credit or financial loss. All emergency actions shall be reported to Council at its next meeting to either ratify or take such as actions as it may deem necessary. The authority of the executive director in these instances includes:

a. Suspend new enrollment in specified programs, degree levels or in all programs and degree levels.

b. Require the institution to provide a guaranty instrument or increase the penal amount or a current guaranty.

c. Take other actions as may be necessary to protect the rights of currently enrolled or future students.

5. Assess administrative fees.
6. Authorize the release of a surety instrument requirement.
7. The executive director may delegate certain administrative responsibilities to the Council staff.

## **8 VAC 40-31-100. Role of the council staff.**

A. The role of Council staff shall include:

1. Oversight and administration for purposes of compliance, Title 23, Chapter 21.1, §§ 23-276.1 through 23-276.12 of the Code of Virginia and chapter.
2. Review initial and annual certification requirements for all institutions.
3. Perform random and periodic site visits to review, inspect and investigate institutional compliance.
4. Investigate as necessary all non-certified postsecondary school activities operating in the Commonwealth of Virginia.
5. Monitor the accreditation activities of all non-accredited postsecondary schools operating in the Commonwealth of Virginia.
6. Investigate all written and signed complaints or adverse publicity or any situation that may adversely affect students or consumers.
7. Share with state or federal agencies and appropriate accrediting bodies information regarding the operation or closure of postsecondary schools operating in Virginia.
8. The executive director may delegate other responsibilities as deemed appropriate.

### PART IV. INSTITUTIONS FOR WHICH CERTIFICATION IS REQUIRED.

## **8 VAC 40-31-110. Certain existing approvals & exemptions continued.**

A. An institution of higher education that was approved or authorized to confer degrees at a particular level or to offer one or more degree programs or program areas may continue to confer those degrees and to offer those programs until and unless the institution's approval or authorization is revoked by the Council in accordance with 8 VAC 40-31-200 of this chapter.

B. A Virginia institution of higher education that is approved or authorized to confer degrees by the Council, the State Board of Education, or act of the General Assembly of Virginia and is subject to the conditions of § 23-276.4 (C) of the Code of Virginia, shall be subject to whatever conditions or stipulations may have been imposed.

## **8 VAC 40-31-120. Certification required for new and existing postsecondary schools.**

A. All instructional offerings in Virginia which are not exempted from these regulations are subject to this chapter, even

though the credit awarded for those offerings may be transferred to a location outside Virginia.

B. A new postsecondary school must become certified to operate prior to engaging in activities related to postsecondary education via telecommunications activity or at a site within the Commonwealth.

1. The determination for certification of telecommunications activities may be based upon, but not limited to, physical presence.
2. Telecommunications activities, with the exception of degree programs, academic credit and other courses offered exclusively from outside the state through individual and private interstate communication, are subject to the certification criteria required for all postsecondary schools.

C. Existing postsecondary schools must re-certify compliance with certification criteria on an annual basis in order to continue offering postsecondary courses and programs.

D. Postsecondary schools operating branches must certify each separately.

E. Postsecondary schools, not previously certified in Virginia, seeking to establish a postsecondary education consortium, agreement, partnership, or other similar arrangement with an existing postsecondary school, must meet all requirements for certification as set forth in these regulations, and must become certified to operate, prior to engaging in postsecondary education activities within the Commonwealth of Virginia.

### PART V. CERTIFICATION CRITERIA.

## **8 VAC 40-31-130. Application of certification criteria.**

A. The certification criteria shall include but not be limited to, (i) procedures by which a postsecondary school may apply for certification, (ii) criteria designed to ensure that all postsecondary schools that are subject to this chapter meet minimal academic or vocational standards.

B. Postsecondary schools, by notarized signature of the Chief Executive Officer, will be responsible for certifying total compliance with certification criteria on an initial and annual basis.

## **8 VAC 40-31-140. Certification criteria for institutions of higher education.**

The following criteria shall apply to each institution for which certification is required:

A. The course, program, curriculum and instruction must be of quality, content and length to adequately achieve the stated objective. Administrators and faculty must be qualified and appropriately credentialed:

1. For terminal occupational/technical programs leading to the Associate of Occupational Science (A.O.S.) degree, general education courses must compose at least 10% of the total credit hours required for the degree.

2. For terminal occupational/technical programs leading to the Associate of Applied Science (A.A.S.) degree, general

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education courses shall compose at least 25% of the total credit hours required for the degree.

3. All instructional faculty teaching in a terminal occupational/technical program leading to the Associate of Applied Science (A.A.S.) or Associate of Occupational Science (A.O.S.) degree shall:

a. If teaching general education courses, hold a baccalaureate degree plus at least 18 graduate credit hours in the discipline being taught.

b. If teaching occupational/technical courses, hold either (i) an associate degree or (ii) qualify for a faculty appointment by virtue of scholarly or professional achievements.

4. For all university parallel associate degree programs, general education courses shall compose at least 25% of the total credit hours required for the degree, and required courses in the major field of study shall compose no more than 50% of the total credit hours required for the degree in a specific discipline.

5. All instructional faculty teaching in a college-transfer program at the associate level shall:

a. If teaching general education courses or in programs in the liberal arts and sciences, hold a baccalaureate degree plus at least 18 graduate credit hours in the discipline being taught.

b. If teaching occupational/technical courses, hold a baccalaureate degree in the discipline being taught or qualify by virtue of professional or scholarly achievement.

6. All instructional faculty members who teach in programs at the baccalaureate level shall:

a. Hold a master's degree in the discipline being taught or hold a master's degree in an area other than that being taught with at least 18 graduate semester hours in the teaching discipline.

b. Exception to academic preparation requirements for instructional faculty may be made in instances where substantial documentation of professional and scholarly achievements can be shown.

7. All instructional faculty teaching in a program at the master's level or higher shall:

a. Hold a doctoral or other terminal degree.

b. Exception to academic preparation requirements for instructional faculty may be made in instances where substantial documentation of professional and scholarly achievements can be shown.

B. In addition to the above instructor qualifications, the institution must certify that:

1. All instructional courses for degree credit require a minimum of 15 contact hours for each semester credit hour or a minimum of 10 contact hours for each quarter credit hour, or the equivalent, and an expectation for additional assignments beyond scheduled instructional activities.

2. The elective and required courses for each program are offered on a schedule and in a sequence that enables both full-time and part-time students to complete the program in a reasonable period of time.

3. The institution's instructional faculty at each site shall hold either full-time, part-time, or adjunct appointments.

4. The institution's academic programs meet the following criteria: (i) ensure a properly credentialed and course qualified instructor teaches each course; (ii) ensure that a credentialed and course qualified academic advisor is available to meet the concerns of the student, and that a student contact by any method will elicit a response from the advisor within a reasonable timeline; (iii) ensure that continual curriculum development and oversight for each major and concentration/track is maintained; and (iv) ensure a program director is named and designated to oversee each program area.

5. A plan to provide for interaction between student and faculty, and among students.

## **8 VAC 40-31-150. Certification criteria for vocational schools.**

The following criteria shall apply to each vocational school for which certification is required:

A. The course, program, curriculum and instruction must be of quality, content and length to adequately achieve the stated objective. Administrators and faculty, if teaching technical courses for vocational programs not leading to a degree and not offered as degree credit, must hold either (i) an associate degree or (ii) have a minimum of two years of technical/occupational experience in the area of teaching responsibility or a related area.

B. In addition to the above instructor qualifications, the vocational school must certify that:

1. Courses of study shall conform to state, federal, trade, or manufacturing standards of training for the occupational fields in which such standards have been established or must conform to recognized training practices in those fields.

2. It has a plan to provide for interaction between student and faculty, and among students.

## **8 VAC 40-31-160. Certification criteria for all postsecondary schools.**

The following criteria shall apply to all postsecondary schools for which certification is required:

A. The postsecondary school shall have a clear, accurate, and comprehensive written statement, which shall be available to the public upon request. The statement minimally shall include the following items:

1. The history and development of the postsecondary school;

2. An identification of any persons, entities, or institutions that have a controlling ownership or interest in the postsecondary school;

3. The purpose of the postsecondary school, including a statement of the relative degree of emphasis on instruction, research, and public service;

4. A description of the postsecondary school's activities including telecommunications activities away from its principal location, including a list of all program areas in which courses are offered away from the principal location;

5. A list of all locations in Virginia at which the postsecondary school offers courses, a list of the degree programs currently offered or planned to be offered in Virginia; and

6. A statement of the postsecondary school's long-range plans.

B. The postsecondary school or branch shall have a current, written document, available to students and the general public upon request that accurately states the powers, duties, and responsibilities of:

1. The governing board or owners of the institution;
2. The chief operating officer, president, or director at that site in Virginia;
3. The principal administrators and their credentials at that site in Virginia;
4. The students, if students participate in institutional governance.

C. The postsecondary school shall have and maintain, and shall provide to all applicants upon request, a policy document accurately defining the minimum requirements for eligibility for admission to the institution and for acceptance at the specific degree level or into all specific degree programs offered by the postsecondary school which are relevant to the school's admissions standards. In addition, the document shall explain:

1. The standards for academic credit or course completion given for experience;
2. The criteria for transfer credit where applicable;
3. The criteria for refunds of tuition and fees; and
4. Students' rights, privileges, and responsibilities.

D. The postsecondary school shall maintain records on all enrolled students. These records minimally 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 postsecondary school's admissions standards. Each student record must reflect the requirements and justification for admission of the student to the postsecondary school. Admissions records must be maintained for five years.
2. Transcript of the student's academic or course work at the school, which shall be retained permanently in either hard copy forms or in a database with backup.
3. A record of student academic or course progress at the school including programs of study, dates of enrollment,

courses taken and completed, grades, and indication of the student's current status (graduated, probation, etc.)

4. The school shall transact a written, binding agreement with another school or records-maintenance organization with which the school is not corporately connected for the preservation of students' transcripts by another institution or agency, as well as for access to the transcripts, in the event of school closure or revocation of certification in Virginia.

E. Each school shall provide or make available to students, prospective students, and other interested persons a catalog, bulletin or brochure containing, as a minimum the following information:

1. A description of any financial aid offered at the school including repayment obligations, standards of academic progress required for continued participation in the program, and source of loan or scholarship.

2. A broad description, including academic and/or vocational objectives of each program offered, the number of hours of instruction in each subject and total number of hours required for course completion, course descriptions, and a statement of the type of credential awarded.

3. A statement of tuition and fees and other charges related to enrollment, such as deposits, fees, books and supplies, tools and equipment, and any other charges for which a student may be responsible.

4. The school's refund policy for tuition and fees pursuant to paragraph M of this section, and the school's procedures for handling complaints, including procedures to ensure that a student will not be subject to unfair actions as a result of his/her initiation of a complaint proceeding.

5. The name and address of the school's accrediting body, if applicable.

6. The minimum requirements for satisfactory completion of each degree level and degree program, or non-degree certifications/diplomas.

7. The school shall ensure that all institutional officials accurately represent the transferability of any courses or programs and state if any of the associate degrees offered by the school are considered terminal degrees.

8. If the institution offers programs leading to the Associate of Applied Science or Associate of Occupational Science degree, that these programs are terminal occupational/technical programs and their credits generally are not applicable to other degrees.

9. The academic or course work schedule for the period covered by the publication.

10. Placement services and employment opportunities shall be accurately stated.

11. Name, location, and address of the main campus, branch or site operating in Virginia.

F. The school must have a clearly defined process by which the curriculum is established, reviewed and evaluated. Evaluation of school effectiveness must be completed on a regular basis and include, but not be limited to:

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1. An explanation of how each program is consistent with the mission of the school.

2. The written process for evaluating each degree level and program, or vocational program, once initiated and written procedures for assessing the extent to which the educational goals are being achieved.

3. Documented use of the results of these evaluations to improve the degree programs.

G. Pursuant to § 23-276.3 (B) of the Code of Virginia, the school must maintain records that demonstrate it is financially sound, exercises proper management, financial controls and business practices and can fulfill its commitments for education or training. The school's financial resources should be characterized by stability, which indicates the school is capable of maintaining operational continuity for an extended period of time. The stability indicator that will be used is the U.S. Department of Education (USDE) Financial Ratio (composite score).

1. Schools shall provide the results of an annual audited financial statement or a reviewed financial statement.

2. The USDE composite score range is - 1.0 to 3.0. Schools with a score of 1.5 to 3.0 meet fully the stability requirement in § 140.1; scores between 1.0 and 1.4 meet the minimum expectations; and, scores less than 1.0 do not meet the requirement and shall be immediately considered for audit.

H. Pursuant to § 23-276.3 (B) of the Code of Virginia, the school shall have and maintain a surety instrument issued by a surety company or banking institution authorized to transact business in Virginia, adequate to provide refunds to students for the unearned non-Title IV portion of tuition and fees for any given semester, quarter or term and to cover the administrative cost associated with the instrument claim. The instrument shall be based on the non-Title IV funds, which have been received from students or agencies for which the education has not yet been delivered. This figure shall be indicated in audited or reviewed financial statements as a Current (non-Title IV) Tuition Liability. Schools certified under this regulation shall be exempt from the surety instrument requirement if they can demonstrate a U.S. Department of Education composite financial responsibility score of 1.5 or greater on their current audited or reviewed financial statement; or if they can demonstrate a composite score between 1.0 and 1.4 on their current audited or reviewed financial statement and have scored at least 1.5 on an audited or reviewed financial statement in either of the prior two years. New schools and unaccredited existing schools must complete at least two calendar years of academic instruction to qualify for the surety waiver.

I. The school shall have a current written policy on faculty accessibility, which shall be distributed, to all students. The school shall ensure that instructional faculty are accessible to students for academic or course advising at stated times outside regularly scheduled class hours at each site when a course is offered and throughout the period during which the course is offered.

J. All recruitment personnel must provide prospective students with current and accurate information on the institution through the use of written and electronic materials and in oral admissions interviews:

1. The school shall be responsible and liable for the acts of its admissions personnel.

2. No school, agent, or admissions personnel knowingly making any statement or representation that is false, inaccurate or misleading regarding the school.

K. All programs offered via telecommunications must be comparable in content, faculty, and resources to those offered in residence, and include regular student-faculty interaction by computer, telephone, mail, and/or face-to-face meetings.

L. The school shall maintain and ensure that students have access to a library with a collection, staff, services, equipment and facilities that are adequate and appropriate for the purpose and enrollment of the institution. Current and formal written agreements with other libraries or with other entities may be used. Institutions offering graduate work shall provide access to library resources that include basic reference and bibliographic works and major journals in each discipline in which the graduate program is offered. Vocational schools shall provide adequate and appropriate resources for completion of course work.

M. In accordance with § 23-276.3 (B) of the Code of Virginia, the school shall establish a tuition refund policy and communicate it to students. Accredited institutions shall adhere to the tuition refund requirements of their accrediting body. All other schools shall adhere to the following tuition refund requirements:

1. The school shall adopt a minimum refund policy relative to the refund of tuition, fees, and other charges. All fees and payments, with the exception of the nonrefundable fee described in subsection 2 below, remitted to the school by a prospective student shall be refunded if the student is not admitted, does not enroll in the school, does not begin the program or course, withdraws, or is dismissed.

2. A school may require the payment of a reasonable nonrefundable initial fee, not to exceed \$10050, to cover expenses in connection with processing a student's enrollment, provided it retains a signed statement in which the parties acknowledge their understanding that the fee is nonrefundable. No other nonrefundable fees shall be allowed prior to enrollment.

3. The school shall provide a period of at least three business days, weekends and holidays excluded, during which a student applicant may cancel his enrollment without financial obligation other than the nonrefundable fee described in subsection 2 above.

4. Following the period described in subsection 3 above, a student applicant (one who has applied for admission to a school) may cancel, by written notice, his enrollment at any time prior to the first class day of the session for which application was made. When cancellation is requested under these circumstances, the school is required to refund all tuition paid by the student, less a maximum tuition fee of 15% of the stated costs of the course or program or \$100

whichever is less. A student applicant will be considered a student as of the first day of classes.

5. An individual's status as a student shall be terminated by the school not later than seven consecutive instructional days after the last day on which the student actually attended the school. Termination may be effected earlier by written notice. In the event that a written notice is submitted, the effective date of termination will be the date the student last attended classes. Schools may require that written notice be transmitted via registered or certified mail, provided that such a stipulation is contained in the written enrollment contract. The school may require that the parents or guardians of students under 18 years of age submit notices of termination on behalf of their children or wards. Schools are required to submit refunds to individuals who have terminated their status as students within 45 days after receipt of a written request or the date the student last attended classes whichever is sooner.

6. The minimum refund policy for schools which financially obligate the student for a quarter, semester, trimester or other period not exceeding 4-1/2 calendar months shall be as follows:

a. A student who enters school but withdraws during the first 1/4 (25%) of the period is entitled to receive as a refund a minimum of 50% of the stated cost of the course or program for the period.

b. A student who enters a school but withdraws after completing 1/4 (25%), but less than 1/2 (50%) of the period is entitled to receive as a refund a minimum of 25% of the stated cost of the course or program for the period.

c. A student who withdraws after completing 1/2 (50%), or more than 1/2 (50%), of the period is not entitled to a refund.

7. The minimum refund policy for schools which financially obligate the student for the entire amount of tuition and fees for the entirety of a program or course shall be as follows:

a. A student who enters the schools but withdraws or is terminated during the first 1/4 of the program shall be entitled to a minimum refund amounting to 75% of the cost of the program.

b. A student who withdraws or is terminated during the second 1/4 of the program shall be entitled to a minimum refund amounting to 50% of the cost of the program.

c. A student who withdraws or is terminated during the third 1/4 of the program shall be entitled to a minimum refund amounting to 25% of the cost of the program.

d. A student who withdraws after completing 3/4 (75%) of the program shall not be entitled to a refund.

8. Fractions of credit for courses completed shall be determined by dividing the total amount of time required to complete the period or the program by the amount of time the student actually spent in the program or the period, or by the number of correspondence course lessons completed, as described in the contract.

9. It is not required that expenses incurred by students for instructional supplies, tools, activities, library, rentals, service charges, deposits, and all other charges be considered in tuition refund computations when these expenses have been represented separately to the student in the enrollment contract and catalogue, or other documents prior to enrollment in the course or program. Schools shall adopt and adhere to reasonable policies regarding the handling of these expenses when calculating the refund and submit the policies to the department for approval.

10. For programs longer than one year, the policy outlined in subsections 7 and 8 above shall apply separately for each year or portion thereof.

11. Schools shall comply with the cancellation and settlement policy outlined in this section, including promissory notes or contracts for tuition or fees sold to third parties.

12. When notes, contracts or enrollment agreements are sold to third parties, the school continues to have the responsibility to provide the training specified regardless of the source of any tuition, fees, or other charges that have been remitted to the school by the student or on behalf of the student.

## PART VI.

### CERTIFICATION REQUIREMENTS.

#### 8 VAC 40-31-170. Initial certification.

A. An institution shall not use the term "college" or "university" until it has received acknowledgment from SCHEV that the name is not in violation of 8 VAC 40-31-20 of these regulations.

1. An institution seeking certification, must notify SCHEV of its proposed name prior to filing such name with the State Corporation Commission.

2. Prior to receiving certification to operate, a copy of the institution's certificate from the Virginia State Corporation Commission authorizing it to transact business in the Commonwealth under the acknowledged name must be submitted.

B. An institution shall not operate in the Commonwealth of Virginia without first receiving certification to operate from Council. Certified institutions shall not enter into any agreement to deliver or develop courses or programs of study in Virginia, with non-certified postsecondary schools.

C. All certifications shall expire on the certificate expiration date. Applications for re-certification must be submitted to SCHEV at least 60 days prior to the expiration date of the current certification.

D. Certification is not transferable. In the event of a change of ownership of a certified institution, the new owner or governing body must secure certification. The institution must apply for certification within 45 days following a change of ownership. During the 45-day period and the time required for the Council to process the new application, up to and not exceeding 90 days, the old certification remains in effect

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*provided that there are no changes in the academic or course work programs, policies, or financial considerations such that the change would constitute or create a violation of SCHEV's policies.*

*E. SCHEV will process all applications and provide notice to applicants within 45 days of receipt.*

*F. Certificate valid dates and re-certification due dates are as follows:*

*1. Out-of-state private degree granting and vocational school certificates are valid for 1 year beginning on 1 September of the calendar year and ending on 31 August of the following calendar year. Applications are due not later than 2 July.*

*2. Out-of-state public institution certificates are valid for 1 year beginning on 15 September of the calendar year and ending on 14 September of the following calendar year. Applications are due not later than 16 July.*

*3. In-state private non-profit institution certificates are valid for 1 year beginning on 1 October of the calendar year and ending on 30 September of the following calendar year. Applications are due not later than 2 August.*

*4. In-state proprietary degree-granting and academic-vocational institution certificates are valid for 1 year beginning on 15 October of the calendar year and ending on 14 October of the following calendar year. Applications are due not later than 16 August.*

*5. In-state proprietary vocational school certificates (letters A-D) are valid for 1 year beginning on 1 November of the calendar year and ending on 31 October of the following calendar year. Applications are due not later than 2 September.*

*6. In-state proprietary vocational school certificates (letters E-P) are valid for 1 year beginning on 15 November of the calendar year and ending on 14 November of the following calendar year. Applications are due not later than 16 September.*

*7. In-state proprietary vocational school certificates (letters Q-Z and others) are valid for 1 year beginning on 1 December of the calendar year and ending on 30 November of the following calendar year. Applications are due not later than 2 October.*

## **8 VAC 40-31-180. Application requirements.**

*A. Each certification to operate attests that the institution is in compliance with § 23-276.1 through 23-276.12 of the Code of Virginia and with this chapter.*

*B. To apply for certification the following information must be submitted:*

*1. A completed certification application form provided by SCHEV.*

*2. A statement regarding the institution's accreditation status.*

*a. Vocational schools need not provide a statement of accreditation but rather a statement that courses of study*

*offered conform to state, federal, trade, or manufacturing standards of training for the occupational fields in which such standards have been established or that courses conform to recognized training practices in those fields.*

*b. Out-of-state Institutions requesting certification must be accredited by an accrediting organization recognized by the United States Department of Education.*

*c. Unaccredited institutions who offer courses for degree credit must submit a plan of action for securing accreditation from an organization recognized by the United States Department of Education, including the name of the accrediting organization and timeframe. In order to remain eligible for certification, an institution must secure as a minimum, candidacy status or equivalent within two three years of its initial date of certification, and initial accreditation not later than five six years after initial certification.*

*d. Unaccredited institutions that undergo a change of ownership during the time period covered by the plan of action for securing accreditation, and that wish to remain eligible for certification under new ownership, will remain on the plan of action timeframe established by the former ownership. This plan of action timeframe begins from the initial date of certification under the former ownership and encompasses the accreditation dates established in the plan of action put into place by the former ownership. No additional time will be granted for obtaining the minimum level of accreditation required of the plan of action due to the change in ownership. Changes to the plan of action timeframe for accreditation will not be granted except at the discretion of the Council.*

*3. A copy of the transacted surety instrument form.*

*4. A completed checklist, signed and dated, acknowledging full compliance with certification criteria, along with a notarized attestation statement signed by the chief executive officer or equivalent .*

*5. A company check in the correct, non-refundable amount, made payable to the Treasurer of Virginia.*

*6. A copy of the institution's certificate from the State Corporation Commission providing authorization to transact business within the Commonwealth.*

*7. For out-of-state institutions, a copy of the institution's authorization to operate from the state agency in which its main campus is domiciled.*

*8. A complete listing of all sites, along with their addresses, phone numbers (if applicable), and classes taught at the site.*

*9. For new postsecondary school applicants, the President or CEO shall provide a signed and notarized statement, which attests to any previous involvement in the operation of a postsecondary school, or any previous involvement by any member of the institutions governing board in the operation of a postsecondary school. As a minimum this statement shall include the name(s) of previous institutions, the dates of the involvement, the positions held within the*

institution, the location, and the status (open/closed, and accredited/non-accredited) of the institution.

10. A complete list of all diploma, certificate, or degree program offerings during the valid period of the certification. This list shall consist of the number of hours required for completion of each program, the Classification of Instructional Programs (CIP) Code where applicable, and the type of program and degree.

a. New and unaccredited Institutions must also include their estimated annual enrollment projections and number of students per program, and;

b. Include from the previous year; degrees conferred, placement information, and fall (or equivalent) headcounts.

C. An existing post-secondary school licensed by any other state agency empowered by the Code of Virginia to license the school, its teachers or curriculum, or both, must become certified prior to enrolling any student into a course for degree credit or program of study. The school must submit an application for certification to operate that shall contain all of the requirements outlined in 8 VAC 40-31-160 A and B.

D. All proprietary postsecondary schools must provide evidence of a valid business license from the locality within which it seeks to operate. Upon confirmation that an institution is operating without the required business license, Council shall take action as required by § 23-276.15 of the Code of Virginia.

### **8 VAC 40-31-190. Withdrawal of application by a postsecondary school.**

A. A school that has submitted an application to the Council may withdraw that application without prejudice at any time.

B. Withdrawal of an application by a school shall result in revocation by the Council of all authorizations associated with that application that previously had been granted to the institution.

C. A school that has withdrawn an application may submit, at any time and without prejudice, a new application to the Council in accordance with Part V of this chapter.

D. A school that withdraws an application prior to receiving notification of certification will receive a refund of the filing fee minus a handling charge.

### **8 VAC 40-31-200. Audit requirements.**

A. All certified postsecondary schools shall be subject to random periodic audits. The purpose of such audit is to verify compliance with certification criteria.

B. At the discretion of Council staff, an audit review committee shall consist of the executive director or designee and may:

1. Include individuals with the experience in the disciplines in which the institution provides instruction; and/or

2. Consist of Council staff.

C. Audits shall be random and/or triggered by, but not limited to, the following events:

1. Staff concerns based on questionable initial or re-certification application information.

2. Volume and frequency of negative student complaints and/or adverse publicity.

3. Difficulty securing accreditation within the specified time period.

4. Adverse action by the U.S. Department of Education or the institution's accrediting agency.

5. A USDE composite financial responsibility score of less than 1.0.

D. Following an audit of the institution, Council staff will prepare a report with recommendations for review by the Council. If a school is found non-compliant, the Council may:

1. Determine no action is necessary and have the report filed;

2. Change the status to probationary certification and require remedial action(s) within a specified timeframe;

3. Revoke or suspend certification;

### **8 VAC 40-31-210. Duplication of, and need for instruction for degree credit is irrelevant.**

In considering an school's application, the Council shall not take into account either duplication of effort by public and private schools in Virginia or need within the Commonwealth for the course for degree credit, program of study, or degree program for which certification is sought.

## PART VII.

### PROCEDURES FOR CONDUCTING FACT-FINDING CONFERENCES AND HEARINGS.

### **8 VAC 40-31-220. Procedural rules for the conduct of fact-finding conferences and hearings (§ 2.2-4019 through 2.2-4030 of the Code of Virginia).**

A. Fact-finding conference; notification, appearance, conduct.

1. Unless there are emergency circumstances requiring immediate action, no certification application shall be denied, suspended or revoked except upon notice stating the proposed basis for such action and the time and place for a fact-finding conference.

2. If a basis exists for a refusal to certify or a suspension or a revocation of a certificate to operate, the council shall notify, by certified mail or by hand delivery, the interested parties at the address of record maintained by the council.

3. Notification shall include the basis for the proposed action and afford interested parties the opportunity to present written and oral information to the Council, which may have a bearing on the proposed action at a fact-finding conference. If there is no withdrawal, a fact-finding conference shall be scheduled at the earliest mutually agreeable date, but no later than 60 days from the date of the notification. Institutions who wish to waive their right to a conference shall notify the Council at least 14 days before the scheduled conference.

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4. If after consideration of information presented during an informal fact-finding conference, a basis for action still exists, the interested parties shall be notified in writing within 60 days of the fact-finding conference, via certified or hand-delivered mail, of the decision and the right to a formal hearing. Parties to the conference may agree to extend the report deadline if more time is needed to consider relevant information.

**B. Hearing; notification, appearance, conduct.**

1. If, after a fact-finding conference, a sufficient basis still exists to deny, suspend or revoke a certification, interested parties shall be notified by certified mail or hand delivery of the proposed action and of the opportunity for a hearing on the proposed action. If an organization desires to request a hearing, it shall notify the council within 14 days of receipt of a report on the conference. Parties may enter into a consent agreement to settle the issues at any time prior to, or subsequent to, an informal fact-finding conference.

2. If an interested party or representative fails to appear at a hearing, the hearing officer may proceed in his absence and make a recommendation.

3. Oral and written arguments may be submitted to and limited by the hearing officer. Oral arguments shall be recorded in an appropriate manner.

**C. Hearing location.** Hearings before a hearing officer shall be held, insofar as practicable, in the county or city in which the institution is located. Hearing officers may conduct hearings at locations convenient to the greatest number of persons or by telephone conference, videoconference or similar technology, in order to expedite the hearing process.

**D. Hearing decisions.**

1. Recommendations of the hearing officer shall be a part of the record and shall include a written statement of the hearing officer's findings of fact and recommendations as well as the reasons or basis for the recommendations. Recommendations shall be based upon all the material issues of fact, law or discretion presented on the record.

2. The Council shall review the recommendation of the hearing officer and render a decision on the recommendation within 30 days of receipt. The decision shall cite the appropriate rule, relief or denial thereof as to each issue.

**E. Agency representation.** The executive director's designee may represent the Council in an informal conference or at a hearing.

**PART VIII.**

**CRIMINAL PROSECUTION FOR VIOLATION; CIVIL ENFORCEMENT.**

**8 VAC 40-31-230. Criminal prosecution for violation.**

A. Any person, firm, association, postsecondary school, trust, or other entity which violates any provision of § 23-276.12 of the Code of Virginia or which, without certification from the Council as provided in this chapter, offers or confers degrees, diplomas, certificates, programs, or courses of study shall be guilty of a class 1 misdemeanor.

B. Each degree, diploma, certificate, program, or course of study offered or conferred in violation of this chapter or each violation of the provisions of § 23-276.12 of the Code of Virginia shall constitute a separate offense.

C. The council shall take any action required by code to deter illegal or improper acts, which may violate the requirement for institutional certification.

**8 VAC 40-31-240. Civil enforcement.**

Upon the determination of the Council that any institution of higher education, or its agents or representatives, is in violation of this chapter, the Council may institute a proceeding in equity to enjoin the violation. It shall not be necessary for the Council to allege or prove an inadequate remedy at law in that proceeding. In the civil proceeding, the Council may also sue for and recover a monetary penalty if no criminal prosecution is instituted as provided by § 23-276.12 B and C of the Code of Virginia.

**PART IX.**

**ADDITIONAL REGULATIONS.**

**8 VAC 40-31-250. Virginia law to apply to agreements.**

The laws of Virginia shall govern any agreement, contract, or instrument of indebtedness executed between a postsecondary school and any person enrolling in any course or program offered or to be offered by a postsecondary school in Virginia and also between that postsecondary school and any person employed or offered employment by that postsecondary school in Virginia.

**8 VAC 40-31-260. Fees.**

A. Fees are included in Schedule A of this regulation.

B. All fees collected by Council staff will be deposited in the State Treasury.

C. All fees are non-refundable with the exception of withdrawal of an application in which case all fees will be refunded minus a reasonable handling charge.

D. Fees must be paid with a company check and made payable to the Treasurer of Virginia.

**8 VAC 40-31-270. Receipt of applications, correspondence and other materials.**

A. All applications, forms, letters or other materials relating to, or required by this chapter should be sent to:

State Council of Higher Education for Virginia  
ATTN: Institutional Certification  
James Monroe Building, 9th Floor  
101 North Fourteenth Street  
Richmond, Virginia 23219

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

**8 VAC 40-31-280. Closure of a postsecondary school.**

A. The Council, on its own motion, may authorize a postsecondary school whose application for certification to operate is denied in accordance with 8 VAC 40-31-200 of this

chapter to continue to offer instruction for degree credit to all currently enrolled students until the end of the semester, quarter, or other academic term during which certification is denied.

B. The Council, on its own motion, may authorize a school whose certification is revoked in accordance with 8 VAC 40-31-200 of this chapter to offer the coursework necessary for all currently enrolled students to complete their programs and to award degrees to those students, provided that the institution:

1. Offers degree coursework only to those students who were enrolled at the time the school's certification was revoked; and
2. Offers all necessary coursework on a schedule that permits all currently enrolled students to complete their programs in a reasonable period of time.

C. When a school decides to voluntarily cease operations it must immediately inform the Council of the following:

1. The planned date for the termination of operations.
2. The planned date and location for the transfer of student records.
3. The name and address of the organization to receive and manage the student records and the name of the official who is designated to manage transcript requests. The organization designated for the preservation of the student records may not be corporately connected to the closing school.
4. Arrangements for the continued education of currently enrolled students via Teach-Out Agreement or other practical solution.
5. Rosters showing the name, address, and current academic status of enrolled students.

D. In the event of institutional closure or revocation of certification, Council may facilitate the transfer of student records to the designated repository.

E. Council shall be responsible for securing and preserving student records until the designated repository accepts them.

F. Council shall seek the advice of the Career College Advisory Board on matters relating to school closures.

### **8 VAC 40-31-290. Waiver by Council.**

The Council may waive or modify the certification requirements for an accredited institution, if the Council finds that such waiver or modification will not conflict with the intent of the regulations and that in light of the institution's mission, literal application of such requirement(s) creates an unreasonable hardship on the institution.

### **8 VAC 40-31-300. Freedom of Information Act to apply.**

All materials submitted by an institution in its application for approval or in response to a request by the council for pertinent information shall be subject to the Virginia Freedom of Information Act (Chapter 21 of Title 2.1 of the Code of Virginia) and shall be available for public inspection in

accordance with the provisions of § 2.1-342 of the Code of Virginia.

### **8 VAC 40-31-310. Student Tuition Guaranty Fund (proprietary schools only).**

A. The Executive Director shall appoint in writing a Director of the Student Guaranty Fund.

B. The purpose of the fund is to reimburse tuition and fees due students at institutions previously approved under § 22.1-321 of the Code of Virginia when the school ceases to operate.

C. Schools seeking initial certification after July 1, 2004, shall not be required to pay into the fund. All other schools which were certified to operate prior to July 1, 2004, under the provisions of § 22.1-321 of the Code of Virginia, shall be subject to the provisions valid at the time of certification.

D. A claim shall be made against the fund only if it arises out of the cessation of operation by a school on or after the effective date of this chapter. If the school holds a surety bond or other guaranty instrument, the first priority shall be to file a claim against the guaranty instrument. Claims shall be filed with the director of the fund on forms prescribed by the Council within three years after cessation of operation by the school. Claims filed after that are not considered. Within a reasonable time after receipt of a claim, the director shall give the school or its owners, or both, notice of the claim and an opportunity to show cause, within 30 days, why the claim should not be reimbursed in whole or part. The director may cause to be made other investigation of the claim as he deems appropriate or may base his determination, without further investigation, upon information contained in the records of the Council.

E. The director's determination shall be in writing and shall be mailed to the claimant and the school or its owners, or both, and shall become final 30 days after the receipt of the determination unless either the claimant or the school, or its owners, within the 30-day period, files with the director a written request for a hearing. Upon request, a hearing shall be held and, subject to the authority of the director to exclude irrelevant or other inappropriate evidence, the claimant and the school or its owners may present such information as they deem pertinent.

F. The Executive Director shall administer the fund upon the following basis:

1. The assets of the fund may not be expended for any purpose other than to pay bona fide claims made against the fund;
2. All payments into the fund shall be maintained by the state comptroller who shall deposit and invest the assets of the fund in any savings accounts or funds which are federally or state insured, and all interests or other return on the fund shall be credited to the fund;
3. Payment into the fund shall be made in the form of a company or cashier's check or money order made payable to the "Student Tuition Guaranty Fund";

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G. When a claim is allowed by the director, the Executive Director, as agent for the fund, shall be subrogated in writing to the amount of the claim and the Executive Director is authorized to take all steps necessary to perfect the subrogation rights before payment of the claim. Refunds will be made, first, to the lender issuing student financial aid or the guarantor of the loan, and second, to the student. In the event there was no financial aid involved, refunds will be made to the student.

## 8 VAC 40-31-320. Agent registration.

A. Agents representing non-certified accredited postsecondary schools must:

1. Register with the Council prior to soliciting in Virginia and;
2. Pay an annual fee of \$300.00 for each registrant.

B. Agents representing non-certified unaccredited postsecondary schools shall not conduct business in Virginia.

C. Agents operating sites in Virginia must seek Council certification.

### Schedule A FLAT-RATE FEES

|  |  |
|--|--|
| Initial fee for all new institutions of higher education =   | \$6,000  |
| Annual fee for all unaccredited institutions of higher education =                                   | \$6,000  |
| Annual fee for all existing accredited institutions of higher education =                            | \$2,500  |
| Initial fee for all new vocational schools =   | \$2,500  |
| Annual fee for all existing vocational schools with gross tuition collected greater than \$150,000 = | \$2,500  |
| Annual fee for all vocational schools with gross tuition collected less than or equal to \$150,000 = | \$1,500  |
| Late fee =   | \$100.00/day for first 10 business days after expiration of annual certification (11th day institution notified to cease and desist and matter referred for prosecution) |
| Non-compliance administrative fees =   | \$1000 for each occurrence of non-compliance found as a result of audit  |

Initial or renewed exemption application/ request for name acknowledgement/agent registration = \$300.00

Non-refundable handling charge (withdrawal of application) = \$300.00

/s/ Mark R. Warner  
Governor

Date: November 2, 2004

VA.R. Doc. No. R05-65; Filed November 8, 2004, 4:04 p.m.



## TITLE 12. HEALTH

### STATE BOARD OF HEALTH

**Title of Regulation:** 12 VAC 5-90. Regulations for Disease Reporting and Control (amending 12 VAC 5-90-10, 12 VAC 5-90-40, 12 VAC 5-90-90, 12 VAC 5-90-100 and 12 VAC 5-90-110; adding 12 VAC 5-90-105 and 12 VAC 5-90-120).

**Statutory Authority:** §§ 32.1-12, 32.1-35 and 32.1-48.05 of the Code of Virginia.

**Effective Dates:** November 5, 2004, through November 4, 2005.

**Agency Contact:** C. Diane Woolard, PhD, MPH, Director, Division of Surveillance and Investigation, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-8141, FAX (804) 864-8139 or e-mail [diane.woolard@vdh.virginia.gov](mailto:diane.woolard@vdh.virginia.gov).

#### Preamble:

The proposed emergency regulations are necessary to comply with Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia. Enacted on April 12, 2004, the law specifies actions to be taken in response to communicable diseases of public health threat related to quarantine and isolation, and requires that regulations must be effective within 280 days from the date of enactment.

This emergency action amends 12 VAC 5-90-40 (Administration) to provide additional detail on the basic responsibilities of the individuals or organizations responsible for the reporting and control of diseases. This includes additional specification of the State Board of Health's role in addressing emergencies or preventing potential emergencies from diseases dangerous to the public health. This also includes further detail on the methods available to the State Health Commissioner to control the spread of any disease of public health importance. In addition, the amendment will provide additional clarification of the role of the local health director and the Office of Epidemiology in the control of diseases of public health importance.

12 VAC 5-90-90 (Those Required to Report) is amended so that some components of the responsibilities of the local

health director is moved to 12 VAC 5-90-100 for consistency, and to provide further explanation of the isolation authorities provided. As well, 12 VAC 5-90-100 has been amended to update the document incorporated by reference, *Control of Communicable Diseases Manual*, to reflect the most recent version (18th edition, 2004).

Two new sections address Isolation for Diseases of Public Health Threat, and Quarantine. These sections (12 VAC 5-90-105 and 12 VAC 5-90-110, respectively) provide the details for the implementation of action to isolate and/or quarantine individuals, groups, or affected areas as a result of a known or suspected risk from a communicable disease of public health threat. As a result of the insertion of these new sections, the section on "dosage and age requirements for immunizations; obtaining immunizations" (previously 12 VAC 5-90-110) has been renumbered to 12 VAC 5-90-120.

Finally, new definitions are proposed in 12 VAC 5-90-10 and some existing definitions have been modified or deleted in order to provide the appropriate context for the above regulation changes and to bring the definitions up to date.

## 12 VAC 5-90-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Affected area" means any part or the whole of the Commonwealth, which has been identified as where individuals reside, or may be located, who are known to have been exposed to or infected with or who are reasonably suspected to have been exposed to or infected with a communicable disease of public health threat.

"Board" means the State Board of Health.

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

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

"Child care center" means a child day center, child day center system, child day program, family day home, family day system, or registered family day home as defined by § 63.2-100 of the Code of Virginia, or a similar place providing day care of children by such other name as may be applied.

"Clinic" means any facility, freestanding or associated with a hospital, that provides preventive, diagnostic, therapeutic, rehabilitative, or palliative care or services to outpatients.

"Commissioner" means the State Health Commissioner, or his duly designated officer or agent, unless stated in a provision of these regulations that it applies to the State Health Commissioner in his sole discretion.

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

intermediate host or a vector or through the inanimate environment.

"Communicable disease of public health significance" means an illness caused by a specific or suspected infectious agent that may be transmitted directly or indirectly from one individual to another. This includes, but is not limited to, infections caused by human immunodeficiency viruses, blood-borne pathogens, and tubercle bacillus. The State Health Commissioner may determine that diseases caused by other pathogens constitute communicable diseases of public health significance.

"Communicable disease of public health threat" means an illness of public health significance, as determined by the State Health Commissioner in accordance with these regulations, caused by a specific or suspected infectious agent that may be reasonably expected or is known to be readily transmitted directly or indirectly from one individual to another and has been found to create a risk of death or significant injury or impairment; this definition shall not, however, be construed to include human immunodeficiency viruses or the tubercle bacilli, unless used as a bioterrorism weapon.

"Companion animal" means any domestic or feral dog, domestic or feral cat, nonhuman primate, guinea pig, hamster, rabbit not raised for human food or fiber, exotic or native animal, reptile, exotic or native bird, or any feral animal or any animal under the care, custody, or ownership of a person or any animal that is bought, sold, traded, or bartered by any person. Agricultural animals, game species, or any animals regulated under federal law as research animals shall not be considered companion animals for the purpose of this article [ Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia ].

"Condition" means any adverse health event ~~that is not technically a disease~~, such as a disease, an infection, a syndrome, or a procedure (including, but not limited to, the results of a physical exam, laboratory test, or imaging interpretation) indicating that an exposure of public health importance has occurred.

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

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

"Decontamination" means the use of physical or chemical means to remove, inactivate, or destroy hazardous substances or organisms from a surface, item or person to the point that such substances or organisms are no longer capable of causing adverse health affects and the surface or item is rendered safe for handling, use, or disposal.

"Department" means the State Department of Health.

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

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

"Essential needs" means basic human needs for sustenance including, but not limited to, food, water and health care, e.g., medications, therapies, testing, and durable medical equipment.

"Exceptional circumstances" means the presence, as determined by the commissioner in his sole discretion, of one or more factors that may affect the ability of the department to effectively control a communicable disease of public health threat. Factors to be considered include, but are not limited to: 1) characteristics or suspected characteristics of the disease-causing organism or suspected disease-causing organism such as virulence, routes of transmission, minimum infectious dose, rapidity of disease spread, the potential for extensive disease spread, and the existence and availability of demonstrated effective treatment; 2) known or suspected risk factors for infection; 3) the potential magnitude of the effect of the disease on the health and welfare of the public; and 4) the extent of voluntary compliance with public health recommendations. The determination of exceptional circumstances by the commissioner may take into account the experience or results of investigation in Virginia, another state or another country.

"Foodborne outbreak" means two or more cases of a similar illness acquired through the consumption of food contaminated with chemicals or an infectious agent or its toxic products. Such illnesses include but are not limited to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, Clostridium perfringens food poisoning, hepatitis A, and Escherichia coli O157:H7 illness.

"Hepatitis C, acute" means the following clinical characteristics are met: (i) discrete onset of symptoms indicative of viral hepatitis and (ii) jaundice or elevated serum aminotransferase levels and the following laboratory criteria are met: (a) serum aminotransferase levels greater than seven times the upper limit of normal; (b) IgM anti-HAV negative; (c) IgM anti-HBc negative (if done) or HBsAg negative; and (d) antibody to hepatitis C virus (anti-HCV) positive verified by a repeat anti-HCV positive test by EIA and confirmed by a more specific assay or positive by RIBA, nucleic acid test, or anti-HCV by EIA with a signal-to-cutoff ratio of 3.8 or greater.

"Hepatitis C, chronic" means that the laboratory criteria specified in clauses (b), (c) and (d) listed above for an acute case are met but clinical symptoms of acute viral hepatitis are not present and serum aminotransferase levels do not exceed seven times the upper limit of normal. This category will include cases that may be acutely infected but not symptomatic.

"Immunization" means a procedure that increases the protective response of an individual's immune system to specified pathogens.

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

"Individual" means a person or companion animal. When the context requires it, "person or persons" shall be deemed to include any individual.

"Infection" means the entry and multiplication or persistence of an organism (prion, virus, rickettsia, bacteria, fungus, protozoan, helminth, or ectoparasite) in the body of an individual. An infection may be inapparent (i.e., without recognizable signs or symptoms but identifiable by laboratory means) or manifest (clinically apparent).

"Invasive" means the organism is affecting a normally sterile site, including but not limited to blood or cerebrospinal fluid.

"Investigation" means an inquiry into the incidence, prevalence, extent, source, mode of transmission, causation of, and other information pertinent to a disease occurrence.

"Isolation" means ~~separation for the period of communicability of infected persons or animals from others in such places and under such conditions as to prevent or limit the direct or indirect transmission of an infectious agent from those infected to those who are susceptible. The means of isolation shall be the least restrictive means appropriate under the facts and circumstances as determined by the commissioner~~ the physical separation, including confinement or restriction of movement, of an individual or individuals who are infected with or are reasonably suspected to be infected with a communicable disease of public health threat in order to prevent or limit the transmission of the communicable disease of public health threat to uninfected and unexposed individuals.

"Isolation, complete" means the full-time confinement or restriction of movement of an individual or individuals infected with, or reasonably suspected to be infected with, a communicable disease in order to prevent or limit the transmission of the communicable disease to uninfected and unexposed individuals.

"Isolation, modified" means a selective, partial limitation of freedom of movement or actions of an individual or individuals infected with, or reasonably suspected to be infected with, a communicable disease. Modified isolation is designed to meet particular situations and includes, but is not limited to, the exclusion of children from school, the prohibition or restriction from engaging in a particular occupation or using public or mass transportation, or requirements for the use of devices or procedures intended to limit disease transmission.

"Isolation, protective" means the physical separation of a susceptible individual or individuals not infected with, or not reasonably suspected to be infected with, a communicable disease from an environment where transmission is occurring, or is reasonably suspected to be occurring, in order to prevent the individual or individuals from acquiring the communicable disease.

"Laboratory" as used herein means a clinical laboratory that examines materials derived from the human body for the purpose of providing information on the diagnosis, prevention, or treatment of disease.

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

*"Law-enforcement agency" means any sheriff's office, police department, adult or youth correctional officer, or other agency or department that employs persons who have law-enforcement authority that is under the direction and control of the Commonwealth or any local governing body. "Law-enforcement agency" shall include, by order of the Governor, the Virginia National Guard.*

*"Lead-elevated blood levels" means a child or children 15 years of age and younger with a confirmed blood level greater than or equal to 10 micrograms of lead per deciliter (µg/dL) of whole blood, a person older than 15 years of age with a venous blood lead level greater than or equal to 25 µg/dL, or such lower blood lead level as may be recommended for individual intervention by the department or the Centers for Disease Control and Prevention.*

*"Least restrictive" means the minimal limitation of the freedom of movement and communication of an individual while under an order of isolation or an order of quarantine that also effectively protects unexposed and susceptible individuals from disease transmission.*

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

*"Midwife" means any person who is licensed as a nurse midwife by the Virginia Boards of Nursing and Medicine or who possesses a midwife permit issued by the State Health Commissioner.*

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

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

*"Occupational outbreak" means a cluster of illness or disease that is indicative of an occupational health problem. Such diseases include but are not limited to silicosis, asbestosis, byssinosis, and tuberculosis.*

*"Outbreak" means the occurrence of more cases of a disease than expected.*

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

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

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

~~1. Complete quarantine. The formal limitation of freedom of movement of well persons or animals exposed to a reportable disease for a period of time not longer than the longest incubation period of the disease in order to prevent effective contact with the unexposed. The means of~~

~~complete quarantine shall be the least restrictive means appropriate under the facts and circumstances, pursuant to 12 VAC 5-90-90 E or as determined by the commissioner.~~

~~2. Modified quarantine. A selective, partial limitation of freedom of movement of persons or domestic animals, determined on the basis of differences in susceptibility, or danger of disease transmission. Modified quarantine is designed to meet particular situations and includes but is not limited to, the exclusion of children from school and the prohibition or restriction of those exposed to or suffering from a communicable disease from engaging in a particular occupation. The means of modified quarantine shall be the least restrictive means appropriate under the facts and circumstances, pursuant to 12 VAC 5-90-90 E or as determined by the commissioner.~~

~~3. Segregation. The separation, for special control or observation, of one or more persons or animals from other persons or animals to facilitate control or surveillance of a reportable disease. The means of segregation shall be the least restrictive means available under the facts and circumstances, as determined by the commissioner the physical separation, including confinement or restriction of movement, of an individual or individuals who are present within an affected area or who are known to have been exposed, or may reasonably be suspected to have been exposed, to a communicable disease of public health threat and who do not yet show signs or symptoms of infection with the communicable disease of public health threat in order to prevent or limit the transmission of the communicable disease of public health threat to unexposed and uninfected individuals.~~

*"Quarantine, complete" means the full-time confinement or restriction of movement of an individual or individuals who do not have signs or symptoms of infection but may have been exposed, or may reasonably be suspected to have been exposed, to a communicable disease of public health threat in order to prevent the transmission of the communicable disease of public health threat to uninfected individuals.*

*"Quarantine, modified" means a selective, partial limitation of freedom of movement or actions of an individual or individuals who do not have signs or symptoms of the infection but have been exposed to, or are reasonably suspected to have been exposed to, a communicable disease of public health threat. Modified quarantine may be designed to meet particular situations and includes, but is not limited to, limiting movement to the home, work, and/or one or more other locations, the prohibition or restriction from using public or mass transportation, or requirements for the use of devices or procedures intended to limit disease transmission.*

*"Reportable disease" means an illness due to a specific toxic substance, occupational exposure, or infectious agent, which affects a susceptible individual, either directly, as from an infected animal or person, or indirectly through an intermediate host, vector, or the environment, as determined by the board.*

*"School" means (i) any public school from kindergarten through grade 12 operated under the authority of any locality within the Commonwealth; (ii) any private or parochial school*

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that offers instruction at any level or grade from kindergarten through grade 12; (iii) any private or parochial nursery school or preschool, or any private or parochial child care center licensed by the Commonwealth; and (iv) any preschool handicap classes or Head Start classes.

"Serology" means the testing of blood, serum, or other body fluids for the presence of antibodies or other markers of an infection or disease process. For the purpose of this regulation, serology includes the concept that a positive test result is defined as one that is outside the normal range of results as determined by the laboratory performing the test.

"Surveillance" means the ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in the planning, implementation and evaluation of public health practice. A surveillance system includes the functional capacity for data analysis as well as the timely dissemination of these data to persons who can undertake effective prevention and control activities.

*"Susceptible individual" means a person or animal who is vulnerable to or potentially able to contract a disease or condition. Factors that affect an individual's susceptibility include, but are not limited to, physical characteristics, genetics, previous or chronic exposures, chronic conditions or infections, immunization exposure, or medications.*

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

"Tuberculosis, active disease" (also "active tuberculosis disease" and "active TB disease"), as defined by § 32.1-49.1 of the Code of Virginia, means a communicable disease caused by an airborne microorganism and characterized by the presence of either (i) a specimen of sputum or other bodily fluid or tissue that has been found to contain tubercle bacilli as evidenced by culture or nucleic acid amplification, including preliminary identification by rapid methodologies, (ii) a specimen of sputum or other bodily fluid or tissue that is suspected to contain tubercle bacilli as evidenced by smear, and sufficient clinical and radiographic evidence of active tuberculosis disease is present as determined by a physician licensed to practice medicine in Virginia, or (iii) sufficient clinical and radiographic evidence of active tuberculosis disease as determined by the commissioner is present, but a specimen of sputum or other bodily fluid or tissue containing or suspected to contain tubercle bacilli is unobtainable.

"Tubercle bacilli" means disease-causing organisms belonging to the Mycobacterium tuberculosis complex and includes Mycobacterium tuberculosis, Mycobacterium bovis and Mycobacterium africanum or other members as established by the commissioner.

"Tuberculosis" means a disease caused by tubercle bacilli.

"Tuberculosis infection in children age less than 4 years" means a significant reaction resulting from a tuberculin skin test (TST) or other approved test for latent infection without clinical or radiographic evidence of active tuberculosis disease, in children from birth up to their fourth birthday.

"Tuberculin skin test (TST)" means a test for infection with tubercle bacilli, performed according to the Mantoux method, in which 5 tuberculin units (5TU=0.1cc) of a standardized preparation of purified protein derivative (PPD-S) are injected intradermally on the volar surface of the arm and the reaction read as the transverse diameter of the palpable area of induration, recorded in mm of induration. The significance of the measured induration is based on existing national and state guidelines.

"Vaccinia, disease or adverse event" means serious or unexpected events in persons who received the smallpox vaccine or their contacts, including but not limited to bacterial infections, eczema vaccinatum, erythema multiforme, generalized vaccinia, progressive vaccinia, inadvertent inoculation, post-vaccinial encephalopathy or encephalomyelitis, ocular vaccinia, and fetal vaccinia.

"Vancomycin-resistant Staphylococcus aureus" means any Staphylococcus aureus culture that demonstrates intermediate or greater resistance to vancomycin.

"Waterborne outbreak" means two or more cases of a similar illness acquired through the ingestion of or other exposure to water contaminated with chemicals or an infectious agent or its toxic products. Such illnesses include but are not limited to giardiasis, viral gastroenteritis, cryptosporidiosis, hepatitis A, cholera, and shigellosis. A single case of laboratory-confirmed primary amebic meningoencephalitis or of waterborne chemical poisoning is considered an outbreak.

## **12 VAC 5-90-40. Administration.**

A. The State Board of Health ("board") has the responsibility for promulgating regulations pertaining to the reporting and control of diseases of public health importance *and to meet any emergency or to prevent a potential emergency caused by a disease dangerous to the public health including, but not limited to, specific procedures for responding to any disease listed pursuant to § 32.1-35 of the Code of Virginia that is determined to be caused by an agent or substance used as a weapon or any communicable disease of public health threat that is involved in an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia.*

B. The State Health Commissioner ("commissioner") is the executive officer for the State Board of Health with the authority of the board when it is not in session, subject to the rules and regulations of and review by the board. *The commissioner has the authority to require quarantine, isolation, immunization, decontamination or treatment of any individual or group of individuals when he determines any such measure to be necessary to control the spread of any disease of public health importance and the authority to issue orders of isolation pursuant to Article 3.01 (§ 32.1-48.01 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia and orders of quarantine and orders of isolation under exceptional circumstances involving any communicable disease of public*

health threat pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia.

C. The local health director is responsible for the surveillance and investigation of those diseases specified by this chapter which occur in his jurisdiction. He is further responsible for reporting all such surveillance and investigations to the Office of Epidemiology. In cooperation with the commissioner, he is responsible for instituting measures for disease control, which may include *implementing the quarantine, and isolation, or segregation as required by orders of the commissioner.*

D. The Office of Epidemiology, an organizational part of the department, is responsible for the statewide surveillance of those diseases specified by this chapter, *for defining and disseminating appropriate disease control protocols for an outbreak situation, for coordinating the investigation of those diseases with the local health director, and for providing direct assistance where necessary.* The director of the Office of Epidemiology acts as the commissioner's designee in reviewing reports and investigations of diseases and recommendations by local health directors for quarantine or isolation. However, authority to order quarantine or isolation resides solely with the commissioner, ~~unless otherwise expressly provided by him.~~

E. All persons responsible for the administration of this chapter shall ensure that the anonymity of patients and practitioners is preserved, according to state and federal law including the provisions of §§ 32.1-38, 32.1-41, and 32.1-71 of the Code of Virginia.

## **12 VAC 5-90-90. Those required to report.**

A. Physicians. Each physician who treats or examines any person who is suffering from or who is suspected of having a reportable disease or condition shall report that person's name, address, age, date of birth, sex, race, name of disease diagnosed or suspected, and the date of onset of illness, except that influenza should be reported by number of cases only (and type of influenza, if available). The pregnancy status of females who test positive for HBsAg should be reported, if available. Reports are to be made to the local health department serving the jurisdiction where the physician practices. A physician may designate someone to report on his behalf, but the physician remains responsible for ensuring that the appropriate report is made. Any physician, designee, or organization making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

Such reports shall be made on a form to be provided by the department (Epi-1), a computer generated printout containing the data items requested on Form Epi-1, or a Centers for Disease Control and Prevention (CDC) surveillance form that provides the same information and shall be made within three days of the suspicion or confirmation of disease unless the disease in question requires rapid reporting under 12 VAC 5-90-80. Reporting may be done by means of secure electronic transmission upon agreement of the physician and the department.

Pursuant to § 32.1-49.1 of the Code of Virginia, additional elements are required to be reported for individuals with

confirmed or suspected active tuberculosis disease. Refer to Part X for details on these requirements.

B. Directors of laboratories. Any person who is in charge of a laboratory conducting business in the Commonwealth shall report any laboratory examination of any specimen derived from the human body, whether performed in-house or referred to an out-of-state laboratory, which yields evidence, by the laboratory method(s) indicated or any other confirmatory test, of a disease listed in 12 VAC 5-90-80 B.

Each report shall give the source of the specimen and the laboratory method and result; the name, age, date of birth, race, sex, and address of the person from whom the specimen was obtained; and the name and address of the physician or medical facility for whom the examination was made. When the influenza virus is isolated, the type should be reported, if available. The pregnancy status of females who test positive for HBsAg should be reported, if available. Reports shall be made within three days of identification of evidence of disease, except that those identified by an asterisk shall be reported within 24 hours by the most rapid means available, to the local health department serving the jurisdiction in which the laboratory is located. Reports shall be made on Form Epi-1 or on the laboratory's own form if it includes the required information. Computer generated reports containing the required information may be submitted. Reporting may be done by means of secure electronic transmission upon agreement of the laboratory director and the department. Any person making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

A laboratory shall fulfill its responsibility to report anthrax, cholera, diphtheria, E. coli O157:H7, H. influenzae infection, Listeria, meningococcal infection, Mycobacterium tuberculosis (see 12 VAC 5-90-225), pertussis, plague, poliomyelitis, Salmonella infection, Shigella infection, invasive Group A streptococcal infection, and other diseases as may be requested by the health department by both notifying the health department of the positive culture and submitting the initial culture to the Virginia Division of Consolidated Laboratory Services (DCLS). Stool specimens that test positive for Shiga toxin shall be submitted to DCLS for organism identification. All specimens must be identified with the patient and physician information required in this subsection. At times, other laboratories may also be requested to submit specimens to the Virginia Division of Consolidated Laboratory Services.

Laboratories operating within a medical care facility shall be considered to be in compliance with the requirement to notify the health department when the director of that medical care facility assumes the reporting responsibility.

C. Person in charge of a medical care facility. Any person in charge of a medical care facility shall make a report to the local health department serving the jurisdiction where the facility is located of the occurrence in or admission to the facility of a patient with a reportable disease listed in 12 VAC 5-90-80 A unless he has evidence that the occurrence has been reported by a physician. Any person making such report as authorized herein shall be immune from liability as provided by § 32.1-38 of the Code of Virginia. The requirement to report

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shall include all inpatient, outpatient and emergency care departments within the medical care facility. Such report shall contain the patient's name, age, date of birth, address, sex, race, name of disease being reported, the date of admission, hospital chart number, date expired (when applicable), and attending physician. Influenza should be reported by number of cases only (and type of influenza, if available). The pregnancy status of females who test positive for HBsAg should be reported, if available. Reports shall be made within three days of the suspicion or confirmation of disease unless the disease in question requires rapid reporting under 12 VAC 5-90-80 and shall be made on Form Epi-1, a computer generated printout containing the data items requested on Form Epi-1, or a Centers for Disease Control and Prevention (CDC) surveillance form that provides the same information. Reporting may be done by means of secure electronic transmission upon agreement of the medical care facility and the department.

A person in charge of a medical care facility may assume the reporting responsibility on behalf of the director of the laboratory operating within the facility.

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

E. Local health director. The local health director shall forward within three days of receipt to the Office of Epidemiology of the State Health Department any report of a disease or report of evidence of a disease which has been made on a resident of his jurisdiction. This report shall be by telecommunication if the disease is one requiring rapid communication, as required in 12 VAC 5-90-80. All such rapid reporting shall be confirmed in writing and submitted to the Office of Epidemiology within seven days. Furthermore, the local health director shall immediately forward to the appropriate local health director any disease reports on individuals residing in the latter's jurisdiction or to the Office of Epidemiology on individuals residing outside Virginia.

~~When notified about a disease specified in 12 VAC 5-90-80, the local health department shall perform contact tracing for HIV infection, infectious syphilis, and active tuberculosis disease and may perform contact tracing for the other diseases if deemed necessary to protect the public health. The local health director shall have the responsibility to accomplish contact tracing by either having patients inform their potential contacts directly or through obtaining pertinent information such as names, descriptions, and addresses to enable the health department staff to inform the contacts. All contacts of HIV infection shall be afforded the opportunity for appropriate counseling, testing, and individual face-to-face disclosure of their test results. In no case shall names of informants or infected persons be revealed to contacts by the health department. All information obtained shall be kept strictly confidential.~~

~~The local health director or his designee shall review reports of diseases received from his jurisdiction and follow up such reports, when indicated, with an appropriate investigation in order to evaluate the severity of the problem. He shall determine, in consultation with the Director of the Office of Epidemiology and the commissioner, if further investigation is required and if complete or modified quarantine will be necessary.~~

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

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

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

- Creutzfeldt-Jakob disease
- Human immunodeficiency virus infection
- Hepatitis B
- Hepatitis C
- Monkeypox
- Rabies
- Smallpox
- Syphilis, infectious
- Tuberculosis, active disease
- Vaccinia, disease or adverse event
- Viral hemorrhagic fever

G. Employees, applicants, and persons in charge of food establishments. 12 VAC 5-421-80 of the Food Regulations requires a food employee or applicant to notify the person in charge of the food establishment when diagnosed with certain diseases that are transmissible through food. 12 VAC 5-421-120 requires the person in charge of the food establishment to notify the health department. Refer to the appropriate sections

of the Virginia Administrative Code for further guidance and clarification regarding these reporting requirements.

## **12 VAC 5-90-100. Methods.**

~~The "Methods of Control" sections of the 17th Edition of the Control of Communicable Diseases Manual (2000) published by the American Public Health Association shall be complied with by The board and commissioner in controlling shall use appropriate disease control measures to manage the diseases listed in 12 VAC 5-90-80 A, except to the extent that the requirements and recommendations therein are outdated, inappropriate, inadequate, or otherwise inapplicable including, but not limited to those described in the "Methods of Control" sections of the 18th Edition of the Control of Communicable Diseases Manual (2004) published by the American Public Health Association. The board and commissioner reserve the right to use any legal means to control any disease which is a threat to the public health.~~

*When notified about a disease specified in 12 VAC 5-90-80, the local health director or his designee shall have the authority and responsibility to perform contact tracing for HIV infection, infectious syphilis, and active tuberculosis disease and may perform contact tracing for the other diseases if deemed necessary to protect the public health. All contacts of HIV infection shall be afforded the opportunity for appropriate counseling, testing, and individual face-to-face disclosure of their test results. In no case shall names of informants or infected individuals be revealed to contacts by the health department. All information obtained shall be kept strictly confidential.*

*The local health director or his designee shall review reports of diseases received from his jurisdiction and follow up such reports, when indicated, with an appropriate investigation in order to evaluate the severity of the problem. The local health director or his designee may recommend to any individual or group of individuals appropriate public health control measures, including but not limited to quarantine, isolation, immunization, decontamination or treatment. He shall determine, in consultation with the Office of Epidemiology and the commissioner, if further investigation is required and if one or more forms of quarantine and/or isolation will be necessary.*

*Complete isolation shall apply to situations where an individual is infected with a communicable disease of public health significance (including, but not limited to, active tuberculosis disease or HIV infection) and is engaging in behavior which places others at risk for infection with the communicable disease of public health significance, in accordance with the provisions of Article 3.01 (§ 32.1-48.01 et seq.) of the Code of Virginia.*

*Modified isolation shall apply to situations in which the local health director would be best able to judge the potential threat of disease transmission. Such situations shall include, but are not limited to, the temporary exclusion of a child with a communicable disease from school, or the temporary prohibition or restriction of any individual(s) with a communicable disease from engaging in activities that may pose a risk to the health of others, such as using public transportation or performing an occupation such as foodhandling or providing healthcare.*

*Protective isolation shall apply to situations such as the exclusion, under § 32.1 47 of the Code of Virginia, of any unimmunized child from a school in which an outbreak, potential epidemic, or epidemic of a vaccine preventable disease has been identified. To the extent permitted by the Code of Virginia, the local health director may be authorized as the commissioner's designee to implement the forms of isolation described in this section*

*When these forms of isolation are deemed to be insufficient, the local health director may use the provisions of Article 3.01 (§ 32.1-48.01 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia for the control of communicable diseases of public health significance or, in consultation with the Office of Epidemiology, shall provide sufficient information to enable the commissioner to prepare an order or orders of isolation and/or quarantine under Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.01 of the Code of Virginia for the control of communicable diseases of public health threat.*

## **12 VAC 5-90-105. Isolation for Communicable Disease of Public Health Threat.**

*A. Application. The commissioner, in his sole discretion, may invoke the provisions of Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia and may declare the isolation of any individual or individuals upon a determination that:*

- 1. Such individual or individuals are known to have been infected with or are reasonably suspected to have been infected with a communicable disease of public health threat, and*
- 2. Exceptional circumstances render the procedures of Article 3.01 (§ 32.1-48.01 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia to be insufficient, or the individual or individuals have failed or refused to comply voluntarily with the control measures directed by the commissioner in response to a communicable disease of public health threat, and*
- 3. Isolation is the necessary means to contain a communicable disease of public health threat, to ensure that such isolated individual or individuals receive appropriate medical treatment subject to the provisions of § 32.1-44 of the Code of Virginia, or to protect health care providers and others who may come into contact with such infected individual or individuals.*

*The commissioner, in his sole discretion, may also order the isolation of an affected area if, in addition to the above, the Governor has declared a state of emergency for such affected area of the Commonwealth.*

*B. Documentation. For isolation for a communicable disease of public health threat, information about the infection or suspected infection, the individual(s) and/or affected area, and the nature or suspected nature of the exposure shall be duly recorded by the local health department, in consultation with the Office of Epidemiology. This information shall be sufficient to enable documenting a record of findings and to enable the commissioner to prepare the order of isolation, including the information required in § 32.1-48.12 of the Code of Virginia. In addition, sufficient information on individuals shall be*

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*maintained by the local health department to enable appropriate follow-up of individuals for health status evaluation and treatment as well as compliance with the order of isolation.*

*The commissioner shall ensure that the protected health information of any individual or individuals subject to the order of isolation is disclosed only in compliance with state and federal law.*

*C. Means of Isolation. The local health department shall assess the situation and, in consultation with the Office of Epidemiology, identify the least restrictive means of isolation that effectively protects unexposed and susceptible individuals. The place of isolation selected shall allow the most freedom of movement and communication with family members and other contacts without allowing disease transmission to others and shall allow the appropriate level of medical care needed by isolated individuals to the extent practicable. The commissioner, in his sole discretion, may order the isolated individual or individuals to remain in their residences when possible, to remain in another place where they are present, or to report to a place or places designated by the commissioner for the duration of their isolation.*

*The commissioner's order of isolation shall be for a duration consistent with the known period of communicability of the communicable disease of public health threat or, if the course of the disease is unknown or uncertain, for a period anticipated as being consistent with the period of communicability of other similar infectious agents. In the situation where an area is under isolation, the duration of isolation shall take into account the transmission characteristics and known or suspected period of communicability.*

*D. Delivery. The local health department shall deliver the order of isolation, or ensure its delivery by an appropriate party, to the individual(s) affected in person to the extent practicable. If, in the opinion of the commissioner, the scope of the notification would exceed the capacity of the local health department to ensure individual notification in a timely manner, then print, radio, television, internet, and/or other available means would be used to inform those affected.*

*E. Enforcement. Upon finding that there is probable cause to believe that any individual or individuals who are subject to an order of isolation may fail or refuse to comply with such order, the commissioner in his sole discretion may issue an emergency detention order requiring such individual or individuals to be taken immediately into custody by law-enforcement agencies and detained for the duration of the order of isolation or until the commissioner determines that the risk of noncompliance is no longer present. For any individual or individuals identified as, or for whom probable cause exists that he may be, in violation of any order of isolation, the enforcement authority directed by the commissioner to law-enforcement agencies shall include, but need not be limited to, the power to detain or arrest.*

*Any individual or individuals so detained shall be held in the least restrictive environment that can provide any required health care or other services for such individual. The commissioner shall ensure that law-enforcement personnel*

*responsible for enforcing an order or orders of isolation are informed of appropriate measures to take to protect themselves from contracting the disease of public health threat.*

*F. Health Status Monitoring. The local health department shall monitor the health of those under isolation either by regular telephone calls, visits, self-reports, or by report of caregivers or healthcare providers or by other means.*

*G. Essential Needs. Upon issuance of an order of isolation to an individual or individuals by the commissioner, the local health department shall manage the isolation, in conjunction with local emergency management resources, such that individual essential needs can be met to the extent practicable. Upon issuance of an order of isolation by the commissioner to an affected area, existing emergency protocols pursuant to § 44-146.13 et seq. of the Code of Virginia shall be utilized for mobilizing appropriate resources to ensure essential needs are met.*

*H. Release from Isolation. Once the commissioner determines that an individual or individuals no longer pose a threat to the public health, the order of isolation has expired, or the order of isolation has been vacated by the court, the individual or individuals under the order of isolation shall be released immediately.*

*I. Affected Area. If the criteria in subsection A of this section are met and an area is known or suspected to have been affected, then the commissioner shall notify the Governor of the situation and the need to order isolation for the affected area. In order for an affected area to be isolated, the Governor must declare a state of emergency for the affected area.*

*If an order of isolation is issued for an affected area, the commissioner shall cause the order of isolation to be communicated to the individuals residing or located in the affected area. The use of multiple forms of communication, including but not limited to, radio, television, internet, and/or other available means may be required in order to reach the individuals who were in the affected area during the known or suspected time of exposure.*

*The provisions for documentation, means of isolation, enforcement, health status monitoring, essential needs, and release from isolation/quarantine described above will apply to the isolation of affected areas. Appropriate management of a disease of public health threat for an affected area may require the coordinated use of local, regional, state and national resources. In specifying one or more affected areas to be placed under isolation, the objective will be to protect as many people as possible using the least restrictive means. As a result, defining the precise boundaries and time frame of the exposure may not be possible, or may change as additional information becomes available. When this occurs, the commissioner shall ensure that the latest information is communicated to those in the affected area.*

## **12 VAC 5-90-110. Quarantine.**

*A. Application. The commissioner, in his sole discretion, may invoke the provisions of Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia and may order a*

complete or modified quarantine of any individual or individuals upon a determination that:

1. Such individual or individuals are known to have been exposed to or are reasonably suspected to have been exposed to a communicable disease of public health threat, and
2. Exceptional circumstances render the procedures of Article 3.01 (§ 32.1-48.01 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia to be insufficient, or the individual or individuals have failed or refused to comply voluntarily with the control measures directed by the commissioner in response to a communicable disease of public health threat, and
3. Quarantine is the necessary means to contain a communicable disease of public health threat to which an individual or individuals have been or may have been exposed and thus may become infected.

The commissioner, in his sole discretion, may also order the quarantine of an affected area if, in addition to the above, the Governor has declared a state of emergency for such affected area of the Commonwealth.

*B. Documentation.* For quarantine for a communicable disease of public health threat, information about the infection or suspected infection, the individual(s) and/or affected area, and the nature or suspected nature of the exposure shall be duly recorded by the local health department, in consultation with the Office of Epidemiology. This information shall be sufficient to enable documenting a record of findings and enable the commissioner to prepare a written order of quarantine, including the information required in § 32.1-48.09 of the Code of Virginia. In addition, sufficient information on individuals shall be maintained by the local health department to enable appropriate follow-up of individuals for health status evaluation and treatment as well as compliance with the order of quarantine.

The commissioner shall ensure that the protected health information of any individual or individuals subject to the order of quarantine is disclosed only in compliance with state and federal law.

*C. Means of Quarantine.* The local health department shall assess the situation, and in consultation with the Office of Epidemiology, shall recommend to the commissioner the least restrictive means of quarantine that effectively protects unexposed and susceptible individuals. The place of quarantine selected shall allow the most freedom of movement and communication with family members and other contacts without allowing disease transmission to others.

The commissioner, in his sole discretion, may order the quarantined individual or individuals to remain in another place where they are present or to report to a place or places designated by the commissioner for the duration of their quarantine.

The commissioner's order of quarantine shall be for a duration consistent with the known incubation period of the communicable disease of public health threat or, if the incubation period is unknown or uncertain, for a period anticipated as being consistent with the incubation period for

other similar infectious agents. In the situation where an area is under quarantine the duration of quarantine shall take into account the transmission characteristics and known or suspected incubation period.

*D. Delivery.* The local health department shall deliver the order of quarantine, or ensure its delivery by an appropriate party, to the individual(s) affected in person to the extent practicable. If, in the opinion of the commissioner, the scope of the notification would exceed the capacity of the local health department to ensure notification in a timely manner, then print, radio, television, internet, and/or other available means would be used to inform those affected.

*E. Enforcement.* Upon finding that there is probable cause to believe that any individual or individuals who are subject to an order of quarantine may fail or refuse to comply with such order, the commissioner in his sole discretion may issue an emergency detention order requiring such individual or individuals to be taken immediately into custody by law-enforcement agencies and detained for the duration of the order of quarantine or until the commissioner determines that the risk of noncompliance is no longer present. For any individual or individuals identified as, or for whom probable cause exists that he may be, in violation of any order of quarantine, the enforcement authority directed by the commissioner to law-enforcement agencies shall include, but need not be limited to, the power to detain or arrest.

Any individual or individuals so detained shall be held in the least restrictive environment that can provide any required health care or other services for such individual. The commissioner shall ensure that law-enforcement personnel responsible for enforcing an order or orders of quarantine are informed of appropriate measures to take to protect themselves from contracting the disease of public health threat.

*F. Health Status Monitoring.* The local health department shall monitor the health of those under quarantine either by regular telephone calls, visits, self-reports, or by report of caregivers or healthcare providers or by other means. If an individual or individuals develop symptoms compatible with the communicable disease of public health threat then 12 VAC-90-105 (Isolation for Communicable Disease of Public Health Threat) would apply to the individual or individuals.

*G. Essential Needs.* Upon issuance of an order of quarantine to an individual or individuals by the commissioner, the local health department shall manage the quarantine, in conjunction with local emergency management resources, such that individual essential needs can be met to the extent practicable. Upon issuance of an order of quarantine by the commissioner to an affected area, existing emergency protocols pursuant to § 44-146.13 et seq. of the Code of Virginia shall be utilized for mobilizing appropriate resources to ensure essential needs are met.

*H. Release from Quarantine.* Once the commissioner determines that an individual or individuals are determined to no longer be at risk of becoming infected and pose no risk of transmitting the communicable disease of public health threat to other individuals, the order of quarantine has expired, or the order of quarantine has been vacated by the court, the

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individuals under the order of quarantine shall be released immediately.

*I. Affected Area. If the criteria in subsection A of this section are met and an area is known or suspected to have been affected, then the commissioner shall notify the Governor of the situation and the need to order quarantine for the affected area. In order for an affected area to be quarantined, the Governor must declare a state of emergency for the affected area.*

*If an order of quarantine is issued for an affected area, the commissioner shall cause the order of quarantine to be communicated to the individuals residing or located in the affected area. The use of multiple forms of communication, including but not limited to, radio, television, internet, and/or other available means may be required in order to reach the individuals who were in the affected area during the known or suspected time of exposure.*

*The provisions for documentation, means of isolation, enforcement, health status monitoring, essential needs, and release from quarantine described above will apply to the quarantine of affected areas. Appropriate management of a disease of public health threat for an affected area may require the coordinated use of local, regional, state and national resources. In specifying one or more affected areas to be placed under quarantine, the objective will be to protect as many people as possible using the least restrictive means. As a result, defining the precise boundaries and time frame of the exposure may not be possible, or may change as additional information becomes available. When this occurs, the commissioner shall ensure that the latest information is communicated to those in the affected area.*

## **~~12 VAC 5-90-110~~ 12 VAC 5-590-120. Dosage and age requirements for immunizations; obtaining immunizations.**

A. Every child in Virginia shall be immunized against the following diseases by receiving the specified number of doses of vaccine by the specified ages, unless replaced by a revised schedule of the U.S. Public Health Service:

1. Diphtheria, Tetanus, and Pertussis (Whooping cough) Vaccine - three doses by one year of age of toxoids of diphtheria and tetanus, combined with pertussis vaccine with the remaining two doses administered in accordance with the most recent schedule of the American Academy of Pediatrics or the U.S. Public Health Service.
2. Poliomyelitis Vaccine, trivalent type - three doses of inactivated poliomyelitis vaccine, preferably by one year of age and no later than 18 months of age. Attenuated (live virus) oral polio virus vaccine may be used if the attending physician feels it is clinically appropriate for a given patient.
3. Measles (Rubeola) Vaccine - one dose of further attenuated (live) measles vaccine between 12-15 months of age and no later than two years of age. A second dose shall also be required at the time of initial entry to school. For those children who did not receive a second dose at initial school entry, a second dose shall be required at the time of entry to grade six.

4. Rubella (German measles) Vaccine - one dose of attenuated (live) rubella virus vaccine between 12-15 months of age and no later than two years of age.

5. Mumps Vaccine - one dose of mumps virus vaccine (live) between 12-15 months of age and no later than two years of age.

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

7. Hepatitis B Vaccine - three doses by 12 months of age and no later than 18 months of age. For children not receiving three doses between 12-18 months of age, three doses will be required at initial school entry and at entry into the sixth grade.

8. Varicella (Chickenpox) Vaccine - one dose of varicella vaccine between 12-18 months of age. For those children who did not receive a dose of vaccine between 12-18 months of age, a dose will be required at initial school entry.

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

### DOCUMENTS INCORPORATED BY REFERENCE

Control of Communicable Diseases Manual, 47~~th~~ 18th Edition, American Public Health Association, ~~2000~~ 2004.

/s/ Mark R. Warner  
Governor

Date: November 2, 2004

VA.R. Doc. No. R05-63; Filed November 5, 2004. 3:10 p.m.

## **DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

Title of Regulation: **12 VAC 30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12 VAC 30-80-40).**

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Dates: December 1, 2004, through November 30, 2005.

Agency Contact: Javier Menendez, R.Ph., Manager, Pharmacy Services, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-2196, FAX (804) 786-1680, or e-mail javier.menendez@dmas.virginia.gov.

### Preamble:

*The Administrative Process Act (§ 2.2-4011) states that an "emergency situation" is: (i) a situation involving an imminent threat to public health or safety; or (ii) a situation in which Virginia statutory law, the Virginia appropriation act, or federal law requires that a regulation shall be*

effective in 280 days or less from its enactment, or in which federal regulation requires a regulation to take effect no later than 280 days from its effective date. This suggested emergency regulation meets the standard at § 2.2-4011(ii) of the Code of Virginia as discussed below.

Chapter 4 of the 2004 Acts of Assembly, Item 326 WW (1) (2) and (3), directs DMAS to amend the State Plan for Medical Assistance to modify the reimbursement methodology used to reimburse for generic drug products. This amendment must be effective within 280 days of the date of enactment of Chapter 4; therefore, it qualifies under the authority of § 2.2-4011(ii) of the Code of Virginia as an emergency regulation.

The purpose of this action is to implement the Virginia Maximum Allowable Cost (VMAC) to modify the reimbursement methodology used for generic, multiple source drug products. The VMAC will replace the existing generic drug methodology and will be more responsive to and more accurately reflect prices of multi-source drugs in today's marketplace. Also, this action establishes the criteria for the department to develop VMAC pricing methodology, publish prices, and maintain a procedure whereby pharmacists may dispute the DMAS price for generic drugs and have their disputes resolved quickly. As a result of this change, DMAS will post to its website a monthly listing of generic drugs, prices and information sources with comparisons to reference standards.

## 12 VAC 30-80-40. Fee-for-service providers: pharmacy.

Payment for pharmacy services shall be the lowest of items 1 through 4 (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 Centers for Medicare and Medicaid Services (CMS) upper limit or VMAC cost) subject to the conditions, where applicable, set forth in subdivisions 6 and 7 of this section:

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

~~2. The Virginia Medicaid Maximum Allowable Cost (VMAC) established by the Virginia Department of Medical Assistance Services to be inclusive of appropriate multiple source and specific high cost drugs plus a dispensing fee. Multiple source drugs may include but are not limited to Food and Drug Administration rated products such as drugs established by a Virginia Voluntary Formulary (VVF) drugs, Federal Upper Limit Drugs and any other state or federally approved listing. "Multisource drugs" means covered outpatient drugs for which there are two or more drug products that:~~

~~a. Are included in the Centers for Medicare and Medicaid Services' state drug rebate program;~~

~~b. Have been approved by the Federal Food and Drug Administration (FDA);~~

~~c. Are included in the Approved Products with Therapeutic Equivalence Evaluations as generically equivalent; and~~

~~d. Are sold or marketed in Virginia.~~

2. The methodology used to reimburse for generic drug products shall be the higher of either: (i) the lowest Wholesale Acquisition Cost (WAC) plus 10 percent, OR (ii) the second lowest WAC plus six percent. This methodology shall reimburse for products' costs based on a Maximum Allowable Cost (VMAC) list to be established by the single state agency. In developing the maximum allowable reimbursement rate for generic pharmaceuticals, the department or its designated contractor shall:

a. Identify three different suppliers, including either manufacturers or wholesalers, that are able to supply, in sufficient quantities, pharmaceutical products. The drugs considered must be listed as therapeutically and pharmaceutically equivalent in the Food and Drug Administration's most recent version of the Approved Drug Products with Therapeutic Equivalence Evaluations ("Orange Book"). Pharmaceutical products that are not available from three different suppliers, including either manufacturers or wholesalers, shall not be subject to the VMAC list;

b. Identify that the use of a VMAC rate is lower than the Federal Upper Limit (FUL) for the drug. The FUL is a known, widely published price provided by CMS; and

c. Distribute the list of state VMAC rates to pharmacy providers in a timely manner prior to the implementation of VMAC rates and subsequent modifications. DMAS shall publish on its website, each month, the information used to set the Commonwealth's prospective VMAC rates, including, but not necessarily limited to:

(i) The identity of applicable reference products used to set the VMAC rates;

(ii) The Generic Code Number (GCN) or National Drug Code (NDC), as may be appropriate of reference products;

(iii) The difference by which the VMAC rate exceeds the appropriate WAC price; and

(iv) The identity and date of the published compendia used to determine reference products and set the VMAC rate. The difference by which the VMAC rate exceeds the appropriate WAC price shall be at least or equal to 10 percent above the lowest-published wholesale acquisition cost for products widely available for purchase in the Commonwealth and shall be included in national pricing compendia.

Development of a VMAC rate that does not have a FUL rate shall not result in the use of higher-cost innovator brand name or single source drugs in the Medicaid program.

DMAS or its designated contractor shall:

(i) Implement and maintain a procedure to add or eliminate products from the list, or modify VMAC rates, consistent with changes in the fluctuating marketplace.

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DMAS or its designated contractor will regularly review manufacturers' pricing and monitor drug availability in the marketplace to determine the inclusion or exclusion of drugs on the VMAC list; and

(ii) Provide a pricing dispute resolution procedure to allow a dispensing provider to contest a listed VMAC rate. DMAS or its designated contractor shall confirm receipt of pricing disputes within 24 hours, via telephone or facsimile, with the appropriate documentation of relevant information, e.g., invoices. Disputes shall be resolved within three business days of confirmation. The pricing dispute resolution process will include DMAS' or the contractor's verification of accurate pricing to ensure consistency with marketplace pricing and drug availability. Providers will be reimbursed, as appropriate, based on findings. Providers shall be required to use this dispute resolution process prior to exercising any applicable appeal rights.

3. The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percentage discount established by the General Assembly (as set forth in subdivision § 7 of this section) or, in the absence thereof, by the following methodology set out in subdivisions a through c below.

- a. Percentage 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.

4. ~~(Reserved.)~~

~~5.~~ 4. The provider's usual and customary charge to the public, as identified by the claim charge.

~~6.~~ 5. 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. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The dispensing fee of \$3.75 (effective July 1, 2003) shall remain in effect.

~~7.~~ 6. The Program pays additional reimbursement for unit dose dispensing system of dispensing drugs. DMAS defines its unit dose dispensing system coverage consistent with that of the Board of Pharmacy of the Department of Health Professions (18 VAC 110-20-420). This service is paid only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose per capita fee to be submitted by the pharmacy for unit dose dispensing services to a nursing home resident. Only one service fee per month may be submitted by the pharmacy for each patient receiving unit dose dispensing services. ~~The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC, based on the 60th percentile or maximum cost level, as identified by the~~

~~state agency or CMS' upper limits as applicable. Multi-source drugs will be reimbursed at the maximum allowed drug cost for specific multiple source drugs, as identified by the state agency or CMS' upper limits as applicable.~~ All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency. The original per capita fee shall be determined by a DMAS analysis of costs related to such dispensing, and shall be reevaluated at periodic intervals for appropriate adjustment.

~~8.~~ 7. Determination of EAC was the result of a report by the Office of the Inspector General that focused on appropriate Medicaid marketplace pricing of pharmaceuticals based on the documented costs to the pharmacy. An EAC of AWP minus 10.25% shall become effective July 1, 2002.

The dispensing fee of \$3.75 (effective July 1, 2003) shall remain in effect, creating a payment methodology based on the previous algorithm (least of 1 through ~~5~~ 4 of this subsection above) plus a dispensing fee where applicable.

~~9.~~ 8. Home infusion therapy.

a. The following therapy categories shall have a pharmacy service day rate payment allowable: hydration therapy, chemotherapy, pain management therapy, drug therapy, total parenteral nutrition (TPN). The service day rate payment for the pharmacy component shall apply to the basic components and services intrinsic to the therapy category. Submission of claims for the per diem rate shall be accomplished by use of the HCFA 1500 claim form.

b. The cost of the active ingredient or ingredients for chemotherapy, pain management and drug therapies shall be submitted as a separate claim through the pharmacy program, using standard pharmacy format. Payment for this component shall be consistent with the current reimbursement for pharmacy services. Multiple applications of the same therapy shall be reimbursed one service day rate for the pharmacy services. Multiple applications of different therapies shall be reimbursed at 100% of standard pharmacy reimbursement for each active ingredient.

/s/ Mark R. Warner

Governor

Date: November 2, 2004

VA.R. Doc. No. R05-58; Filed November 3, 2004, 2:48 p.m.

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Title of Regulation: **12 VAC 30-120. Waiver Services (amending 12 VAC 30-120-211, 12 VAC 30-120-213, 12 VAC 30-120-215, 12 VAC 30-120-219, 12 VAC 30-120-223, 12 VAC 30-120-225, 12 VAC 30-120-227, 12 VAC 30-120-229, 12 VAC 30-120-233, 12 VAC 30-120-237, 12 VAC 30-120-241, 12 VAC 30-120-243, 12 VAC 30-120-245, 12 VAC 30-120-247, 12 VAC 30-120-249).**

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

**Effective Dates:** December 1, 2004, through November 30, 2005.

**Agency Contact:** Suzanne Klaas, Analyst, Department of Medical Assistance Services, Division of Long Term Care and Quality Assurance, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 225-4239, FAX (804) 786-1680, or e-mail [suzanne.klaas@dmas.virginia.gov](mailto:suzanne.klaas@dmas.virginia.gov).

**Preamble:**

*The Administrative Process Act (§ 2.2-4011) states that an "emergency situation" is: (i) a situation involving an imminent threat to public health or safety; or (ii) a situation in which Virginia statutory law, the Virginia Appropriation Act, or federal law requires that a regulation shall be effective in 280 days or less from its enactment, or in which federal regulation requires a regulation to take effect no later than 280 days from its effective date. This suggested emergency regulation meets the standard at § 2.2-4011 of the Code of Virginia (ii) as discussed below.*

*The Department of Medical Assistance Services was directed in Chapter 4 of the 2004 Acts of Assembly, Item 326 PP, to renew its waiver program for persons with mental retardation:*

*Due to the requirements of federal law, the previously approved MR waiver application is due to expire in September 2004. In order to continue claiming federal matching dollars for this valuable home and community-based service, DMAS sought federal approval of a renewal of the existing waiver program based on recommendations from its MR Waiver Advisory Committee. This committee consisted of a diverse group of stakeholders (waiver recipients, family members/caregivers of individuals with disabilities, advocates, providers and other state agency (specifically DMHMRSAS representatives)) to advise the agency about waiver program policies. The waiver renewal application submitted to CMS reflected DMAS' efforts, in collaboration with the MR Waiver Advisory Committee, to better meet the needs of individuals who receive waiver services and to streamline processes.*

*The federal funding agency, the Centers for Medicare and Medicaid Services, approved the renewal of this waiver as reflected in these regulatory revisions.*

*In general, regulation changes include the following:*

- 1. Clarifies that individuals found to have committed barrier crimes listed in § 37.1-183.3 of the Code of Virginia will be ineligible to be providers under this waiver.*
- 2. Revises the situations that are considered at risk for crisis stabilization services.*
- 3. Adds language to clarify that crisis supervision is an optional component of crisis stabilization.*
- 4. Changes the due date for submission of the crisis stabilization individual service plan to the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to within 72 hours of "the requested start date of authorization."*

*5. Clarifies that "group" supported employment services are limited to 780 units per consumer service plan year.*

*6. Adds a definition of center-based and noncenter-based prevocational services.*

*7. Adds a definition of criteria for receiving prevocational services at the intensive level.*

*8. Changes the definition of skilled nursing services to indicate that the services to be offered must be those that do not meet the home health criteria. In addition, skilled nursing may be used to provide consultation for nurse delegation activities and provide oversight of direct care staff who provide the actual nursing care.*

*9. Removes the requirement that individuals living under the same roof need to provide documentation that they are the only provider available in order to provide care.*

*10. Clarifies that DMHMRSAS approves the test direct care staff of licensed providers have to take.*

**12 VAC 30-120-211. Definitions.**

"Activities of daily living" or "ADL" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Appeal" means the process used to challenge adverse actions regarding services, benefits and reimbursement provided by Medicaid pursuant to 12 VAC 30-110 and 12 VAC 30-20-500 through 12 VAC 30-20-560.

"Assistive technology" or "AT" means specialized medical equipment and supplies to include devices, controls, or appliances, specified in the consumer service plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the Medicaid State Plan.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county under Chapter 15 (§ 37.1-242 et seq.) of Title 37.1 of the Code of Virginia that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the locality that it serves.

"CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Case management" means the assessing and planning of services; linking the individual to services and supports identified in the consumer service plan; assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making

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collateral contacts to promote the implementation of the consumer service plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the consumer service plan.

"Case manager" means the individual on behalf of the community services board or behavioral health authority possessing a combination of mental retardation work experience and relevant education that indicates that the individual possesses the knowledge, skills and abilities, at entry level, as established by the Department of Medical Assistance Services in 12 VAC 30-50-450.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities or ~~cities and counties~~ under Chapter 10 (§ 37.1-194 et seq.) of Title 37.1 of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion" means, for the purpose of these regulations, a person who provides companion services.

"Companion services" means nonmedical care, support, and socialization, provided to an adult (age 18 and over). The provision of companion services does not entail hands-on nursing care. It is provided in accordance with a therapeutic goal in the consumer service plan and is not purely diversional in nature.

"Comprehensive assessment" means the gathering of relevant social, psychological, medical and level of care information by the case manager and is used as a basis for the development of the consumer service plan.

"Consumer-directed services" means services for which the individual or family/caregiver is responsible for hiring, training, supervising, and firing of the staff.

"Consumer-directed (CD) services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.

"Consumer service plan" or "CSP" means documents addressing needs in all life areas of individuals who receive mental retardation waiver services, and is comprised of individual service plans as dictated by the individual's health care and support needs. The individual service plans are incorporated in the CSP by the case manager.

"Crisis stabilization" means direct intervention to persons with mental retardation who are experiencing serious psychiatric or behavioral challenges that jeopardize their current community living situation, by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so the

individual can be supported in the community during and beyond the crisis period.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by the Department of Medical Assistance Services.

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

"DMHMRSAS staff" means persons employed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level.

"Developmental risk" means the presence before, during or after an individual's birth of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through existing diagnostic and evaluative criteria.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts or special opportunities to eligible individuals or family/caregivers as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual or family/caregiver, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's or family/caregiver's use of the providers' services.

"Enroll" means that the individual has been determined by the case manager to meet the eligibility requirements for the MR Waiver and DMHMRSAS has verified the availability of a MR Waiver slot for that individual.

"Entrepreneurial model" means a small business employing eight or fewer individuals who have disabilities on a shift and usually involves interactions with the public and with coworkers without disabilities.

"Environmental modifications" means physical adaptations to a house, place of residence, or vehicle that are necessary to ensure the individual's health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines that prescribe preventive and treatment services for Medicaid-eligible children as defined in 12 VAC 30-50-130.

~~"Facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.~~

"Fiscal agent" means an agency or organization within DMAS or contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed personal assistance, respite, and companion services.

"Health and safety standard" means that an individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written individual service plan.

"Home and community-based waiver services" or "waiver services" means the range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to § 1915(c) of the Social Security Act to be offered to persons with mental retardation and children younger than age six who are at developmental risk who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR.)

"ICF/MR" means a facility or distinct part of a facility certified by the Virginia Department of Health, as meeting the federal certification regulations for an Intermediate Care Facility for the Mentally Retarded and persons with related conditions. These facilities must address the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, and must provide active treatment.

"Individual" means the person receiving the services or evaluations established in these regulations.

"Individual service plan" or "ISP" means the service plan related solely to the specific waiver service. Multiple ISPs help to comprise the overall consumer service plan.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.

"ISAR" means the Individual Service Authorization Request and is the DMAS form used by providers to request prior authorization for MR waiver services.

"Mental retardation" or "MR" means mental retardation as defined by the American Association on Mental Retardation (AAMR).

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and DMHMRSAS, and has a current, signed provider participation agreement with DMAS.

"Pend" means delaying the consideration of an individual's request for services until all required information is received by DMHMRSAS.

"Personal assistance services" means assistance with activities of daily living, instrumental activities of daily living, access to the community, self-administration of medication, or other medical needs, and the monitoring of health status and physical condition.

"Personal assistant" means a person who provides personal assistance services.

"Personal emergency response system (PERS)" is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Preauthorized" means that an individual service has been approved by DMHMRSAS prior to commencement of the service by the service provider for initiation and reimbursement of services.

"Prevocational services" means services aimed at preparing an individual for paid or unpaid employment. The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage.

"Qualified mental retardation professional" means a professional possessing: (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

"Residential support services" means support provided in the individual's home by a DMHMRSAS-licensed residential provider or a DSS-approved provider of adult foster care services. This service is one in which training, assistance, and supervision is routinely provided to enable individuals to maintain or improve their health, to develop skills in activities of daily living and safety in the use of community resources, to adapt their behavior to community and home-like environments, to develop relationships, and participate as citizens in the community.

"Respite services" means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care.

*"Services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and family/caregiver by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-*

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*directed companion, personal assistance, and respite services.*

"Skilled nursing services" means services that are ordered by a physician and required to prevent institutionalization, that are not otherwise available under the State Plan for Medical Assistance and that are provided by a licensed registered professional nurse, or by a licensed practical nurse under the supervision of a licensed registered professional nurse, in each case who is licensed to practice in the Commonwealth.

"Slot" means an opening or vacancy of waiver services for an individual.

"State Plan for Medical Assistance" or "Plan" means the ~~regulations~~ *Commonwealth's legal document approved by CMS* identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supported employment" means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual with mental retardation to maintain paid employment.

"Support plan" means the report of recommendations resulting from a therapeutic consultation.

"Therapeutic consultation" means activities to assist the individual, family/caregivers, staff of residential support, day support, and any other providers in implementing an individual service plan.

## **12 VAC 30-120-213. General coverage and requirements for MR waiver services.**

A. Waiver service populations. Home and community-based waiver services shall be available through a § 1915(c) of the Social Security Act waiver for the following individuals who have been determined to require the level of care provided in an ICF/MR.

1. Individuals with mental retardation; or
2. Individuals younger than the age of six who are at developmental risk. At the age of six years, these individuals must have a diagnosis of mental retardation to continue to receive home and community-based waiver services specifically under this program.

B. Covered services.

1. Covered services shall include: residential support services, day support, supported employment, personal assistance (both consumer and agency-directed), respite services (both consumer and agency-directed), assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, prevocational services, personal emergency response systems (PERS), and companion services (both consumer and agency-directed.)

2. These services shall be appropriate and necessary to maintain the individual in the community. Federal waiver requirements provide that the average per capita fiscal year

expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in Intermediate Care Facilities for the Mentally Retarded under the State Plan that would have been provided had the waiver not been granted.

3. Under this § 1915(c) waiver, DMAS waives § 1902(a)(10)(B) of the Social Security Act related to comparability.

C. All requests for increased services by MR waiver recipients will be reviewed under the health and safety standard. This standard assures that an individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written ISP.

D. Appeals. Individual appeals shall be considered pursuant to 12 VAC 30-110-10 through 12 VAC 30-110-380. Provider appeals shall be considered pursuant to 12 VAC 30-10-1000 and 12 VAC 30-20-500 through 12 VAC 30-20-560.

E. Urgent criteria. The CSB/BHA will determine, from among the individuals included in the urgent category, who should be served first, based on the needs of the individual at the time a slot becomes available and not on any predetermined numerical or chronological order.

1. The urgent category will be assigned when the individual is in need of services because he is determined to meet one of the criteria established in subdivision 2 of this subsection. Assignment to the urgent category may be requested by the individual, his legally responsible relative, or primary caregiver. The urgent category may be assigned only when the individual, the individual's spouse, or the parent of an individual who is a minor child would accept the requested service if it were offered. Only after all individuals in the Commonwealth who meet the urgent criteria have been served can individuals in the nonurgent category be served. Individuals in the nonurgent category are those who meet the diagnostic and functional criteria for the waiver, including the need for services within 30 days, but who do not meet the urgent criteria. In the event that a CSB/BHA has a vacant slot and does not have an individual who meets the urgent criteria, the slot can be held by the CSB/BHA for 90 days from the date it is identified as vacant, in case someone in an urgent situation is identified. If no one meeting the urgent criteria is identified within 90 days, the slot will be made available for allocation to another CSB/BHA in the Health Planning Region (HPR). If there is no urgent need at the time that the HPR is to make a regional reallocation of a waiver slot, the HPR shall notify DMHMRSAS. DMHMRSAS shall have the authority to reallocate said slot to another HPR or CSB/BHA where there is unmet urgent need. Said authority must be exercised, if at all, within 30 days from receiving such notice.

2. Satisfaction of one or more of the following criteria shall indicate that the individual should be placed on the urgent need of waiver services list:

- a. Both primary caregivers are 55 years of age or older, or if there is one primary caregiver, that primary caregiver is 55 years of age or older;

b. The individual is living with a primary caregiver, who is providing the service voluntarily and without pay, and the primary caregiver indicates that he can no longer care for the individual with mental retardation;

c. There is a clear risk of abuse, neglect, or exploitation;

d. One primary caregiver *has*, or both caregivers *have*, ~~has~~ a chronic or long-term physical or psychiatric condition or conditions which significantly limits the abilities of the primary caregiver or caregivers to care for the individual with mental retardation;

e. Individual is aging out of publicly funded residential placement or otherwise becoming homeless (exclusive of children who are graduating from high school); or

f. The individual with mental retardation lives with the primary caregiver and there is a risk to the health or safety of the individual, primary caregiver, or other individual living in the home due to either of the following conditions:

(1) The individual's behavior or behaviors present a risk to himself or others which cannot be effectively managed by the primary caregiver even with generic or specialized support arranged or provided by the CSB/BHA; or

(2) There are physical care needs (such as lifting or bathing) or medical needs that cannot be managed by the primary caregiver even with generic or specialized supports arranged or provided by the CSB/BHA.

F. Reevaluation of service need and utilization review. Providers shall meet the documentation requirements as specified in 12 VAC 30-120-217 B.

1. The consumer service plan (CSP).

a. The CSP shall be developed by the case manager mutually with the individual, the individual's family/caregiver, other service providers, consultants, and other interested parties based on relevant, current assessment data. The CSP development process identifies the services to be rendered to individuals, the frequency of services, the type of service provider or providers, and a description of the services to be offered. The ISP from each waiver service provider shall be incorporated into the CSP. Only services authorized on the CSP by DMHMRSAS according to DMAS policies will be reimbursed by DMAS.

b. The case manager is responsible for continuous monitoring of the appropriateness of the individual's services and revisions to the CSP as indicated by the changing needs of the individual. At a minimum, the case manager must review the CSP every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

c. Any modification to the amount or type of services in the CSP must be authorized by DMHMRSAS or DMAS.

2. Review of level of care.

a. The case manager shall complete a comprehensive assessment annually, in coordination with the individual, family/caregiver, and service providers. If warranted, the case manager shall coordinate a medical examination and a psychological evaluation for the individual. The reassessment shall include an update of the level of care and functional assessment instrument and any other appropriate assessment data. The CSP shall be revised as appropriate.

b. A medical examination must be completed for adults based on need identified by the individual, family/caregiver, provider, case manager, or DMHMRSAS staff. Medical examinations and screenings for children must be completed according to the recommended frequency and periodicity of the EPSDT program.

c. A psychological evaluation or standardized developmental assessment for children under six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities. A new psychological evaluation shall be required whenever the individual's functioning has undergone significant change and is no longer reflective of the past psychological evaluation.

3. Case manager must request an updated DMAS-122 form from DSS annually and forward a copy of the updated DMAS-122 form to all service providers when obtained.

**12 VAC 30-120-215. Individual eligibility requirements.**

A. Individuals receiving services under this waiver must meet the following requirements. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy groups under 42 CFR 435.211, 435.217, and 435.230. The income level used for 42 CFR 435.211, 435.217 and 435.230 is 300% of the current Supplemental Security Income payment standard for one person.

1. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of care criteria. The deeming rules are applied to waiver eligible individuals as if the individual were residing in an institution or would require that level of care.

2. Virginia shall reduce its payment for home and community-based waiver services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and § 1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after the deductions listed below:

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a. For individuals to whom § 1924(d) applies and for whom Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.)

(2) For an individual with only a spouse at home, the community spousal income allowance determined in accordance with § 1924(d) of the Social Security Act.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with § 1924(d) of the Social Security Act.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the plan.

b. For individuals to whom § 1924(d) does not apply and for whom Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income

allowance plus guardianship fees) for the individual exceed 300% of SSI. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.)

(2) For an individual with a dependent child or children, an additional amount for the maintenance needs of the child or children, which shall be equal to the Title XIX medically needy income standard based on the number of dependent children.

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the State Medical Assistance Plan.

3. The following four criteria shall apply to all mental retardation waiver services:

a. Individuals qualifying for mental retardation waiver services must have a demonstrated ~~clinical~~ need for the service resulting in significant functional limitations in major life activities. The need for the service must arise from either (i) an individual having a diagnosed condition of mental retardation or (ii) a child younger than six years of age being at developmental risk of significant functional limitations in major life activities;

b. The CSP and services that are delivered must be consistent with the Medicaid definition of each service;

c. Services must be recommended by the case manager based on a current functional assessment using a DMHMRSAS approved assessment instrument and a demonstrated need for each specific service; and

d. Individuals qualifying for mental retardation waiver services must meet the ICF/MR level of care criteria.

B. Assessment and authorization of home and community-based waiver services.

1. To ensure that Virginia's home and community-based waiver programs serve only individuals who would otherwise be placed in an ICF/MR, home and community-based *waiver* services shall be considered only for individuals who are eligible for admission to an ICF/MR with a diagnosis of mental retardation, or who are under six years of age and at developmental risk. Home and community-based waiver services shall be the critical service that enables the individual to remain at home and in the community rather than being placed in an ICF/MR.

2. The case manager shall recommend the individual for home and community-based *waiver* services after completion of a comprehensive assessment of the individual's needs and available supports. The comprehensive assessment includes relevant medical, social, level of care and psychological data, and identifies all services received by the individual. Medical examinations and social assessments shall be current, completed prior to the individual's entry to the waiver, and no earlier than 12 months prior to beginning waiver services. Psychological evaluations or standardized

developmental evaluations for children under the age of six years must reflect the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of functioning of the individuals.

3. An essential part of the case manager's assessment process shall be determining the level of care required by applying the existing DMAS ICF/MR criteria (12 VAC 30-130-430 et seq.).

4. The case manager shall complete the assessment, determine whether the individual meets the ICF/MR criteria and develop the CSP with input from the individual, family/caregivers, and service and support providers involved in the individual's support in the community. Completion of this assessment process for home and community-based waiver services by the case manager is mandatory before Medicaid will assume payment responsibility of home and community-based waiver services. For the case manager to make a recommendation for waiver services, MR Waiver services must be determined to be an appropriate service alternative to delay or avoid placement in an ICF/MR, or promote exiting from either an ICF/MR placement or inappropriate institutional placement.

5. The case manager shall provide the individual and family/caregiver with the choice of MR waiver services or ICF/MR placement, choice of needed services available under the MR waiver, including agency or consumer-directed services, and explore alternative settings and services to provide the services needed by the individual. A CSP shall be developed for the individual based on the assessment of needs as reflected in the level of care and functional assessment instruments and the individual's, family/caregiver's preferences.

6. The case manager must submit the results of the comprehensive assessment and a recommendation to the DMHMRSAS staff for final determination of ICF/MR level of care and authorization for community-based services. DMHMRSAS will communicate in writing to the case manager whether the recommended services have been approved and the amounts and type of services authorized or if any have been denied. Medicaid will not pay for any home and community-based waiver services delivered prior to the authorization date approved by DMHMRSAS if prior authorization is required.

7. Mental retardation waiver services may be recommended by the case manager only if:

- a. The individual is Medicaid eligible as determined by the local office of the Department of Social Services;
- b. The individual has a diagnosis of mental retardation as defined by the American Association on Mental Retardation, or is a child under the age of six at developmental risk, who would in the absence of waiver services, require the level of care provided in an ICF/MR facility the cost of which would be reimbursed under the Plan;

c. The contents of the individual service plans are consistent with the Medicaid definition of each service; and

d. The individual requesting waiver services is not receiving such services while an inpatient of a nursing facility, an ICF/MR, or hospital.

8. All consumer service plans are subject to approval by DMAS. DMAS shall be the single state agency authority responsible for the supervision of the administration of the MR waiver and is responsible for conducting utilization review activities. DMAS has contracted with DMHMRSAS for recommendation of preauthorization of waiver services.

C. Waiver approval process: accessing services.

1. Once the case manager has determined an individual meets the functional criteria for mental retardation (MR) waiver services, has determined that a slot is available, and that the individual has chosen this service, the case manager shall submit enrollment information to DMHMRSAS to confirm level of care eligibility and the availability of a slot. DMHMRSAS shall only enroll the individual if a slot is available.

2. If no slot is available, the individual's name will be placed on either the urgent or nonurgent statewide waiting list until such time as a slot becomes available. Once notification has been received from DMHMRSAS that the individual has been placed on either the urgent or nonurgent waiting list, the case manager must notify the individual in writing within 10 working days of his placement on either list, and offer appeal rights.

3. Once the individual has been enrolled by DMHMRSAS, the case manager will submit a DMAS-122 along with a written confirmation from DMHMRSAS of level of care eligibility, to the local DSS to determine financial eligibility for the waiver program and any patient pay responsibilities. After the case manager has received written notification of Medicaid eligibility by DSS and written enrollment from DMHMRSAS, the case manager shall inform the individual or family/caregiver so that the CSP can be developed. The individual or individual's family/caregiver will meet with the case manager within 30 calendar days to discuss the individual's needs and existing supports, and to develop a CSP that will establish and document the needed services. The individual or case manager shall contact chosen service providers so that services can be initiated within 60 days. If services are not initiated by the provider within 60 days, the case manager must submit written information to DMHMRSAS requesting more time to initiate services. A copy of the request must be provided to the individual or the individual's family/caregiver. DMHMRSAS has the authority to approve the request in 30-day extensions or deny the request to retain the waiver slot for that individual. DMHMRSAS shall provide a written response to the case manager indicating denial or approval of the extension. DMHMRSAS shall submit this response within 10 working days of the receipt of the request for extension.

4. The service providers will develop Individual Service Plans (ISP) for each service and will submit a copy of these plans to the case manager. The case manager will review

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and ensure the ISP meets the established service criteria for the identified needs and forward the required documentation to DMHMRSAS for prior authorization. DMHMRSAS shall, within 10 working days of receiving all supporting documentation, review and approve, pend for more information, or deny the individual service requests.

5. The case manager will monitor the service providers' ISPs to ensure that all providers are working toward the identified goals of the affected individuals.

6. Case managers will be required to conduct monthly onsite visits for all MR waiver individuals residing in DSS-licensed assisted living facilities or approved adult foster care placements.

## **12 VAC 30-120-219. Participation standards for home and community-based waiver services participating providers.**

A. Requests for participation will be screened to determine whether the provider applicant meets the basic requirements for participation.

B. For DMAS to approve provider agreements with home and community-based waiver providers, the following standards shall be met:

1. For services that have licensure and certification requirements, licensure and certification requirements pursuant to 42 CFR 441.302;

2. Disclosure of ownership pursuant to 42 CFR 455.104 and 455.105; and

3. The ability to document and maintain individual case records in accordance with state and federal requirements.

C. The case manager must inform the individual of all available waiver providers in the community in which he desires services and he shall have the option of selecting the provider of his choice from among those providers meeting the individual's needs.

D. DMAS shall be responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and periodically recertify each provider for participation agreement renewal with DMAS to provide home and community-based waiver services. A provider's noncompliance with DMAS policies and procedures, as required in the provider's participation agreement, may result in a written request from DMAS for a corrective action plan that details the steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies that have been cited.

E. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 days' written notification. DMAS may terminate at will a provider's participation agreement on 30 days written notice as specified in the DMAS participation agreement. DMAS may also immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the program. Such action precludes further payment by DMAS for services

provided to individuals subsequent to the date specified in the termination notice.

F. A provider shall have the right to appeal adverse action taken by DMAS. Adverse actions may include, but shall not be limited to, termination of the provider agreement by DMAS, and retraction of payments from the provider by DMAS for noncompliance with applicable law, regulation, policy, or procedure. All disputes regarding provider reimbursement or termination of the agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be conducted pursuant to the Virginia Administrative Process Act, Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 of the Code of Virginia, the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia, and duly promulgated regulations. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

G. Section 32.1-325 of the Code of Virginia mandates that "any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states or Washington, DC, must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. In addition, termination of a provider participation agreement will occur as may be required for federal financial participation.

H. Case manager's responsibility for the Individual Information Form (DMAS-122). It shall be the responsibility of the case management provider to notify DMHMRSAS and DSS, in writing, when any of the following circumstances occur. Furthermore, it shall be the responsibility of DMHMRSAS to update DMAS, as requested, when any of the following events occur:

1. Home and community-based waiver services are implemented.

2. A recipient dies.

3. A recipient is discharged from all MR waiver services.

4. Any other circumstances (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 days.

5. A selection by the individual or family/caregiver of a different community services board/behavioral health authority providing case management services.

I. Changes or termination of services. It is the DMHMRSAS staff's responsibility to authorize changes to an individual's CSP based on the recommendations of the case management provider. Providers of direct service are responsible for modifying their individual service plans with the involvement of the individual or family/caregiver, and submitting it to the case manager any time there is a change in the individual's condition or circumstances which may warrant a change in the amount or type of service rendered. The case manager will review the need for a change and may recommend a change to the ISP to the DMHMRSAS staff. DMHMRSAS will review

and approve, deny, or pend *for* additional information regarding the requested change to the individual's ISP, and communicate this to the case manager within 10 working days of receiving all supporting documentation regarding the request for change or in the case of an emergency, within 72 hours of receipt of the request for change.

The individual or family/caregiver will be notified, in writing, of the right to appeal the decision or decisions to reduce, terminate, suspend or deny services pursuant to DMAS client appeals regulations, Part I (12 VAC 30-110-10 et seq.) of 12 VAC 30-110. The case manager must submit this notification to the individual in writing within 12 days of the decision. All CSPs are subject to approval by the Medicaid agency.

1. In a nonemergency situation, the participating provider shall give the individual or family/caregiver and case manager 12 days written notification of the provider's intent to discontinue services. The notification letter shall provide the reasons and the effective date the provider is discontinuing services. The effective date shall be at least 12 days from the date of the notification letter. The individual is not eligible for appeal rights in this situation and may pursue services from another provider.

2. In an emergency situation when the health and safety of the individual, other individuals in that setting, or provider personnel is endangered, the case manager and DMHMRSAS must be notified prior to discontinuing services. The 12-day written notification period shall not be required. If appropriate, the local DSS adult protective services or child protective services and DMHMRSAS Offices of Licensing and Human Rights must be notified immediately.

3. In the case of termination of home and community-based waiver services by the CSB/BHA, DMHMRSAS or DMAS staff, individuals shall be notified of their appeal rights by the case manager pursuant to Part I (12 VAC 30-110-10 et seq.) of 12 VAC 30-110. The case manager shall have the responsibility to identify those individuals who no longer meet the level of care criteria or for whom home and community-based waiver services are no longer an appropriate alternative.

**12 VAC 30-120-223. Companion services (agency-directed model).**

A. Service description. Companion services provide nonmedical care, socialization, or support to an adult (age 18 or older). Companions may assist or support the individual with such tasks as meal preparation, community access and activities, laundry and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks. This service is provided in accordance with a therapeutic goal in the CSP and is not purely diversional in nature.

B. Criteria. In order to qualify for companion services, the individual shall have demonstrated a need for assistance with IADLs, light housekeeping, community access, medication self-administration or support to assure safety. The provision of companion services does not entail hands-on nursing care.

C. Service units and service limitations.

1. The unit of service for companion services is one hour and the amount that may be included in the ISP shall not exceed eight hours per 24-hour day. There is a limit of 8 hours per 24-hour day for companion services, either agency or consumer-directed or combined.

2. A companion shall not be permitted to provide the care associated with ventilators, continuous tube feedings, or suctioning of airways.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12 VAC 30-120-217 and 12 VAC 30-120-219, companion service providers must meet the following qualifications:

1. Companion services provider shall include DMHMRSAS-licensed residential services providers, DMHMRSAS-licensed supportive residential services providers, DMHMRSAS-licensed day support service providers, DMHMRSAS-licensed respite service providers, and DMAS-enrolled personal care/respite care providers.

2. Companion qualifications. Providers must employ staff to provide companion services who meet the following requirements:

- a. Be at least 18 years of age;
- b. Possess basic reading, writing, and math skills;
- c. Be capable of following an ISP with minimal supervision;
- d. Submit to a criminal history record check. The companion will not be compensated for services provided to the individual if the records check verifies the companion has been convicted of crimes described in § 37.1-183.3 of the Code of Virginia;
- e. Possess a valid Social Security number; and
- f. Be capable of aiding in instrumental activities of daily living.

3. Companion service providers may not be the parents of individuals who are minors or the individual's spouse. Other family members living under the same roof as the individual being served may not provide companion services unless there is objective written documentation as to why there are no other providers available to provide the service. Companion services shall not be provided by adult foster care/family care providers or any other paid caregivers. This service shall not be provided in congregate settings by staff employed by the congregate provider.

4. Family members who are reimbursed to provide companion services must meet the companion qualifications.

5. Companions will be employees of providers that will have participation agreements with DMAS to provide companion services. Providers will be required to have a companion services supervisor to monitor companion services. The supervisor must have a bachelor's degree in a human services field and at least one year of experience working in

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the mental retardation field, or be an LPN or an RN with at least one year of experience working in the mental retardation field. An LPN or RN must have a current license or certification to practice nursing in the Commonwealth within his or her profession.

6. The provider must conduct an initial home visit prior to initiating companion services to document the efficacy and appropriateness of services and to establish an individual service plan for the individual. The provider must provide follow-up home visits to monitor the provision of services quarterly or as often as needed.

7. Required documentation in the individual's record. The provider must maintain a record of each individual receiving companion services. At a minimum these records must contain:

a. An initial assessment completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;

b. ~~The ISP goals, objectives, and activities.~~ The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual or family/caregiver.

c. All correspondence to the individual, family/caregiver, case manager, DMAS, and DMHMRSAS;

d. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;

e. The companion services supervisor must document in the individual's record in a summary note following significant contacts with the companion and quarterly home visits with the individual:

- (1) Whether companion services continue to be appropriate;
- (2) Whether the plan is adequate to meet the individual's needs or changes are indicated in the plan;
- (3) The individual's satisfaction with the service; and
- (4) The presence or absence of the companion during the supervisor's visit.

f. All companion records. The companion record must contain:

- (1) The specific services delivered to the individual by the companion, dated the day of service delivery, and the individual's responses;
- (2) The companion's arrival and departure times;
- (3) The companion's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

(4) The companion's and individual's or family/caregiver's weekly signatures recorded on the last day of service delivery for any given week to verify that companion services during that week have been rendered.

g. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 from the case manager.

## **12 VAC 30-120-225. Consumer-directed services: personal assistance, companion, and respite.**

### A. Service definition.

1. Consumer-directed personal assistance services ~~is~~ *are* hands-on care of either a supportive or health-related nature and may include, but ~~is~~ *are* not limited to, assistance with activities of daily living, access to the community, monitoring of self-administration of medication or other medical needs, monitoring health status and physical condition, and work-related personal assistance. When specified, such supportive services may include assistance with instrumental activities of daily living (IADLs). Personal assistance does not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Subtitle III of Title 54.1 of the Code of Virginia, as appropriate.

2. Consumer-directed respite services are specifically designed to provide temporary, periodic, or routine relief to the unpaid primary caregiver of an individual. Respite services include, but are not limited to, assistance with personal hygiene, nutritional support, and environmental support. This service may be provided in the individual's home or other community settings.

3. Consumer-directed companion services provide nonmedical care, socialization, or support to an adult (age 18 and older). Companions may assist or support the individual with such tasks as meal preparation, community access and activities, laundry and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks. This service is provided in accordance with a therapeutic goal in the CSP and is not purely diversional in nature.

4. DMAS shall either provide for fiscal agent services or contract for the services of a fiscal agent for consumer-directed personal assistance services, consumer-directed companion services, and consumer-directed respite services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the individual for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

5. Individuals choosing consumer-directed services must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed personal assistance, respite, or

companion services. The CD Service Facilitator will be responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the ISP, providing training to the individual and family/caregiver on his responsibilities as an employer, and providing ongoing support of the consumer-directed services. The CD service facilitator cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver employing the assistant/companion.

## B. Criteria.

1. In order to qualify for consumer-directed personal assistance services, the individual must demonstrate a need for personal assistance in activities of daily living, community access, self-administration of medication, or other medical needs, or monitoring health status or physical condition.

2. Consumer-directed respite services may only be offered to individuals who have an unpaid caregiver living in the home that requires temporary relief to avoid institutionalization of the individual. Respite services are designed to focus on the need of the unpaid caregiver for temporary relief and to help prevent the breakdown of the unpaid caregiver due to the physical burden and emotional stress of providing continuous support and care to the individual.

3. The inclusion of consumer-directed companion services in the CSP shall be appropriate when the individual has a demonstrated need for assistance with IADLs, community access and activities, self-administration of medication, or support to assure safety.

4. Individuals who are eligible for consumer-directed services must have the capability to hire and train their own personal assistants or companions and supervise the assistant's or companion's performance. If an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

5. The individual, or if the individual is unable, then a family/caregiver, shall be the employer in this service, and therefore shall be responsible for hiring, training, supervising, and firing assistants and companions. Specific employer duties include checking of references of personal assistants/companions, determining that personal assistants/companions meet basic qualifications, training assistants/companions, supervising the assistant's/companion's performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual or family/caregiver must have a back-up plan in case the assistant/companion does not show up for work as expected or terminates employment without prior notice.

## C. Service units and service limitations.

1. The unit of service for consumer-directed respite services is one hour. Consumer-directed respite services are limited to a maximum of 720 hours per calendar year. Individuals

who receive consumer-directed respite and agency-directed respite services may not receive more than 720 hours combined.

2. No more than two unrelated individuals who live in the same home are permitted to share the authorized work hours of the assistant or companion.

3. The unit of service for consumer-directed personal assistance services is one hour. ~~Each individual must have a back-up plan in case the assistant does not show up for work as expected or terminates employment without prior notice.~~ Consumer-directed personal assistance is not available to individuals who receive congregate residential services or live in assisted living facilities.

4. The unit of service for consumer-directed companion services is one hour. The amount of consumer-directed companion time must be included in the ISP. The amount of companion services included in the ISP may not exceed eight hours per 24-hour day. There is a limit of 8 hours per 24-hour day for consumer-directed services, either as a stand-alone service or combined with agency-directed services. A companion shall not be permitted to provide the care associated with ventilators, tube feedings, or suctioning of airways.

D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12 VAC 30-120-217 and 12 VAC 30-120-219, the CD services facilitator must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall have sufficient resources to perform the required activities. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

2. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in a human service field working with persons with mental retardation. The facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

### a. Knowledge of:

(1) Types of functional limitations and health problems that may occur in persons with mental retardation, or persons with other disabilities, as well as strategies to reduce limitations and health problems;

(2) Physical assistance that may be required by people with mental retardation, such as transferring, bathing

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techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications that may be required by people with mental retardation that ~~reduces~~ *reduce* the need for human help and improve safety;

(4) Various long-term care program requirements, including nursing home and ICF/MR placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance, respite, and companion services;

(5) MR waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in service planning;

(7) Interviewing techniques;

(8) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed personal assistance, companion, and respite services, including hiring, training, managing, approving time sheets, and firing an assistant/companion;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals, family/caregivers, and service providers;

(2) Assessing, supporting, observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to individuals with mental retardation; and

(4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

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

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

(6) Develop a rapport and communicate with persons of diverse cultural backgrounds.

3. If the CD services facilitator is not a RN, the CD services facilitator must inform the primary health care provider that

services are being provided and request *skilled nursing* consultation as needed.

4. Initiation of services and service monitoring.

a. For consumer-directed services, the CD services facilitator must make an initial comprehensive home visit to collaborate with the individual and family/caregiver to identify the needs, assist in the development of the ISP with the individual or family/caregiver, and provide employee management training. The initial comprehensive home visit is done only once upon the individual's entry into the service. If a waiver individual changes CD services facilitators, the new CD services facilitator must complete a reassessment visit in lieu of a comprehensive visit.

b. After the initial visit, the CD services facilitator will continue to monitor the companion or assistant ISP quarterly and on an as-needed basis. The CD services facilitator will review the utilization of consumer-directed respite services, either every six months or upon the use of 300 respite services hours, whichever comes first.

c. A face-to-face meeting with the individual must be conducted at least every six months to ensure appropriateness of any CD services received by the individual.

5. During visits with the individual, the CD services facilitator must observe, evaluate, and consult with the individual or family/caregiver, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical, and social needs. The CD services facilitator's written summary of the visit must include, but is not necessarily limited to:

a. Discussion with the individual or family/caregiver whether the service is adequate to meet the individual's needs;

b. Any suspected abuse, neglect, or exploitation and who it was reported to;

c. Any special tasks performed by the assistant/companion and the assistant's/companion's qualifications to perform these tasks;

d. Individual's or family/caregiver's satisfaction with the service;

e. Any hospitalization or change in medical condition, functioning, or cognitive status; and

f. The presence or absence of the assistant/companion in the home during the CD services facilitator's visit.

6. The CD services facilitator must be available to the individual by telephone.

7. The CD services facilitator must submit a criminal record check pertaining to the assistant/companion on behalf of the individual and report findings of the criminal record check to the individual or the family/caregiver and the program's fiscal agent. If the individual is a minor, the assistant/companion must also be screened through the

DSS Child Protective Services Central Registry. Assistants/companions will not be reimbursed for services provided to the individual effective the date that the criminal record check confirms an assistant/companion has been found to have been convicted of a crime as described in § 37.1-183.3 of the Code of Virginia or if the assistant/companion has a confirmed record on the DSS Child Protective Services *Central* Registry. The criminal record check and DSS Child Protective Services *Central* Registry finding must be requested by the CD services facilitator prior to beginning CD services.

8. The CD services facilitator shall review timesheets during the face-to-face visits to ensure that the number of ISP-approved hours are not exceeded. If discrepancies are identified, the CD services facilitator must discuss these with the individual to resolve discrepancies and must notify the fiscal agent.

9. The CD services facilitator must maintain a list of persons who are available to provide consumer-directed personal assistance, consumer-directed companion, or consumer-directed respite services.

10. The CD services facilitator must maintain records of each individual. At a minimum these records must contain:

- a. Results of the initial comprehensive home visit completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;
- b. The ISP goals and activities. The companion or personal assistance ISP goals, objectives, and activities must be reviewed by the ~~provider~~ *services facilitator* quarterly, annually, and more often as needed, modified as appropriate, and the results of these reviews submitted to the case manager. Respite ISP goals, objectives, and activities must be reviewed by the ~~provider~~ *services facilitator* annually and every six months or when 300 service hours have been used. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual;
- c. CD services facilitator's dated notes documenting any contacts with the individual, family/caregiver, and visits to the individual's home;
- d. All correspondence to the individual, case manager, DMAS, and DMHMRSAS;
- e. Records of contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;
- f. All training provided to the assistants/companions on behalf of the individual or family/caregiver;
- g. All employee management training provided to the individual or family/caregiver, including the individual's or family/caregiver's receipt of training on their responsibility for the accuracy of the assistant's/companion's timesheets;

h. All documents signed by the individual or the individual's family/caregiver that acknowledge the responsibilities as the employer; and

i. A copy of the most recently completed DMAS-122. The facilitator must clearly document efforts to obtain the completed DMAS-122 from the case manager.

11. For consumer-directed personal assistance, consumer-directed companion, and consumer-directed respite services, individuals or family/caregivers will hire their own personal assistants/companions and manage and supervise their performance. The assistant/companion must meet the following requirements:

- a. Be 18 years of age or older;
- b. Have the required skills to perform consumer-directed services as specified in the individual's supporting documentation;
- c. Possess basic math, reading, and writing skills;
- d. Possess a valid Social Security number;
- e. Submit to a criminal records check and, if the individual is a minor, consent to a search of the DSS Child Protective Services Central Registry. The assistant/companion will not be compensated for services provided to the individual if either of these records checks verifies the assistant/companion has been convicted of crimes described in § 37.1-183.3 of the Code of Virginia or if the assistant/companion has a founded complaint confirmed by the DSS Child Protective Services Central Registry;
- f. Be willing to attend training at the individual's or family/caregiver's request;
- g. Understand and agree to comply with the DMAS MR waiver requirements; and
- h. Receive periodic tuberculosis (TB) screening, cardiopulmonary resuscitation (CPR) training and an annual flu shot (unless medically contraindicated).

12. Assistants/companions may not be the parents of individuals who are minors or the individuals' spouses. Payment may not be made for services furnished by other family/caregivers living under the same roof as the individual being served unless there is objective written documentation as to why there are no other providers available to provide the care. Companion services shall not be provided by adult foster care/family care providers or any other paid caregivers. This service shall not be provided in congregate settings by staff employed by the congregate provider.

13. Family members who are reimbursed to provide consumer-directed services must meet the assistant/companion qualifications.

14. Upon the individual's request, the CD services facilitator shall provide the individual or family/caregiver with a list of persons who can provide temporary assistance until the assistant/companion returns or the individual is able to select and hire a new personal assistant/companion. If an

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individual is consistently unable to hire and retain the employment of an assistant/companion to provide consumer-directed personal assistance, companion, or respite services, the CD services facilitator will make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the individual or family/caregiver other service options.

## 12 VAC 30-120-227. Crisis stabilization services.

A. Crisis stabilization services involve direct interventions that provide temporary intensive services and support that avert emergency psychiatric hospitalization or institutional placement of persons with mental retardation who are experiencing serious psychiatric or behavioral problems that jeopardize their current community living situation. Crisis stabilization services will include, as appropriate, neuro-psychiatric, psychiatric, psychological, and other functional assessments and stabilization techniques, medication management and monitoring, behavior assessment and positive behavioral support, and intensive service coordination with other agencies and providers. This service is designed to stabilize the individual and strengthen the current living situation, so that the individual remains in the community during and beyond the crisis period. These services shall be provided to:

1. Assist with planning and delivery of services and supports to enable the individual to remain in the community;
2. Train family/caregivers and service providers in positive behavioral supports to maintain the individual in the community; and
3. Provide temporary crisis supervision to ensure the safety of the individual and others.

## B. Criteria.

1. In order to receive crisis stabilization services, the individual must meet at least one of the following criteria:
  - a. The individual is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
  - b. The individual is experiencing extreme increase in emotional distress;
  - c. The individual needs continuous intervention to maintain stability; or
  - d. The individual is causing harm to self or others.
2. The individual must be at risk of at least one of the following:
  - a. Psychiatric hospitalization;
  - b. Emergency ICF/MR placement;
  - c. ~~Disruption of community status (living arrangement, day placement, or school); Immediate threat of loss of a community service due to a severe situational reaction;~~ or
  - d. Causing harm to self or others.

C. Service units and service limitations. Crisis stabilization services may only be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional.

1. The unit for each component of the service is one hour. This service may only be authorized in 15-day increments but no more than 60 days in a calendar year may be used. The actual service units per episode shall be based on the documented clinical needs of the individual being served. Extension of services, beyond the 15-day limit per authorization, may only be authorized following a documented face-to-face reassessment conducted by a qualified mental retardation professional.
2. Crisis stabilization services may be provided directly in the following settings (examples below are not exclusive):
  - a. The home of an individual who lives with family, friends, or other primary caregiver or caregivers;
  - b. The home of an individual who lives independently or semi-independently to augment any current services and supports;
  - c. A community-based residential program to augment current services and supports;
  - d. A day program or setting to augment current services and supports; or
  - e. A respite care setting to augment current services and supports.

3. *Crisis supervision is an optional component of crisis stabilization in which one-to-one supervision of the individual in crisis is provided by agency staff in order to ensure the safety of the individual and others in the environment.* Crisis supervision may be provided as a component of crisis stabilization only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision must be provided one-to-one and face-to-face with the individual. Crisis supervision, if provided as a part of this service, shall be separately billed in hourly service units.

4. Crisis stabilization services shall not be used for continuous long-term care. Room, board, and general supervision are not components of this service.

5. If appropriate, the assessment and any reassessments, shall be conducted jointly with a licensed mental health professional or other appropriate professional or professionals.

D. Provider requirements. In addition to the general conditions and requirements for home and community-based participating providers as specified in 12 VAC 30-120-217 and 12 VAC 30-120-219, the following crisis stabilization provider qualifications apply:

1. Crisis stabilization services shall be provided by providers licensed by DMHMRSAS as a provider of outpatient services, residential, or supportive residential services, or day support services. The provider must employ or utilize qualified mental retardation professionals, licensed mental health professionals or other qualified personnel competent

to provide crisis stabilization and related activities to individuals with mental retardation who are experiencing serious psychiatric or behavioral problems. The qualified mental retardation professional shall have: (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession;

2. To provide the crisis supervision component, ~~agencies~~ *providers* must be licensed by DMHMRSAS as providers of residential services, supportive residential services, or day support services;

3. Required documentation in the individual's record. The provider must maintain a record regarding each individual receiving crisis stabilization services. At a minimum, the record must contain the following:

a. Documentation of the face-to-face assessment and any reassessments completed by a qualified mental retardation professional;

b. An ISP which contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports;

(2) The individual's goals;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) A timetable for the accomplishment of the individual's goals and objectives;

(5) The estimated duration of the individual's needs for services; and

(6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. An ISP must be developed or revised and submitted to the case manager for submission to DMHMRSAS within 72 hours of ~~assessment or reassessment~~ *the requested start date for authorization*;

d. Documentation indicating the dates and times of crisis stabilization services, the amount and type of service or services provided, and specific information regarding the individual's response to the services and supports as agreed to in the ISP objectives; and

e. Documentation of qualifications of providers must be maintained for review by DMHMRSAS and DMAS staff.

## **12 VAC 30-120-229. Day support services.**

A. Service description. Day support services shall include a variety of training, assistance, support, and specialized supervision for the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. These services

are typically offered in a nonresidential setting that allows peer interactions and community and social integration.

B. Criteria. For day support services, individuals must demonstrate the need for functional training, assistance, and specialized supervision offered primarily in settings other than the individual's own residence that allows an opportunity for being productive and contributing members of communities.

C. Levels of day support. The amount and type of day support included in the individual's service plan is determined according to the services required for that individual. There are two types of day support: center-based, which is provided primarily at one location/building, or noncenter-based, which is provided primarily in community settings. Both types of day support may be provided at either intensive or regular levels.

D. Intensive level criteria. To be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) requires physical assistance to meet the basic personal care needs (toileting, feeding, etc); (ii) has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish his service goals; or (iii) requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral objectives are required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

E. Service units and service limitations. Day support services are billed in units. Day support cannot be regularly or temporarily provided in an individual's home or other residential setting (e.g., due to inclement weather or individual illness) without prior written approval from DMHMRSAS. Noncenter-based day support services must be separate and distinguishable from either residential support services or personal assistance services. There must be separate supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. The supporting documentation must provide an estimate of the amount of day support required by the individual. Service providers are reimbursed only for the amount and type of day support services included in the individual's approved ISP based on the setting, intensity, and duration of the service to be delivered. This service, ~~either as a stand-alone service or in combination with prevocational and supported employment services~~ shall be limited to 780 units per CSP year. *If this service is used in combination with prevocational and supported employment services, the combined total units for these services cannot exceed 780 units per CSP year.*

F. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12 VAC 30-120-217 and 12 VAC 30-120-219, day support providers need to meet additional requirements.

1. The provider of day support services must be licensed by DMHMRSAS as a provider of day support services. Day support staff must also have training in the characteristics of mental retardation and appropriate interventions, training

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strategies, and support methods for persons with mental retardation and functional limitations.

2. A functional assessment must be conducted by the provider to evaluate each individual in the day support environment and community settings.

3. An ISP must be developed which contains, at a minimum, the following elements:

- a. The individual's strengths, desired outcomes, required or desired supports and training needs;
- b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;
- c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;
- d. A timetable for the accomplishment of the individual's goals and objectives as appropriate;
- e. The estimated duration of the individual's needs for services; and
- f. The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

4. Documentation must confirm the individual's attendance and amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives.

- a. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed with the individual receiving the services or his family/caregiver, and the results of the review submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual or family/caregiver.
- b. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units provided.
- c. Documentation must indicate whether the services were center-based or noncenter-based.
- d. In instances where day support staff are required to ride with the individual to and from day support, the day support staff time can be billed as day support, provided that the billing for this time does not exceed 25% of the total time spent in the day support activity for that day. Documentation must be maintained to verify that billing for day support staff coverage during transportation does not exceed 25% of the total time spent in the day support for that day.
- e. If intensive day support services are requested, documentation must be present in the individual's record to indicate the specific supports and the reasons they are needed. For ongoing intensive day support services, there must be clear documentation of the ongoing needs and associated staff supports.

f. Copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

## **12 VAC 30-120-233. Personal assistance services (agency-directed model).**

A. Service description. Personal assistance services are provided to individuals in the areas of activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. It may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

B. Criteria. In order to qualify for these services, the individual must demonstrate a need for assistance with activities of daily living, self-administration of medications or other medical needs, or monitoring of health status or physical condition.

C. Service units and service limitations. The unit of service for personal assistance services is one hour. Each individual must have a back-up plan in case the personal assistant does not show up for work as expected or terminates employment without prior notice. Personal assistance is not available to individuals: (i) who receive *congregate* residential services or live in assisted living facilities; (ii) who would benefit from personal assistance training and skill development; or (iii) who receive comparable services provided through another program or service.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12 VAC 30-120-217 and 12 VAC 30-120-219, personal assistance providers must meet additional provider requirements.

1. Personal assistance services shall be provided by an enrolled DMAS personal care/respice care provider or by a DMHMRSAS-licensed residential support services provider. All personal assistants must pass the ~~DMHMRSAS~~ *an objective standardized test of skills, knowledge, and abilities developed approved* by DMHMRSAS and administered according to ~~DMHMRSAS policies~~ *DMHMRSAS' defined procedures*.

2. For DMHMRSAS-licensed residential support providers, a residential supervisor will provide ongoing supervision of all personal assistants.

~~2.~~ 3. For DMAS-enrolled personal care/respice care providers, the personal assistance provider must employ or subcontract with and directly supervise a RN or an LPN who will provide ongoing supervision of all personal assistants. The supervising RN or LPN must be currently licensed to practice nursing in the Commonwealth and have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/MR or nursing facility.

~~a.~~ 4. The supervisor must make a home visit to conduct an initial assessment prior to the start of services for all individuals requesting personal assistance services. The supervisor must also perform any subsequent

reassessments or changes to the supporting documentation.

~~b~~- 5. The supervisor must make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 to 90 days depending on the individual's needs.

~~c~~- 6. Based on continuing evaluations of the assistant's performance and individual's needs, the supervisor shall identify any gaps in the assistant's ability to function competently and shall provide training as indicated.

~~d~~- 7. The personal assistance provider must employ and directly supervise personal assistants who will provide direct service to individuals receiving personal assistance. Each assistant hired by the provider shall be evaluated by the provider to ensure compliance with minimum qualifications as required by the DMAS. Each assistant must:

- ~~(1)~~ a. Be 18 years of age or older;
- ~~(2)~~ b. Be able to read and write English to the degree necessary to perform the tasks expected;
- ~~(3)~~ c. *Employees of personal care/respice care agencies must complete a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to an individual, the provider must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:*
  - ~~(a)~~ (1) Registration as a certified nurse aide;
  - ~~(b)~~ (2) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistance, or home health aide;
  - ~~(c)~~ (3) Completion of provider-offered training, which is consistent with the basic course outline approved by DMAS;
- ~~(4)~~ d. Be physically able to do the work;
- ~~(5)~~ e. Have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children; and

~~3~~- 8. Personal assistants may not be the parents of individuals who are minors, or the individuals' spouses. Payment may not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the service. Family members who are approved to be reimbursed for providing this service must meet the personal assistant qualifications.

~~4~~- 9. Provider inability to render services and substitution of assistants.

- a. When a personal assistant is absent, the provider is responsible for ensuring that services continue to be provided to individuals. The provider may either provide another assistant, obtain a substitute assistant from

another provider, if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another provider. The personal assistance provider that has the authorization to provide services to the individual must contact the case manager to determine if additional preauthorization is necessary.

b. If no other provider is available who can supply a substitute assistant, the provider shall notify the individual, family/caregiver and case manager so that the case manager may find another available provider of the individual's choice.

c. During temporary, short-term lapses in coverage not to exceed two weeks in duration, the following procedures must apply:

- (1) The preauthorized personal assistance provider must provide the supervision for the substitute assistant;
- (2) The provider of the substitute assistant must send a copy of the assistant's daily documentation signed by the individual or family/caregiver on his behalf and the assistant to the personal assistance provider having the authorization; and
- (3) The preauthorized provider must bill DMAS for services rendered by the substitute assistant.

d. If a provider secures a substitute assistant, the provider agency is responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant and documentation that the substitute assistant's qualifications meet DMAS' requirements. The two providers involved are responsible for negotiating the financial arrangements of paying the substitute assistant.

~~5~~- 10. Required documentation in the individual's record. The provider must maintain records regarding each individual receiving personal assistance. At a minimum these records must contain:

- a. An initial assessment completed by the supervisor prior to or on the date services are initiated;
- b. An ISP, that contains, at a minimum, the following elements:
  - (1) The individual's strengths, desired outcomes, required or desired supports;
  - (2) The individual's goals and objectives to meet the above identified outcomes;
  - (3) Services to be rendered and the frequency of services to accomplish the above goals and objectives; and
  - (4) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed modified as appropriate and results of these reviews submitted to the case manager. For the

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annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual.

d. Dated notes of any contacts with the personal assistant, individual and family/caregiver during supervisory visits to the individual's home. The written summary of the supervision visits must include:

- (1) Whether personal assistance services continue to be appropriate;
- (2) Whether the ISP is adequate to meet the need or if changes are indicated in the ISP;
- (3) Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;
- (4) The individual's satisfaction with the service;
- (5) Any hospitalization or change in medical condition or functioning status;
- (6) Other services received and their amount; and
- (7) The presence or absence of the assistant in the home during the supervisor's visit.

e. All correspondence to the individual, family/caregiver, case manager, DMAS, and DMHMRSAS;

f. Reassessments and any changes to supporting documentation made during the provision of services;

g. Contacts made with family/caregivers, physicians, formal and informal service providers, and all professionals concerning the individual;

h. All personal assistant records. The personal assistant record must contain:

- (1) The specific services delivered to the individual by the assistant, dated the day of service delivery, and the individual's responses;
- (2) The assistant's arrival and departure times;
- (3) The assistant's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and
- (4) The assistant's and individual's or family/caregiver's weekly signatures recorded on the last day of service delivery for any given week to verify that personal assistance services during that week have been rendered.

i. Copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

## **12 VAC 30-120-237. Prevocational services.**

A. Service description. Prevocational services are services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services, (excluding supported

employment programs). Activities included in this service are not primarily directed at teaching specific job skills but at underlying rehabilitative goals such as accepting supervision, attendance, task completion, problem solving, and safety.

B. Criteria. In order to qualify for prevocational services, the individual shall have a demonstrated need for support in skills that are aimed toward preparation of paid employment that may be offered in a variety of community settings.

C. Service units and service limitations. Billing is for one unit of service. This service, ~~either as a stand-alone service or in combination with day support and supported employment services~~ is limited to 780 units per CSP year. *If this service is used in combination with day support and supported employment services, the combined total units for these services cannot exceed 780 units per CSP year.* Prevocational services can be provided in center- or noncenter-based settings. *Center-based means services are provided primarily at one location/building and noncenter-based means services are provided primarily in community settings. Both center-based or noncenter-based prevocational services may be provided at either regular or intensive levels.*

1. *For prevocational services to be authorized at the intensive level, the individual must meet at least one of the following criteria: (a) require physical assistance to meet the basic personal care needs (toileting, feeding, etc); (b) have extensive disability-related difficulties and require additional, ongoing support to fully participate in programming and to accomplish his service goals; or (c) require extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral objectives are required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.*

2. There must be documentation regarding whether prevocational services are available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). If the individual is not eligible for § services through the IDEA, documentation is required only for lack of DRS funding. When services are provided through these sources, the ISP shall not authorize them as a waiver expenditure. Prevocational services can only be provided when the individual's compensation is less than 50% of the minimum wage.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12 VAC 30-120-217 and 12 VAC 30-120-219, prevocational providers must also meet the following qualifications:

1. The provider of prevocational services must be a vendor of extended employment services, long-term employment services, or supported employment services for DRS, or be licensed by DMHMRSAS as a provider of day support services. Providers must ensure and document that persons providing prevocational services have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations.

2. Required documentation in the individual's record. The provider must maintain a record regarding each individual receiving prevocational services. At a minimum, the records must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the prevocational environment and community settings.

b. An ISP, which contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports, and training needs;

(2) The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) A timetable for the accomplishment of the individual's goals and objectives;

(5) The estimated duration of the individual's needs for services; and

(6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

3. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual.

4. Documentation must confirm the individual's attendance, amount of time spent in services, and type of services rendered, and provide specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives.

5. In instances where prevocational staff are required to ride with the individual to and from prevocational services, the prevocational staff time can be billed for prevocational services, provided that billing for this time does not exceed 25% of the total time spent in prevocational services for that day. Documentation must be maintained to verify that billing for prevocational staff coverage during transportation does not exceed 25% of the total time spent in the prevocational services for that day.

6. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

## **12 VAC 30-120-241. Residential support services.**

A. Service description. Residential support services consist of training, assistance or specialized supervision provided primarily in an individual's home or in a licensed or approved residence to enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Service providers shall be reimbursed only for the amount and type of residential support services included in the individual's approved ISP. Residential support services shall be authorized in the ISP only when the individual requires these services and these services exceed the services included in the individual's room and board arrangements for individuals residing in group homes, or, for other individuals, if these services exceed supports provided by the family/caregiver. Services will not be routinely reimbursed for a continuous 24-hour period.

### **B. Criteria.**

1. In order for Medicaid to reimburse for residential support services, the individual shall have a demonstrated need for supports to be provided by staff who are paid by the residential support provider.

2. In order to qualify for this service in a congregate setting, the individual shall have a demonstrated need for continuous training, assistance, and supervision for up to 24 hours per day provided by a DMHMRSAS-licensed residential provider.

3. A functional assessment must be conducted to evaluate each individual in his home environment and community settings.

4. The residential support ISP must indicate the necessary amount and type of activities required by the individual, the schedule of residential support services, and the total number of projected hours per week of waiver reimbursed residential support.

C. Service units and service limitations. ~~Residential supports shall be reimbursed for time the residential support staff is working directly with the individual.~~ Total billing cannot exceed the authorized amount in the ISP. The provider must maintain documentation of the date and times that services were provided, and specific circumstances that prevented provision of all of the scheduled services.

1. This service must be provided on an individual-specific basis according to the ISP and service setting requirements;

2. Congregate residential support services may not be provided to any individual who receives personal assistance services under the MR Waiver or other residential services that provide a comparable level of care. Respite services may be provided in conjunction with in-home residential support services to unpaid caregivers.

3. Room, board, and general supervision shall not be components of this service;

4. This service shall not be used solely to provide routine or emergency respite for the family/caregiver with whom the individual lives; and

5. Medicaid reimbursement is available only for residential support services provided when the individual is present and when a qualified provider is providing the services.

### **D. Provider requirements.**

1. In addition to meeting the general conditions and requirements for home and community-based participating

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providers as specified in 12 VAC 30-120-217 and 12 VAC 30-120-219, the provider of residential services must have the appropriate DMHMRSAS residential license.

2. Residential support services may also be provided in adult foster care homes approved by local DSS offices pursuant to state DSS regulations.

3. In addition to licensing requirements, persons providing residential support services are required to participate in training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for individuals with mental retardation and functional limitations. ~~All persons providing providers of residential support services must pass an objective, standardized test of skills, knowledge, and abilities developed approved by DMHMRSAS and administered according to DMHMRSAS policies DMHMRSAS' defined procedures.~~

4. Required documentation in the individual's record. The provider agency must maintain records of each individual receiving residential support services. At a minimum these records must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the residential environment and community settings.

b. An ISP containing the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports, or both, and training needs;

(2) The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

(3) The services to be rendered and the schedule of services to accomplish the above goals, objectives, and desired outcomes;

(4) A timetable for the accomplishment of the individual's goals and objectives;

(5) The estimated duration of the individual's needs for services; and

(6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual or family/caregiver.

d. Documentation must confirm attendance, the amount of time in services, and provide specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives.

e. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

## **12 VAC 30-120-243. Respite services (agency-directed model).**

A. Service description. Respite services are supports for that which is normally provided by the family or other unpaid primary caregiver of an individual. These services are furnished on a short-term basis because of the absence or need for relief of those unpaid caregivers normally providing the care for the individuals.

B. Criteria. Respite services may only be offered to individuals who have an unpaid primary caregiver living in the home who requires temporary relief to avoid institutionalization of the individual. Respite services are designed to focus on the need of the unpaid caregiver for temporary relief and to help prevent the breakdown of the unpaid caregiver due to the physical burden and emotional stress of providing continuous support and care to the individual.

C. Service units and service limitations. The unit of service is one hour. Respite services shall be limited to a maximum of 720 hours per calendar year. This service shall not be provided to relieve group home or assisted living facility staff where residential care is provided in shifts. Respite services shall not be provided by adult foster care/family care providers for an individual residing in that home. Training of the individual is not provided with respite services. Individuals who are receiving consumer-directed respite and agency-directed respite services cannot exceed 720 hours per calendar year combined.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12 VAC 30-120-217 and 12 VAC 30-120-219, respite providers must meet the following qualifications:

1. Respite services shall be provided by a DMAS enrolled personal care/respite care provider, a DMHMRSAS-licensed residential provider, a DMHMRSAS-licensed respite services provider, or a DSS-approved foster care home for children or adult foster home provider.

2. For DMHMRSAS-licensed residential or respite services providers, a residential supervisor will provide ongoing supervision of all respite assistants.

~~2-~~ 3. For DMAS-enrolled personal care/respite care providers, the respite services provider must employ or subcontract with and directly supervise a RN or an LPN who will provide ongoing supervision of all respite assistants. The supervising RN or LPN must be currently licensed to practice nursing in the Commonwealth and have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/MR or nursing facility.

~~a-~~ 4. The supervisor must make an initial assessment visit prior to the start of care for any individual requesting respite services. The supervisor must also perform any

subsequent reassessments or changes to the supporting documentation; and

~~b~~- 5. The supervisor must make supervisory visits as often as needed to ensure both quality and appropriateness of services;

~~(1)~~ a. When respite services are received on a routine basis, the minimum acceptable frequency of these supervisory visits shall be every 30 to 90 days based on the needs of the individual;

~~(2)~~ b. When respite services are not received on a routine basis, but are episodic in nature, the supervisor is not required to conduct a supervisory visit every 30 to 90 days. Instead, the supervisor must conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite period;

~~(3)~~ c. When respite services are routine in nature and offered in conjunction with personal assistance, the 30- to 90-day supervisory visit conducted for personal assistance may serve as the supervisory visit for respite services. However, the supervisor must document supervision of respite services separately. For this purpose, the same individual record can be used with a separate section for respite services documentation;

~~e~~- 6. Based on continuing evaluations of the assistants' performances and individuals' needs, the supervisor shall identify any gaps in the assistants' ability to function competently and shall provide training as indicated;

~~d~~- 7. Basic qualifications for respite assistants include:

~~(1)~~ a. Be at least 18 years of age or older;

~~(2)~~ b. Be physically able to do the work;

~~(3)~~ c. Have the ability to read and write in English to the degree necessary to perform the tasks expected;

~~(4)~~ d. *Employees of personal care/respite care agencies must have completed a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to an individual, the provider must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:*

~~(a)~~ (1) Registration as a certified nurse aide;

~~(b)~~ (2) Graduation from an approved educational curriculum which offers certificates qualifying the student as a nursing assistant, geriatric assistance, or home health aide; or

~~(c)~~ (3) Completion of provider-offered training, which is consistent with the basic course outline approved by DMAS.

~~(5)~~ e. Have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children;

~~3~~- 8. Respite assistants may not be the parents of individuals who are minors, or the individuals' spouses. Payment may not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who are approved to provide paid respite services must meet the qualifications for respite assistants.

~~4~~- 9. Inability to provide services and substitution of assistants.

a. When a respite assistant is absent, the provider is responsible for ensuring that services continue to individuals. The provider may provide another assistant, obtain a substitute assistant from another provider if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another provider. The respite provider that has the authorization to provide services to the individual must contact the case manager to determine if additional preauthorization is necessary.

b. If no other provider is available who can supply an assistant, the provider shall notify the individual, family/caregiver, and case manager so that the case manager can locate another available provider of the individual's choice.

c. During temporary, short-term lapses in coverage, not to exceed two weeks in duration, a substitute assistant may be secured from another respite provider. Under these circumstances, the following requirements apply:

(1) The preauthorized respite services provider is responsible for providing the supervision for the substitute assistant;

(2) The provider of the substitute assistant must send a copy of the assistant's records signed by the individual or family/caregiver on his behalf and the substitute assistant to the respite provider having the authorization. All documentation of services rendered by the substitute assistant must be in the individual's record. The documentation of the substitute assistant's qualifications must also be obtained and recorded in the personnel files of the provider having individual care responsibility. The two providers involved are responsible for negotiating the financial arrangements of paying the substitute assistant; and

(3) Only the provider authorized for services may bill DMAS for services rendered by the substitute assistant.

d. Substitute assistants obtained from other providers may be used only in cases where no other arrangements can be made for individual respite services coverage and may be used only on a temporary basis. If a substitute assistant is needed for more than two weeks, the case must be transferred to another respite services provider that has the assistant capability to serve the individual or individuals.

~~5~~- 10. Required documentation for individual's record. The provider must maintain records of each individual receiving

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respite services. These records must be separated from those of other services. At a minimum these records must contain:

a. Initial assessment completed prior to or on the date services are initiated and subsequent reassessments and changes to supporting documentation by the supervisor, if required;

b. An ISP, which contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports;

(2) The individual's goals;

(3) The estimated duration of the individual's needs for services and the amount of hours needed; and

(4) The provider staff responsible for the overall coordination and integration of the services specified in the ISP;

c. Dated notes documenting contacts with the respite services assistant and of supervisory visits to the individual's home when required. The supervisor must document in a summary note of the supervision visit:

(1) Whether respite services continue to be appropriate;

(2) Whether the service is adequate to meet the individual's needs or if changes need to be made;

(3) The individual's or family/caregiver's satisfaction with the service;

(4) Any hospitalization or change in medical condition or functioning status;

(5) Other services received and the amount;

(6) The presence or absence of the assistant in the home during the supervisor's visit; and

(7) Any special tasks performed by the assistant (e.g., assistance with bowel/bladder programs, range of motion exercises, etc.) and the assistant's qualifications to perform these tasks.

d. All correspondence to the individual, family/caregiver, case manager, DMAS, and DMHMRSAS;

e. Significant contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;

f. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 from the case manager; and

g. Respite assistant record of services rendered and individual's responses. The assistant record must contain:

(1) The specific services delivered to the individual by the respite assistant and the individual's response;

(2) The arrival and departure time of the assistant for respite services only;

(3) Comments or observations about the individual. Assistant comments must include, at a minimum, observation of the individual's physical and emotional condition, daily activities, and the individual's responses to services rendered; and

(4) The signature of the assistant, individual, or family/caregiver as appropriate, for each respite event to verify that respite services have been rendered.

## 12 VAC 30-120-245. Skilled nursing services.

A. Service description. Skilled nursing services *that do not meet home health criteria* shall be provided for individuals with serious medical conditions and complex health care needs that require specific skilled nursing services that cannot be provided by non-nursing personnel. Skilled nursing may be provided in the individual's home or other community setting on a regularly scheduled or intermittent need basis. It may include consultation, *nurse delegation as appropriate*, *oversight of direct care staff as appropriate*, and training for other providers.

B. Criteria. In order to qualify for these services, the individual shall have demonstrated complex health care needs that require specific skilled nursing services ordered by a physician and that cannot be otherwise accessed under the Title XIX State Plan for Medical Assistance. The CSP must indicate that the service is necessary in order to prevent institutionalization and is not available under the State Plan for Medical Assistance.

C. Service units and service limitations. Skilled nursing services to be rendered by either registered or licensed practical nurses are provided in hourly units. The services must be explicitly detailed in an ISP and must be specifically ordered by a physician as medically necessary to prevent institutionalization.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12 VAC 30-120-217 and 12 VAC 30-120-219, participating skilled nursing providers must meet the following qualifications:

1. Skilled nursing services shall be provided by either a DMAS-enrolled home care organization provider or home health provider, or by a registered nurse licensed by the commonwealth or licensed practical nurse licensed by the commonwealth (under the supervision of a registered nurse licensed by the commonwealth), contracted or employed by dmhmrsas-licensed day Support, respite, or residential providers.

2. Skilled nursing services providers may not be the parents of individuals who are minors, or the individual's spouse. Payment may not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who provide skilled nursing services must meet the skilled nursing requirements.

3. Foster care providers may not be the skilled nursing services providers for the same individuals to whom they provide foster care.

4. Required documentation. The provider must maintain a record that contains:

a. An ISP that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports;

(2) The individual's goals;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) The estimated duration of the individual's needs for services; and

(5) The provider staff responsible for the overall coordination and integration of the services specified in the ISP;

b. Documentation of any training of family/caregivers or staff, or both, to be provided, including the person or persons being trained and the content of the training, consistent with the Nurse Practice Act;

c. Documentation of the determination of medical necessity by a physician prior to services being rendered;

d. Documentation of nursing license/qualifications of providers;

e. Documentation indicating the dates and times of nursing services and the amount and type of service or training provided;

f. Documentation that the ISP was reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual.

g. Documentation that the ISP has been reviewed by a physician within 30 days of initiation of services, when any changes are made to the ISP, and also reviewed and approved annually by a physician; and

h. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

## **12 VAC 30-120-247. Supported employment services.**

### **A. Service description.**

1. Supported employment services is work in settings in which persons without disabilities are employed. It is especially designed for individuals with developmental disabilities, including individuals with mental retardation, who face severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential.

2. Supported employment services are available to individuals for whom competitive employment at or above the minimum wage is unlikely without ongoing supports and who because of their disability need ongoing support to perform in a work setting.

3. Supported employment can be provided in one of two models. Individual supported employment shall be defined as intermittent support, usually provided one-on-one by a job coach to an individual in a supported employment position. Group supported employment shall be defined as continuous support provided by staff to eight or fewer individuals with disabilities in an enclave, work crew, bench work, or entrepreneurial model. The individual's assessment and CSP must clearly reflect the individual's need for training and supports.

### **B. Criteria.**

1. Only job development tasks that specifically include the individual are allowable job search activities under the MR waiver supported employment and only after determining this service is not available from DRS.

2. In order to qualify for these services, the individual shall have demonstrated that competitive employment at or above the minimum wage is unlikely without ongoing supports, and who because of his disability, needs ongoing support to perform in a work setting.

3. A functional assessment must be conducted to evaluate the individual in his work environment and related community settings.

4. The ISP must document the amount of supported employment required by the individual. Service providers are reimbursed only for the amount and type of supported employment included in the individual's ISP based on the intensity and duration of the service delivered.

### **C. Service units and service limitations.**

1. Supported employment for individual job placement is provided in one hour units. This service, when in combination with prevocational and day support, is limited to 780 units per CSP year.

2. Group models of supported employment (enclaves, work crews, bench work and entrepreneurial model of supported employment) will be billed at the unit rate. This service is limited to 780 units per CSP year. ~~This service, either as a stand-alone service or in combination with prevocational and day support, is limited to~~ *If used in combination with prevocational and day support services, the combined total units for these services cannot exceed 780 units per CSP year.*

3. For the individual job placement model, reimbursement of supported employment will be limited to actual documented interventions or collateral contacts by the provider, not the amount of time the individual is in the supported employment situation.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12 VAC 30-120-217 and

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# Emergency Regulations

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12 VAC 30-120-219, supported employment provider qualifications include:

1. Supported employment shall be provided only by agencies that are DRS vendors of supported employment services;
2. Individual ineligibility for supported employment services through DRS or IDEA must be documented in the individual's record, as applicable. If the individual is not eligible through IDEA, documentation is required only for the lack of DRS funding;
3. There must be an ISP that contains, at a minimum, the following elements:
  - a. The individual's strengths, desired outcomes, required/desired supports and training needs;
  - b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;
  - c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;
  - d. A timetable for the accomplishment of the individual's goals and objectives;
  - e. The estimated duration of the individual's needs for services; and
  - f. Provider staff responsible for the overall coordination and integration of the services specified in the plan.
4. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and the results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual or family/caregiver.
5. In instances where supported employment staff are required to ride with the individual to and from supported employment activities, the supported employment staff time can be billed for supported employment provided that the billing for this time does not exceed 25% of the total time spent in supported employment for that day. Documentation must be maintained to verify that billing for supported employment staff coverage during transportation does not exceed 25% of the total time spent in supported employment for that day.
6. There must be a copy of the completed DMAS-122 in the record. Providers must clearly document efforts to obtain the DMAS-122 form from the case manager.

## 12 VAC 30-120-249. Therapeutic consultation.

A. Service description. Therapeutic consultation provides expertise, training and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual. The specialty areas are (i) psychology, (ii) behavioral consultation, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering. The need for any of these services, is based on the individual's CSP, and provided to

those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their ability to function in the community. Therapeutic consultation services may be provided in the individual's home, and in appropriate community settings and are intended to facilitate implementation of the individual's desired outcomes as identified in his CSP.

B. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the CSP cannot be implemented effectively and efficiently without such consultation from this service.

1. The individual's therapeutic consultation ISP must clearly reflect the individual's needs, as documented in the social assessment, for specialized consultation provided to family/caregivers and providers in order to implement the ISP effectively.
2. Therapeutic consultation services may not include direct therapy provided to waiver individuals or monitoring activities, and may not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance.

C. Service units and service limitations. The unit of service shall equal one hour. The services must be explicitly detailed in the ISP. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic consultation may not be billed solely for purposes of monitoring. Only behavioral consultation may be offered in the absence of any other waiver service when the consultation is determined to be necessary to prevent institutionalization.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12 VAC 30-120-217 and 12 VAC 30-120-219, professionals rendering therapeutic consultation services shall meet all applicable state licensure or certification requirements. Persons providing rehabilitation consultation shall be rehabilitation engineers or certified rehabilitation specialists. Behavioral consultation may be performed by professionals based on the professionals' work experience, education, and demonstrated knowledge, skills, and abilities.

The following documentation is required for therapeutic consultation:

1. An ISP, that contains at a minimum, the following elements:
  - a. Identifying information:
  - b. Targeted objectives, time frames, and expected outcomes; *and*
  - c. Specific consultation activities; ~~and~~.
- ~~2.~~ 2. A written support plan detailing the *recommended* interventions or support strategies.
- ~~3.~~ 3. Ongoing documentation of consultative services rendered in the form of contact-by-contact or monthly notes that identify each contact.



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# Emergency Regulations

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## 18 VAC 105-20-10. Licensure by examination.

A. The applicant, in order to be eligible for licensure by examination to practice optometry in the Commonwealth, shall meet the requirements for TPA certification in 18 VAC 105-20-16 and shall:

1. Be a graduate of a school of optometry accredited by the Council on Optometric Education; have an official transcript verifying graduation sent to the board;
2. Request submission of an official report from the National Board of Examiners in Optometry of a score received on each required part of the examination of the National Board of Examiners in Optometry or other board-approved examination; and
3. Submit a completed application and the prescribed fee.

B. Applicants who passed the National Board Examination prior to May 1985 shall apply for licensure by endorsement as provided for in 18 VAC 105-20-15.

C. Required examinations.

1. For the purpose of § 54.1-3211 of the Code of Virginia, the board adopts all parts of the examination of the National Board of Examiners in Optometry as its written examination for licensure. After July 1, 1997, the board shall require passage as determined by the board of Parts I, II, and III of the National Board Examination.
2. As part of the application for licensure, an applicant must sign a statement attesting that he has read, understands, and will comply with the statutes and regulations governing the practice of optometry in Virginia.

## 18 VAC 105-20-15. Licensure by endorsement.

A. An applicant for licensure by endorsement shall meet the requirements for TPA certification in 18 VAC 105-20-16, pay the fee as prescribed in 18 VAC 105-20-20 and file a completed application that certifies the following:

1. The applicant has successfully completed a licensing examination or certification in optometry in any jurisdiction of the United States that is approximately comparable to the Virginia examination at the time of initial licensure.
2. The applicant has been engaged in active clinical practice for at least 36 months out of the last 60 months immediately preceding application.
3. The applicant is not a respondent in a pending or unresolved malpractice claim.
4. Each jurisdiction in which the applicant is currently licensed has verified that:

- a. The license is full and unrestricted, and all continuing education requirements have been completed, if applicable;
- b. The applicant is not a respondent in any pending or unresolved board action;
- c. The applicant has not committed any act which would constitute a violation of § 54.1-3204 or § 54.1-3215 of the Code of Virginia; and

d. The applicant has graduated from an accredited school or college of optometry.

B. The applicant shall also provide proof of competency in the use of diagnostic pharmaceutical agents (DPAs) which shall consist of a report from the national board of passing scores on all sections of Parts I and II of the National Board Examination taken in May 1985 or thereafter. If the applicant does not qualify through examination, he shall provide other proof of meeting the requirements for the use of DPA as provided in §§ 54.1-3220 and 54.1-3221 of the Code of Virginia.

C. As part of the application for licensure, an applicant must sign a statement attesting that he has read, understands, and will comply with the statutes and regulations governing the practice of optometry in Virginia.

D. In the case of a federal service optometrist, the commanding officer shall also verify that the applicant is in good standing and provide proof of credentialing and quality assurance review to satisfy compliance with applicable requirements of subsection A of this section.

E. In the event the examinations for initial licensure are determined not comparable, the board may require the applicant to take and pass a regional or national practical examination.

F. An optometrist previously licensed in Virginia is not eligible for licensure by endorsement but may apply for reinstatement of licensure under 18 VAC 105-20-60.

## 18 VAC 105-20-16. Requirements for TPA certification.

A. An applicant for licensure shall meet the following requirements for TPA certification:

1. Complete a full-time, postgraduate or equivalent graduate-level optometric training program which is approved by the board and which shall include a minimum of 20 hours of clinical supervision by an ophthalmologist; and
2. Take and pass the TPA certification examination, which shall be Treatment and Management of Ocular Disease (TMOD) of the National Board of Optometric Examiners or if TPA-certified by a state examination, provide evidence of comparability to the NBOE examination that is satisfactory to the board.

B. A candidate for certification by the board who fails the examination as required in 18 VAC 105-20-16 B, following three attempts, shall complete additional postgraduate training as determined by the board to be eligible for TPA certification.

## 18 VAC 105-20-20. Fees.

A. Required fees.

|  |       |
|--|-------|
| Initial application and licensure (including TPA certification)      | \$245 |
| Endorsement of certification to use diagnostic pharmaceutical agents | \$300 |
| Annual licensure renewal without TPA certification                   | \$100 |
| Annual licensure renewal with TPA                                    | \$200 |

*certification*

|   |       |
|---|-------|
| Late renewal <i>without TPA certification</i>                   | \$50  |
| Late renewal <i>with TPA certification</i>                      | \$65  |
| Returned check  | \$25  |
| Professional designation application                            | \$100 |
| Annual professional designation renewal (per location)          | \$50  |
| Late renewal of professional designation                        | \$20  |
| Reinstatement application fee (including renewal and late fees) | \$450 |
| Reinstatement application after disciplinary action             | \$500 |
| Duplicate wall certificate                                      | \$25  |
| Duplicate license   | \$10  |
| Licensure verification  | \$10  |

B. Unless otherwise specified, all fees are nonrefundable.

**18 VAC 105-20-70. Requirements for continuing education.**

A. Each license renewal shall be conditioned upon submission of evidence to the board of 16 hours of continuing education taken by the applicant during the previous license period.

1. Fourteen of the 16 hours shall pertain directly to the care of the patient. The 16 hours may include up to two hours of recordkeeping for patient care and up to two hours of training in cardiopulmonary resuscitation (CPR). *Optometrists with TPA certification shall complete at least two hours annually of continuing education directly related to the prescribing and administration of TPA's.*
2. For optometrists who are certified in the use of therapeutic pharmaceutical agents, at least two of the required continuing education hours shall be directly related to the prescribing and administration of such drugs.
3. Courses that are solely designed to promote the sale of specific instruments or products and courses offering instruction on augmenting income are excluded and will not receive credit by the board.

B. Each licensee shall attest to fulfillment of continuing education hours on the required annual renewal form. All continuing education shall be completed prior to December 31 unless an extension or waiver has been granted by the Continuing Education Committee.

C. All continuing education courses shall be offered by an approved sponsor listed in subsection G of this section. Courses that are not approved by a board-recognized sponsor in advance shall not be accepted for continuing education credit. For those courses that have a post-test requirement, credit will only be given if the optometrist receives a passing grade as indicated on the certificate.

D. Licensees shall maintain continuing education documentation for a period of not less than three years. A random audit of licensees may be conducted by the board which will require that the licensee provide evidence substantiating participation in required continuing education courses within 14 days of the renewal date.

E. Documentation of hours shall clearly indicate the name of the continuing education provider and its affiliation with an approved sponsor as listed in subsection G of this section. Documents that do not have the required information shall not be accepted by the board for determining compliance. Correspondence courses shall be credited according to the date on which the post-test was graded as indicated on the continuing education certificate.

F. A licensee shall be exempt from the continuing competency requirements for the first renewal following the date of initial licensure by examination in Virginia.

G. An approved continuing education course or program, whether offered by correspondence, electronically or in person, shall be sponsored or approved by one of the following:

1. The American Optometric Association and its constituent organizations.
2. Regional optometric organizations.
3. State optometric associations and their affiliate local societies.
4. Accredited colleges and universities providing optometric or medical courses.
5. The American Academy of Optometry and its affiliate organizations.
6. The American Academy of Ophthalmology and its affiliate organizations.
7. The Virginia Academy of Optometry.
8. Council on Optometric Practitioner Education (C.O.P.E.).
9. State or federal governmental agencies.
10. College of Optometrists in Vision Development.
11. The Accreditation Council for Continuing Medical Education of the American Medical Association for Category 1 or Category 2 credit.
12. Providers of training in cardiopulmonary resuscitation (CPR).
13. Optometric Extension Program.

/s/ Mark R. Warner  
Governor

Date: November 2, 2004

VA.R. Doc. No. R05-61; Filed November 4, 2004, 11:05 a.m.



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# GENERAL NOTICES/ERRATA

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## STATE CORPORATION COMMISSION

November 5, 2004

Administrative Letter 2004-07

TO: All Agencies and Insurers Licensed to Write Title Insurance in Virginia

RE: Unfair Discrimination and Rebating Applicable to Title Insurance

**NOTE: EACH INSURER RECEIVING THIS ADMINISTRATIVE LETTER IS INSTRUCTED TO PROVIDE A COPY TO EACH OF ITS CURRENTLY APPOINTED AGENTS, AND TO EACH NEWLY APPOINTED AGENT COMMENCING IMMEDIATELY.**

On March 19, 2003, the Bureau issued Administrative Letter 2003-03 pertaining to a market practice in which a title insurer was issuing new price schedules to certain appointed agents, while other appointed agents of the company were allowed to continue to sell policies using the old price schedules. Administrative Letter 2003-03 stated that the Bureau considered this market practice to constitute unfair discrimination. The Bureau has received numerous questions from the title insurance industry regarding how the letter applied to other pricing practices such as bidding, negotiating, discounting or forfeiting of title insurance premiums. The Bureau has continued to evaluate issues relating to title insurance pricing practices, including the issue of rebating.

The standards for title insurance risk rates are set forth in § 38.2-4608 of the Code of Virginia and require that title insurance risk rates (i) be reasonable and adequate for the class of risk to which they apply and (ii) not be unfairly discriminatory between risks involving essentially the same hazards and expense elements. Section 38.2-509 of the Code of Virginia prohibits rebating by insurers and agents. In an effort to provide guidance to the title insurance industry, this administrative letter sets forth the Bureau's position regarding the scope of its regulatory authority over title insurance risk rates, rebating and other similar practices in a series of questions and answers, which address many of the questions posed by the industry:

**1. For the purposes of title insurance risk rates, what constitutes unfair discrimination?**

Based on the provisions of § 38.2-4608, "unfair discrimination" in title insurance occurs where risks are charged a different rate when there is essentially no difference in the hazards insured against or when there is no difference in the expense elements presented by the risks. The Bureau would consider bidding, negotiating, discounting or forfeiting of all or part of the title insurance premium for competitive purposes to constitute unfair discrimination and rebating if such practices result in risks being charged different rates and there is no difference in the hazards or expenses associated with the risks.

**2. How will the Bureau determine that unfair discrimination or rebating has occurred?**

The Bureau will review the company's price schedules (or any other means by which the company communicates its prices) to determine whether unfair discrimination has occurred. While Chapter 46 does not specifically require that price schedules be issued or published, the business of title insurance cannot be conducted without issued or published prices. Once a title insurer makes its prices available, the prices become "published" regardless of the method used to communicate the prices. Section 38.2-4608 essentially establishes a system of "publish and use" for title insurance risk rates. The Bureau's analysis would be similar in determining whether a violation of § 38.2-509 has occurred.

**3. What documentation or evidence does an insurer need in order to demonstrate compliance with Virginia law or demonstrate the differences between classes of risks?**

Insurers should rely on § 38.2-4608 for guidance in making such determinations. For example, the statute contemplates risks being grouped into classes for the establishment of rates. Many title insurers establish classes or risks such as commercial versus residential and new policies versus re-issued coverage. Using re-issued coverage as an illustration, title insurers often charge less for title insurance policies when the transaction involves a mortgage re-finance and an insured with an existing title insurance policy on the property. In order to justify the re-issue rate, the title insurer would need to be able to establish and document a reduced level of exposure to loss or a reduced level of expense associated with the underwriting of such risks. In addition, the insurer would have to use the re-issue rate in all similar transactions.

In addition, § 38.2-4608 B allows insurers to price title insurance policies that are "unusually hazardous." The statute defines such situations to be risks with an "alleged defect or irregularity in the title insured or because of uncertainty regarding the proper interpretation or application of the law involved." Insurers are permitted to distinguish individual risks for pricing purposes based on this provision. However, the insurer would need to specifically document the qualities of the risk that warrant pricing other than the company's published pricing schedules.

**4. Does the Bureau intend to promulgate requirements or standards outlining the level of information sufficient to establish compliance with § 38.2-4608?**

No. It is the insurer's obligation to demonstrate to the Bureau that characteristics used to price or differentiate among classes of risks are specific, documented and representative of the difference(s) in the hazards or expense elements presented by the risk or classes of risks.

**5. Are there any exceptions to the statutory provisions for adhering to published prices?**

Yes. Subsection B of § 38.2-4608 allows insurers to price for unusually hazardous conditions involving alleged

defects or irregularities in the title insured or because of uncertainty regarding the proper interpretation or application of the law involved.

**6. How will the Bureau enforce the consistent application of an insurer's published rates and the rebating statutes?**

Enforcement will be accomplished through on-site or target market conduct examinations, consumer/industry complaints and/or agent investigations.

Insurers and agents will be expected to retain information sufficient to establish the consistent application of pricing schedules. Insurers will be expected to be able to produce evidence sufficient to establish compliance with the rate standards for the company's pricing schedules and pricing practices.

**7. Are insurers permitted to grant risk-specific discounts or to develop a rating plan for determining risk-specific discounts for competitive purposes?**

No. Chapter 46 of Title 38.2 of the Code of Virginia does not set forth a means by which to allow insurers to provide risk-specific discounts. In other words, a title insurer would not be permitted to discount its published rates for an individual risk in order to reduce the premium for competitive purposes. Further, discounts or any plan for establishing risk-specific discounts would constitute unlawful rebating pursuant to § 38.2-509.

**8. Is it permissible for an insurer with a risk valued, for example, at \$1,500,000, to have a published rate of \$1.00 per \$1,000 for values up to \$1,000,000 and then charge \$0.50 per \$1,000 for the additional \$500,000 in value?**

The title insurer must be able to demonstrate that the higher amounts of coverage warrant a lower rate. In addition, the title insurer's published price schedules must reflect such differential and the differential must be used consistently with all such risks.

**9. Is it permissible for an agent to forfeit all or a portion of his/her title insurance commission in order to reduce the premium owed by the insured?**

No. The provisions of § 38.2-509 prohibit rebating.

**10. May settlement agents give discounts, rebates, or other credits to property purchasers at settlement?**

Section 38.2-509 prohibits title agents and insurers from giving credits, discounts or rebates if such credits, discounts or rebates are used to induce the purchase of an insurance contract. For example, there cannot be a requirement that the property purchaser buy a title insurance policy from the settlement agent in order to receive a credit, discount or reduction in closing costs. Administration Letter 1992-6 should be reviewed for further clarification.

**11. What are the consequences for violating §§ 38.2-4608 or 38.2-509?**

Sections 38.2-218 and 38.2-219 outline monetary penalties for violations of certain statutes. In addition, restitution may be ordered and other regulatory actions affecting the individual's or entity's license to transact business in Virginia may also be warranted.

Questions regarding title insurance rate standards should be directed to Rebecca Nichols, CPCU, CIC, AIE, Principal Insurance Market Examiner, Property and Casualty Division - Personal Lines Forms and Rates Section, at (804) 371-9965 or by email at [rnichols@scc.state.va.us](mailto:rnichols@scc.state.va.us). Questions regarding rebating should be addressed to Steve Shipman, CISR, Senior Investigator, Property and Casualty Agent Investigation Section, Agent Regulation and Administration Division, at (804) 371-9465.

/s/ Alfred W. Gross  
Commissioner of Insurance

## DEPARTMENT OF ENVIRONMENTAL QUALITY

### Removal of Middle Creek in Tazewell County from the Total Maximum Daily Load (TMDL) List

The Department of Environmental Quality (DEQ) and the Department of Mines, Minerals and Energy seek written and oral comments from interested persons on the removal of Middle Creek in Tazewell County, Virginia, from the Total Maximum Daily Load (TMDL) list. This stream was listed on the 1998 303(d) TMDL Priority List and Report as impaired due to violations of the state's water quality standards for the General Standard (Benthic Macroinvertebrates).

A public meeting regarding removing Middle Creek from the TMDL list due to recent data that shows an improvement in the aquatic organism community will be November 16, 2004, at 7 p.m., at the Cedar Bluff Town Hall in Cedar Bluff, Virginia. The Town Hall is located next to Town Square on Business Route 460 in Cedar Bluff. Cedar Bluff is in Tazewell County off Route 460, between Claypool Hill and the Town of Richlands. The recent data on Middle Creek indicates it is fully supporting aquatic life use.

Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia require DEQ to develop TMDLs for pollutants responsible for each impaired water contained in Virginia's 303(d) TMDL Priority List and Report.

The fully supporting segment of Middle Creek is located in Tazewell County. It includes the entire length of stream, 10.01 miles beginning at the headwaters and ending at its confluence with Clinch River in Cedar Bluff.

The public comment period will end on December 17, 2004. Information about Middle Creek is available upon request or can be viewed at the DEQ website, [www.deq.virginia.gov/tmdl](http://www.deq.virginia.gov/tmdl). Questions or written comments should include the name, address, and telephone number of the person submitting the comments and be addressed to Nancy T. Norton, P. E., Department of Environmental Quality, 355 Deadmore Street, P.O. Box 1688, Abingdon, VA 24212, telephone (276) 676-4807, FAX (276) 676-4899 or e-mail [ntnorton@deq.virginia.gov](mailto:ntnorton@deq.virginia.gov).

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# General Notices/Errata

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## STATE LOTTERY DEPARTMENT

### Director's Orders

The following Director's Orders of the State Lottery Department were filed with the Virginia Registrar of Regulations on November 4, 2004. The orders may be viewed at the State Lottery Department, 900 E. Main Street, Richmond, Virginia, or at the office of the Registrar of Regulations, 910 Capitol Street, 2nd Floor, Richmond, Virginia.

Final Rules for Game Operation:

Director's Order Number Thirty-Four (04)

Virginia's Instant Game Lottery 626; "Candy Cane Cash," (effective 10/26/04)

Director's Order Number Thirty-Six (04)

Virginia's Instant Game Lottery 624; "Gingerbread Dough," (effective 10/26/04)

Director's Order Number Thirty-Eight (04)

Virginia's Instant Game Lottery 625; "Stocking Stuffer," (effective 10/26/04)

Director's Order Number Thirty-Nine (04)

Virginia's Instant Game Lottery 273; "Winter Double Doubler," (effective 10/26/04)

Director's Order Number Fifty-One (04)

Virginia's Instant Game Lottery 264; "High Card," (effective 10/26/04)

Director's Order Number Fifty-Two (04)

Virginia's Instant Game Lottery 611; "Phat Cat Tripler," (effective 10/26/04)

Director's Order Number Fifty-Three (04)

Virginia's Instant Game Lottery 627; "Casino Night," (effective 10/26/04)

Director's Order Number Fifty-Four (04)

Virginia's Instant Game Lottery 628; "Bonus Money," (effective 10/26/04)

Director's Order Number Fifty-Five (04)

Virginia's Instant Game Lottery 629; "High Stakes," (effective 10/26/04)

Director's Order Number Fifty-Six (04)

Certain Virginia Instant Game Lotteries; End of Games.

In accordance with the authority granted by §§ 2.2-4002 B (15) and 58.1-4006 A of the Code of Virginia, I hereby give notice that the following Virginia Lottery instant games will officially end at midnight on November 12, 2004:

|          |                  |
|----------|------------------|
| Game 244 | Double Your Luck |
| Game 253 | Wild Card        |
| Game 255 | Queen of Hearts  |
| Game 259 | Double Deal      |
| Game 260 | 21               |
| Game 270 | Creepy Cash      |
| Game 520 | Win For Life     |
| Game 547 | Vegas            |
| Game 561 | Mega Bucks       |
| Game 572 | Ruby Red 7's     |

|          |                         |
|----------|-------------------------|
| Game 574 | Up The Ante             |
| Game 575 | High 5's                |
| Game 580 | Royal Flush             |
| Game 581 | Price Is Right          |
| Game 585 | Spicy Hot Cash          |
| Game 596 | Wild Cash               |
| Game 597 | Lucky Blackjack         |
| Game 599 | Tough Trucks, Big Bucks |
| Game 600 | Pot of Gold             |
| Game 614 | Witch's Riches          |

The last day for lottery retailers to return for credit unsold tickets from any of these games will be December 31, 2004. The last day to redeem winning tickets for any of these games will be May 11, 2005, 180 days from the declared official end of the game. Claims for winning tickets from any of these games will not be accepted after that date. Claims that are mailed and received in an envelope bearing a postmark of the United States Postal Service or another sovereign nation of May 11, 2005, will be deemed to have been received on time. This notice amplifies and conforms to the duly adopted State Lottery Board regulations for the conduct of lottery games.

This order is available for inspection and copying during normal business hours at the Virginia Lottery headquarters, 900 East Main Street, Richmond, Virginia; and at any Virginia Lottery regional office. A copy may be requested by mail by writing to: Director's Office, Virginia Lottery, 900 East Main Street, Richmond, Virginia 23219.

This Director's Order becomes effective on the date of its signing and shall remain in full force and effect unless amended or rescinded by further Director's Order.

/s/ Penelope W. Kyle  
Executive Director  
Date: November 3, 2004

## VIRGINIA CODE COMMISSION

### Notice to State Agencies

**Mailing Address:** Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, FAX (804) 692-0625.

### Forms for Filing Material for Publication in the Virginia Register of Regulations

All agencies are required to use the appropriate forms when furnishing material for publication in the Virginia Register of Regulations. The forms may be obtained from: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

**Internet:** Forms and other Virginia Register resources may be printed or downloaded from the Virginia Register web page: <http://register.state.va.us>.

#### 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 OBJECTIONS-  
RR08  
RESPONSE TO PETITION FOR RULEMAKING-RR13  
FAST-TRACK RULEMAKING ACTION-RR14

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# CALENDAR OF EVENTS

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## Symbol Key

- † Indicates entries since last publication of the *Virginia Register*  
♿ Location accessible to persons with disabilities  
☎ Teletype (TTY)/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. If you are unable to find a meeting notice for an organization in which you are interested, please check the Commonwealth Calendar at [www.vipnet.org](http://www.vipnet.org) or contact the organization directly.

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) 698-1500 or Senate Information and Constituent Services at (804) 698-7410 or (804) 698-7419/TTY☎, or visit the General Assembly web site's Legislative Information System (<http://leg1.state.va.us/lis.htm>) and select "Meetings."

VIRGINIA CODE COMMISSION

## EXECUTIVE

### BOARD OF ACCOUNTANCY

**December 3, 2004 - 10 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation,  
3600 West Broad Street, Suite 395, Richmond, Virginia.♿  
(Interpreter for the deaf provided upon request)

A meeting to discuss general business matters. A public comment period will be held at the beginning of the meeting. All meetings are subject to cancellation. The time of the meeting is subject to change. Any person desiring to attend the meeting and requiring special accommodations or interpreter services should contact the board at least 10 days prior to the meeting so that suitable arrangements can be made. The board fully complies with the American with Disabilities Act.

**Contact:** Nancy Taylor Feldman, Executive Director, Board of Accountancy, 3600 W. Broad St., Suite 378, Richmond, VA 23230, telephone (804) 367-8505, FAX (804) 367-2174, (804) 367-9753/TTY☎, e-mail [boa@boa.state.va.us](mailto:boa@boa.state.va.us).

### COMMONWEALTH COUNCIL ON AGING

**December 2, 2004 - 9 a.m.** -- Open Meeting  
Department for the Aging, 1610 Forest Avenue, Suite 100,  
Richmond, Virginia.♿ (Interpreter for the deaf provided upon request)

A regular business meeting of the Planning and Development Committee. Public comments are welcome.

**Contact:** Marsha Mucha, Virginia Department for the Aging, 1610 Forest Ave., Suite 100, Richmond, VA 23229, telephone (804) 662-9312.

**December 2, 2004 - 9 a.m.** -- Open Meeting  
Department for the Aging, 1610 Forest Avenue, Suite 100,  
Richmond, Virginia.♿ (Interpreter for the deaf provided upon request)

A business meeting of the Ad Hoc Committee to review the council's annual report. Public comments are welcome.

**Contact:** Robin Brannon, Communications Director, Department for the Aging, 1610 Forest Ave., Suite 100, Richmond, VA 23229, telephone (804) 662-9323.

**December 2, 2004 - 9 a.m.** -- Open Meeting  
Department for the Aging, 1610 Forest Avenue, Suite 100,  
Richmond, Virginia.♿ (Interpreter for the deaf provided upon request)

A regular business meeting of the Executive Committee. Public comments are welcome.

**Contact:** Marsha Mucha, Department for the Aging, 1610 Forest Ave., Suite 100, Richmond, VA 23229, telephone (804) 662-9312.

**December 2, 2004 - 10 a.m.** -- Open Meeting  
Department for the Aging, 1610 Forest Avenue, Suite 100,  
Richmond, Virginia.♿ (Interpreter for the deaf provided upon request)

A regular business meeting. Public comments are welcome.

**Contact:** Marsha Mucha, Virginia Department for the Aging, 1610 Forest Ave., Suite 100, Richmond, VA 23229, telephone (804) 662-9312.

### BOARD OF AGRICULTURE AND CONSUMER SERVICES

**December 9, 2004 - 9 a.m.** -- Open Meeting  
Washington Building, 1100 Bank Street, Suite 211, Second Floor Boardroom, Richmond, Virginia.♿

The board will meet to discuss issues related to Virginia agriculture and consumer services. The board may consider the Food and Drug Administration's Food Code, and supplements thereto, and portions thereof, and 2 VAC 5-580, Rules and Regulations Pertaining to the Sanitary and Operating Requirements in Retail Food Stores.

**Contact:** Roy E. Seward, Board Secretary, Department of Agriculture and Consumer Services, Washington Bldg., 1100

Bank St., Suite 211. Richmond, VA 23219, telephone (804) 786-3538, FAX (804) 371-2945, e-mail Roy.Seward@vdacs.virginia.gov.

## DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

### Virginia Corn Board

**December 7, 2004 - 9 a.m.** -- Open Meeting  
Wallace Manor, 3821 North Courthouse Road, Providence Forge, Virginia. 

The board will hear and approve previous meeting minutes, review checkoff revenues, and the financial status resulting from the sale of the 2004 Virginia corn crop. As well, reports will be heard from the Chairman, board member representation to the U. S. Grains Council, the National Corn Growers Association, and the Virginia Corn Growers' Association. In addition, the nomination and election of 2005 officers will take place at this meeting. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact the person identified in this notice at least five days before the meeting date so that suitable arrangements can be made.

**Contact:** Philip T. Hickman, Program Director, Department of Agriculture and Consumer Services, 1100 Bank St., Room 906, Richmond, VA 23219, telephone (804) 371-6157, FAX (804) 371-7786, e-mail phickman@vdacs.state.va.us.

### Virginia Marine Products Board

**January 25, 2005 - 6 p.m.** -- Open Meeting  
Dolphin Cove Restaurant, Route 17, 4329 George Washington Memorial Highway, Gloucester, Virginia. 

The board will hear the reading and approval minutes of previous board meeting and. In addition, the board expects to hear reports on finance, trade shows, festivals, industry tours, and calendar sales. Cooperative programs with the Virginia Department of Agriculture and Consumer Services and croaker exports will be discussed. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact the person identified in this notice at least five days before the meeting date, so that suitable arrangements can be made for any appropriate accommodation.

**Contact:** Shirley Estes, Executive Director, Department of Agriculture and Consumer Services, 554 Denbigh Blvd., Suite B, Newport News, VA, telephone (757) 874-3474, FAX (757) 886-0671, e-mail Shirley.Estes@vdacs.virginia.gov.

### Virginia Soybean Board

**December 2, 2004 - 10 a.m.** -- Open Meeting  
Virginia Soybean Association, 151 Kristiansand Drive, Suite E, Williamsburg, Virginia. 

The board will hear and approve previous meeting minutes, review checkoff revenues, and hear the financial status resulting from sale of the 2004 Virginia Soybean crop. As well, reports will be heard from the Chairman, the United Soybean Board Representative, and the Virginia Soybean Association. In addition, the nomination and election of 2005 officers will take place at this meeting. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact the person identified in this notice at least five days before the meeting date so that suitable arrangements can be made.

**Contact:** Philip T. Hickman, Program Director, Department of Agriculture and Consumer Services, 1100 Bank St., Room 906, Richmond, VA 23219, telephone (804) 371-6157, FAX (804) 371-7786, e-mail Phil.Hickman@vdacs.virginia.gov.

## STATE AIR POLLUTION CONTROL BOARD

**† December 15, 2004 - 7 p.m.** -- Public Hearing  
Department of Environmental Quality, West Central Regional Office, 3019 Peters Creek Road, Roanoke, Virginia. 

A public hearing on a proposed revision to the Commonwealth of Virginia State Implementation Plan. The hearing will be held to accept testimony concerning the proposed revision. The proposed revision consists of a number of determinations as to reasonably available control technology (RACT) for the control of emissions of nitrogen oxides (NO<sub>x</sub>) to the atmosphere from the facilities cited below located in the Roanoke portion (Botetourt County, Roanoke County, Roanoke City and Salem City) of the Western Virginia Emissions Control Area. The RACT determinations are being made pursuant to 9 VAC 5-40-310 of state regulations. State operating permits are being issued as administrative mechanisms to enforce the RACT determinations. The permits are being issued pursuant to Article 5 (9 VAC 5-80-800 et seq.) of 9 VAC 5 Chapter 80 of state regulations and are federally enforceable upon issuance. The affected facilities are located at the following businesses: the Norfolk Southern Railway Company - East End Shops, the Roanoke Electric Steel Corporation, and the Roanoke Cement Company.

**Contact:** Lillian Alexander, State Air Pollution Control Board, 3019 Peters Creek Rd., Roanoke, VA 24019, telephone (540) 562-6783, FAX (540) 562-6729, e-mail ljalexander@deq.virginia.gov.

**† January 5, 2005 - 1 p.m.** -- Open Meeting  
Department of Environmental Quality, 629 East Main Street, Richmond, Virginia. 

A public meeting on the notice of intended regulatory action to amend the regulations for the control and abatement of air pollution concerning VOC and NO<sub>x</sub> emissions control areas (revision D04). The notice of intended regulatory action will appear in the Virginia Register of Regulations on November 29, 2004. The public comment period will close on January 12, 2005.

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# Calendar of Events

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**Contact:** Gary Graham, State Air Pollution Control Board, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4103, FAX (804) 698-4510, e-mail [gegraham@deq.virginia.gov](mailto:gegraham@deq.virginia.gov).

## ALCOHOLIC BEVERAGE CONTROL BOARD

**December 6, 2004 - 9 a.m.** -- Open Meeting

**December 20, 2004 - 9 a.m.** -- Open Meeting

Department of Alcoholic Beverage Control, 2901 Hermitage Road, Richmond, Virginia. 

A meeting to receive and discuss reports and activities from staff members and to discuss other matters not yet determined.

**Contact:** W. Curtis Coleburn, III, Secretary to the Board, Department of Alcoholic Beverage Control, 2901 Hermitage Rd., Richmond, VA 23220, telephone (804) 213-4409, FAX (804) 213-4411, (804) 213-4687/TTY , e-mail [wccolen@abc.state.va.us](mailto:wccolen@abc.state.va.us).

## ALZHEIMER'S DISEASE AND RELATED DISORDERS COMMISSION

**December 7, 2004 - 10 a.m.** -- Open Meeting

Department for the Aging, 1610 Forest Avenue, Suite 100, Richmond, Virginia. 

A quarterly meeting.

**Contact:** Janet L. Honeycutt, Director of Grant Operations, Alzheimer's Disease and Related Disorders Commission, 1610 Forest Ave., Suite 100, Richmond, VA 23229, telephone (804) 662-9333, FAX (804) 662-9354, toll-free (800) 552-3402, (804) 662-9333/TTY , e-mail [janet.honeycutt@vda.virginia.gov](mailto:janet.honeycutt@vda.virginia.gov).

## BOARD FOR ARCHITECTS, PROFESSIONAL ENGINEERS, LAND SURVEYORS, CERTIFIED INTERIOR DESIGNERS AND LANDSCAPE ARCHITECTS

**December 9, 2004 - 9 a.m.** -- Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A meeting of the board to conduct board business. The meeting is open to the public; however, a portion of the board's business may be discussed in closed session. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact the department at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

**Contact:** Mark N. Courtney, Executive Director, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX

(804) 367-2475, (804) 367-9753/TTY , e-mail [APELSCIDLA@dpor.virginia.gov](mailto:APELSCIDLA@dpor.virginia.gov).

**December 14, 2004 - 9 a.m.** -- Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Room 453, Richmond, Virginia. 

An informal fact-finding conference.

**Contact:** Mark N. Courtney, Executive Director, Board for Architects, Professional Engineers, Land Surveyors, Certified Interior Designers and Landscape Architects, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY , e-mail [APELSCIDLA@dpor.virginia.gov](mailto:APELSCIDLA@dpor.virginia.gov).

## ART AND ARCHITECTURAL REVIEW BOARD

**December 3, 2004 - 10 a.m.** -- Open Meeting

Science Museum of Virginia, 2500 West Broad Street, Richmond, Virginia. 

A monthly meeting to review projects submitted by state agencies. Art and Architectural Review Board submittal forms and submittal instructions can be downloaded by visiting the DGS forms at [www.dgs.state.va.us](http://www.dgs.state.va.us). Request Submittal Form #DGS-30-905 or DGS Submittal Instructions Form #DGS-30-906.

**Contact:** Richard L. Ford, AIA Chairman, 101 Shockoe Slip, 3rd Floor, Richmond, VA 23219, telephone (804) 648-5040, FAX (804) 225-0329, toll free (804) 786-6152, or e-mail [rford@comarchs.com](mailto:rford@comarchs.com).

## VIRGINIA COMMISSION FOR THE ARTS

† **December 2, 2004 - 9 a.m.** -- Open Meeting

Blue Ridge Institute, Ferrum, Virginia. 

A quarterly meeting.

**Contact:** Peggy Baggett, Executive Director, Virginia Commission for the Arts, 223 Governor St., Richmond, VA 23219, telephone (804) 225-3132, FAX (804) 225-4327, (804) 225-3132/TTY , e-mail [peggy.baggett@arts.virginia.gov](mailto:peggy.baggett@arts.virginia.gov).

## VIRGINIA BOARD FOR ASBESTOS, LEAD, AND HOME INSPECTORS

**December 2, 2004 - 9 a.m.** -- Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Room 453, Richmond, Virginia. 

An informal fact-finding conference.

**Contact:** David Dick, Assistant Director, Virginia Board for Asbestos, Lead, and Home Inspectors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595, FAX (804) 367-2475, (804) 367-9753/TTY , e-mail [asbestos@dpor.virginia.gov](mailto:asbestos@dpor.virginia.gov).

† **February 16, 2005 - 9 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation,  
3600 West Broad Street, Richmond, Virginia. 

A meeting to conduct board business.

**Contact:** David E. Dick, Executive Director, Virginia Board for Asbestos, Lead, and Home Inspectors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8507, FAX (804) 367-6128, (804) 367-9753/TTY  e-mail [alhi@dpor.virginia.gov](mailto:alhi@dpor.virginia.gov).

## AUCTIONEERS BOARD

**December 7, 2004 - 10 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation,  
3600 West Broad Street 4th Floor, Richmond, Virginia. 

Informal fact-finding conferences.

**Contact:** Marian H. Brooks, Regulatory Board Administrator, Auctioneers Board, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY  e-mail [Auctioneers@dpor.virginia.gov](mailto:Auctioneers@dpor.virginia.gov).

## VIRGINIA AVIATION BOARD

† **December 14, 2004 - 1 p.m.** -- Open Meeting  
Wyndham Hotel, 4700 South Laburnum Avenue, Richmond, Virginia. 

A meeting to discuss land use capability issues.

**Contact:** Carolyn Toth, Administrative Assistant, Department of Aviation, 5702 Gulfstream Rd., Richmond, VA 23250, telephone (804) 236-3637, FAX (804) 236-3635, toll-free (800) 292-1034, e-mail [carolyn.toth@doav.virginia.gov](mailto:carolyn.toth@doav.virginia.gov).

† **December 14, 2004 - 3 p.m.** -- Open Meeting  
† **December 15, 2004 - 9 a.m.** -- Open Meeting  
Wyndham Hotel, 4700 South Laburnum Avenue, Richmond, Virginia. 

A regular bimonthly meeting. Applications for state funding will be presented to the board and other matters of interest to the Virginia aviation community will be discussed. Individuals with disabilities should contact Carolyn Toth 10 days prior to the meeting if assistance is needed.

**Contact:** Carolyn Toth, Administrative Assistant, Department of Aviation, 5702 Gulfstream Rd., Richmond, VA 23250, telephone (804) 236-3637, FAX (804) 236-3635, toll-free (800) 292-1034, e-mail [carolyn.toth@doav.virginia.gov](mailto:carolyn.toth@doav.virginia.gov).

## DEPARTMENT OF BUSINESS ASSISTANCE

### Small Business Advisory Board

† **December 13, 2004 - 10 a.m.** -- Open Meeting  
707 East Main Street, 3rd Floor Board Room, Richmond, Virginia. 

A regular meeting.

**Contact:** Barbara E. Anderson, Assistant to the Director, EBS, Department of Business Assistance, 707 E. Main St., Suite 300, Richmond, VA 23219, telephone (804) 371-8230, FAX (804) 371-2142, toll-free (866) 248-8814, e-mail [barbara.anderson@dba.virginia.gov](mailto:barbara.anderson@dba.virginia.gov).

## CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

† **December 13, 2004 - 10 a.m.** -- Open Meeting  
The Heritage Center, Pocahontas State Park, Chesterfield, Virginia.

A regular business meeting.

**Contact:** David C. Dowling, Policy and Planning Manager, Department of Conservation and Recreation, 203 Governor St., Suite 302, Richmond, VA 23219, telephone (804) 786-2291, FAX (804) 786-6141, e-mail [david.dowling@dcr.virginia.gov](mailto:david.dowling@dcr.virginia.gov).

## STATE CHILD FATALITY REVIEW TEAM

† **January 11, 2005 - 10 a.m.** -- Open Meeting  
Office of the Chief Medical Examiner, 400 East Jackson Street, Richmond, Virginia. 

The business portion of the State Child Fatality Review Team meeting, from 10 a.m. to 10:30 a.m. is open to the public. At the conclusion of the open meeting, the team will go into closed session for confidential case review.

**Contact:** Angela Myrick, Coordinator, Department of Health, 400 E. Jackson St., Richmond, VA 23219, telephone (804) 786-1047, FAX (804) 371-8595, toll-free (800) 447-1708, e-mail [Angela.Myrick@vdh.virginia.gov](mailto:Angela.Myrick@vdh.virginia.gov).

## STATE BOARD FOR COMMUNITY COLLEGES

**January 19, 2005 - 1:30 p.m.** -- Open Meeting  
Virginia Community College System, James Monroe Building, 101 North 14th Street, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

Meetings of the Academic, Student Affairs and Workforce Committee, the Audit Committee, and the Budget and Finance Committee at 1:30 p.m. The Facilities Committee and the Personnel Committee will meet at 3 p.m.

**Contact:** D. Susan Hayden, Director of Public Affairs, Virginia Community College System, 101 N. 14th St., Richmond, VA 23219, telephone (804) 819-4961, FAX (804) 819-4768, (804) 371-8504/TTY 

**January 20, 2005 - 9 a.m.** -- Open Meeting  
James Monroe Building, 101 North 14th Street, Godwin-Hamel Board Room, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A meeting of the full board. Public comment may be received at the beginning of the meeting upon notification at least five working days prior to the meeting.

**Contact:** D. Susan Hayden, Director of Public Affairs, Virginia Community College System, 15th Floor, 101 N. 14th St.,

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# Calendar of Events

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Richmond, VA 23219, telephone (804) 819-4961, FAX (804) 819-4768, (804) 371-8504/TTY ☎

## COMPENSATION BOARD

**December 15, 2004 - 11 a.m.** -- Open Meeting  
202 North 9th Street, 10th Floor, Richmond, Virginia. ♿

A monthly board meeting.

**Contact:** Cindy Waddell, Compensation Board, P.O. Box 710, Richmond, VA 23218, telephone (804) 786-0786, FAX (804) 371-0235, e-mail [cindy.waddell@scb.virginia.gov](mailto:cindy.waddell@scb.virginia.gov).

## DEPARTMENT OF CONSERVATION AND RECREATION

### Virginia Soil and Water Conservation Board

**December 8, 2004 - 9:30 a.m.** -- Open Meeting  
Hotel Roanoke, 110 Shenandoah Avenue, Roanoke, Virginia.

A regular business meeting in joint session with the Board of Directors of the Virginia Association of Soil and Water Conservation District Directors.

**Contact:** David C. Dowling, Policy and Planning Manager, Department of Conservation and Recreation, 203 Governor St., Suite 302, Richmond, VA 23219, telephone (804) 786-2291, FAX (804) 786-6141, e-mail [david.dowling@dcr.virginia.gov](mailto:david.dowling@dcr.virginia.gov).

## BOARD FOR CONTRACTORS

**November 30, 2004 - 9 a.m.** -- Open Meeting  
**December 2, 2004 - 9 a.m.** -- Open Meeting  
**† December 7, 2004 - 9 a.m.** -- Open Meeting  
**† December 8, 2004 - 9 a.m.** -- Open Meeting  
**† December 9, 2004 - 9 a.m.** -- Open Meeting  
**December 16, 2004 - 9 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation,  
3600 West Broad Street, 4th Floor, Richmond, Virginia. ♿

Informal fact-finding conferences.

**Contact:** Eric L. Olson, Executive Director, Board for Contractors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY ☎, e-mail [contractors@dpor.virginia.gov](mailto:contractors@dpor.virginia.gov).

**December 14, 2004 - 9 a.m.** -- Open Meeting  
**January 18, 2005 - 9 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation,  
3600 West Broad Street, Richmond, Virginia.

A regular meeting to address policy and procedural issues, review and render decisions on applications for contractors' licenses, and review and render case decisions on matured complaints against licensees. The meeting is open to the public; however, a portion of the board's business may be conducted in closed session. The department fully complies with the Americans with Disabilities Act.

**Contact:** Eric L. Olson, Executive Director, Board for Contractors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY ☎, e-mail [contractors@dpor.virginia.gov](mailto:contractors@dpor.virginia.gov).

**† February 23, 2005 - 10 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation,  
3600 West Broad Street, Richmond, Virginia. ♿

A meeting of the Tradesman and Education Committee to conduct committee business. The department fully complies with the Americans with Disabilities Act.

**Contact:** Eric L. Olson, Executive Director, Board for Contractors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY ☎, e-mail [contractors@dpor.virginia.gov](mailto:contractors@dpor.virginia.gov).

## CRIMINAL JUSTICE SERVICES BOARD

**December 9, 2004 - 9 a.m.** -- Public Hearing  
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Criminal Justice Services Board intends to adopt regulations entitled **6 VAC 20-230, Regulations Relating to Special Conservators of the Peace**. The purpose of the proposed action is to establish a registration process to include a fingerprint-based background check, registration fees, entry-level training standards, and administration of the regulatory system. The regulation will authorize the department to receive complaints concerning the conduct of any person whose activities are monitored by the board; conduct investigations; issue disciplinary action; and revoke, suspend, and refuse to renew a registration.

Statutory Authority: § 9.1-150.2 of the Code of Virginia.

**Contact:** Ellen B. Spain, Regulatory Programs Coordinator, Department of Criminal Justice Services, 805 E. Broad St., Richmond, VA 23219, telephone (804) 786-1018, FAX (804) 692-6344 or e-mail [ellen.spain@dcjs.virginia.gov](mailto:ellen.spain@dcjs.virginia.gov).

**December 9, 2004 - 11 a.m.** -- Open Meeting  
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia.

A general business meeting.

**Contact:** Judith Kirkendall, Department of Criminal Justice Services, 8th Street Office Bldg., 805 E. Broad St., 10th Floor, Richmond, VA 23219, telephone (804) 786-8003, FAX (804) 786-0410, e-mail [jkirkendall@dcjs.virginia.gov](mailto:jkirkendall@dcjs.virginia.gov).

**† December 15, 2004 - 10 a.m.** -- Open Meeting  
Department of Health Professions, 6603 West Broad Street, Board Room 3, Richmond, Virginia.

A general business meeting of the Private Security Services Advisory Board.

**Contact:** Leon D. Baker, Jr., Division Director, Criminal Justice Services Board, 8th Street Office Bldg., 805 E. Broad

St., 10th Floor, Richmond, VA 23219, telephone (804) 225-4086, FAX (804) 786-0588, e-mail lbaker@dcs.state.va.us.

## BOARD OF DENTISTRY

**December 3, 2004 - 9 a.m.** -- Open Meeting  
**December 10, 2004 - 9 a.m.** -- Open Meeting  
**December 17, 2004 - 9 a.m.** -- Open Meeting  
Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, Virginia. 

A Special Conference Committee will meet to hold informal conferences. There will not be a public comment period.

**Contact:** Cheri Emma-Leigh, Operations Manager, Department of Health Professions, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9906, FAX (804) 662-7246, (804) 662-7197/TTY , e-mail Cheri.Emma-Leigh@dhp.virginia.gov.

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† **January 21, 2005 - 9 a.m.** -- Public Hearing  
Department of Health Professions, 6603 West Broad Street, 5th Floor, Board Room 1, Richmond, Virginia. 

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Dentistry intends to amend regulations entitled **18 VAC 60-20, Regulations Governing the Practice of Dentistry and Dental Hygiene**. The purpose of the proposed action is to update certain requirements and terminology, clarify the board's requirements, especially related to dental education, eliminate a jurisprudence examination, and add requirements for additional training for applicants who have had multiple examination failures. Amendments also modify educational, monitoring and equipment requirements for administration of various forms of analgesia, sedation and anesthesia as minimally necessary to ensure public safety.

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

Public comments may be submitted until January 28, 2005, to Sandra Reen, Executive Director, Board of Dentistry, 6603 West Broad Street, Richmond, VA 23230-1712.

**Contact:** Elaine J. Yeatts, Regulatory Coordinator, Department of Health Professions, 6603 W. Broad St., Richmond, VA 23230-1712, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.virginia.gov.

## DESIGN-BUILD/CONSTRUCTION MANAGEMENT REVIEW BOARD

**December 16, 2004 - 11 a.m.** -- Open Meeting  
Department of General Services, Eighth Street Office Building, 805 East Broad Street, 3rd Floor, Richmond, Virginia.   
(Interpreter for the deaf provided upon request)

A monthly meeting to review requests submitted by localities to use design-build or construction-management-type contracts. Contact the Division of Engineering and Building to confirm the meeting.

**Contact:** Rhonda M. Bishton, Administrative Assistant, Department of General Services, 805 E. Broad Street, Room 101, Richmond, VA 23219, telephone (804) 786-3263, FAX (804) 371-7934, (804) 786-6152/, or e-mail rbishton@dgs.state.va.us.

## BOARD OF EDUCATION

**December 6, 2004** - Public comments may be submitted until 5 p.m. on this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Education intends to amend regulations entitled **8 VAC 20-30, Regulations Governing Adult High School Programs**. The purpose of the proposed action is twofold. First, adult high school programs, at which adults are able to earn a standard or advanced studies diploma, will be required to maintain the same high standards as regular day school programs. Second, the change provides a high-standard alternative diploma (the Adult Education Diploma) for adults who are unable to complete the requirements for a standard or advanced studies diploma.

Statutory Authority: § 22.1-224 of the Code of Virginia.

**Contact:** Robert MacGillivray, Adult Education Services, Department of Education, P.O. Box 2120, Richmond, VA 23218, telephone (804) 371-2333, FAX (804) 225-2524, or e-mail rmacgill@mail.vak12ed.edu.

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**December 17, 2004** - Public comments may be submitted until 5 p.m. on this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Education intends to repeal regulations entitled **8 VAC 20-140, Regulations Governing Retention Schedule for Uniform Pupil Accounting Records**. The purpose of the proposed action is to repeal the regulation because it is in conflict with the Code of Virginia. Section 42.1-82 of the Code of Virginia vests the Library of Virginia with the authority to set the retention and disposition schedules for public records. The Library of Virginia has developed a retention schedule specific to the maintenance of records in Virginia's public schools. Therefore, the Board of Education no longer has the authority to set this schedule.

Statutory Authority: § 22.1-16 of the Code of Virginia.

**Contact:** Dr. Margaret N. Roberts, Office of Policy and Public Affairs, Department of Education, P.O. Box 2120, James Monroe Bldg., 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, or e-mail mroberts@mail.vak12ed.edu.

**January 12, 2005 - 9 a.m.** -- Open Meeting  
† **February 23, 2005 - 9 a.m.** -- Open Meeting  
James Monroe Building, 101 North 14th Street, Main Lobby Level, Conference Rooms C and D, Richmond, Virginia. 

A regular business meeting of the board. The public is urged to confirm arrangements prior to each meeting by

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# Calendar of Events

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viewing the Department of Education's public meeting calendar at <http://www.pen.k12.va.us/VDOE/meetings.html>. This site will contain the latest information on the meeting arrangements and will note any last-minute changes in time or location. Persons who wish to speak or who require the services of an interpreter for the deaf should contact the agency at least 72 hours in advance.

**Contact:** Dr. Margaret N. Roberts, Office of Policy and Public Affairs, Department of Education, P.O. Box 2120, James Monroe Bldg., 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, e-mail [mroberts@mail.vak12ed.edu](mailto:mroberts@mail.vak12ed.edu).

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**January 18, 2005** - Public comments may be submitted until 5 p.m. on this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Education intends to repeal regulations entitled **8 VAC 20-470, Nurses, Physicians, and Therapist Standards**. The purpose of the proposed action is to repeal the regulation because the requirements are unnecessary. Section 22.1-274 of the Code of Virginia states that local school boards may employ school nurses, physicians, physical therapists, occupational therapists and speech therapists under the same provisions as provided by the board regulation. Since the Code of Virginia already permits schools divisions to employ these personnel and board regulations are not required, this regulation is unnecessary.

Statutory Authority: § 22.1-16 of the Code of Virginia.

**Contact:** Dr. Margaret N. Roberts, Office of Policy and Public Affairs, Department of Education, P.O. Box 2120, James Monroe Bldg., 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, or e-mail [mroberts@mail.vak12ed.edu](mailto:mroberts@mail.vak12ed.edu).

**January 20, 2005 - 8:45 a.m.** -- Open Meeting

**January 21, 2005 - 8:45 a.m.** -- Open Meeting  
Richmond Holiday Inn, Koger Center, 10800 Midlothian Turnpike, Richmond, Virginia.

A meeting of the State Special Education Advisory Committee.

**Contact:** Dr. Margaret N. Roberts, Office of Policy and Public Affairs, Department of Education, P.O. Box 2120, James Monroe Bldg., 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, or e-mail [mroberts@mail.vak12ed.edu](mailto:mroberts@mail.vak12ed.edu).

**January 24, 2005 - 8:45 a.m.** -- Open Meeting

Location to be announced.

A meeting of the Advisory Board for Teacher Education and Licensure. The public is urged to confirm arrangements prior to each meeting by viewing the Department of Education's public meeting calendar at <http://www.pen.k12.va.us/VDOE/meetings.html>. This site will contain the latest information on the meeting arrangements and will note any last-minute changes in time or location. Please note that persons requesting the

services of an interpreter for the deaf are asked to do so at least 72 hours in advance so that the appropriate arrangements may be made.

**Contact:** Dr. Margaret N. Roberts, Office of Policy and Public Affairs, Department of Education, P.O. Box 2120, James Monroe Bldg., 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, e-mail [mroberts@mail.vak12ed.edu](mailto:mroberts@mail.vak12ed.edu).

## STATE BOARD OF ELECTIONS

**December 2, 2004 - 10:30 a.m.** -- Open Meeting  
State Capitol, House Room 2, Richmond, Virginia. 

A meeting to approve old business and review administrative process voting equipment certification and other business.

**Contact:** Vanessa E. Archie, Administrative Assistant, State Board of Elections, 200 N. 9th St., Room 101, Richmond, VA 23219, telephone (804) 864-8901, FAX (804) 371-0194, toll-free (800) 552-9745, (800) 260-3466/TTY , e-mail [vanessa.archie@sbe.virginia.gov](mailto:vanessa.archie@sbe.virginia.gov).

## LOCAL EMERGENCY PLANNING COMMITTEE - CITY OF WINCHESTER

**December 1, 2004 - 3 p.m.** -- Open Meeting  
Timbrook Safety Center, 231 Piccadilly Street, Winchester, Virginia. 

A monthly meeting.

**Contact:** L.A. Miller, Fire and Rescue Department, 231 E. Piccadilly St., Winchester, VA 22601, telephone (540) 662-2298 for (540) 662-4131/TTY 

## DEPARTMENT OF ENVIRONMENTAL QUALITY

**December 9, 2004 - 7 p.m.** -- Open Meeting  
Thomas Jefferson Planning District Office, 300 East Main Street, Charlottesville, Virginia. 

The final public meeting on the draft implementation plan for the bacteria TMDL for Moores Creek in the City of Charlottesville and the County of Albemarle. The public comment period begins with publication of the notice on November 15, 2004, and closes on January 9, 2005.

**Contact:** Robert Brent, Department of Environmental Quality, P.O. Box 3000, Harrisonburg, VA 22801, telephone (540) 574-7848, FAX (540) 574-7878, e-mail [rbrent@deq.virginia.gov](mailto:rbrent@deq.virginia.gov).

## VIRGINIA FIRE SERVICES BOARD

**December 1, 2004 - Noon** -- Open Meeting  
Prince William County CPAT Facility, 8494 Kao Circle, Manassas, Virginia.  (Interpreter for the deaf provided upon request)

This work session will be for FY05 Training Mini-Grants.

**Contact:** Christy L. King, Policy, Planning, and Legislative Affairs Manager, Department of Fire Services, 101 N. 14th St., 18th Floor, Richmond, VA 23219, telephone (804) 371-0220, FAX (804) 371-0219, e-mail cking@vdfp.state.va.us.

**December 2, 2004 - 10 a.m.** -- Open Meeting  
Prince William County CPAT Facility, 8494 Kao Circle, Manassas, Virginia.  (Interpreter for the deaf provided upon request)

Fire Education and Training Committee will meet at 10 a.m.  
Fire Prevention and Control Committee will meet at 1 p.m.  
Administration, Policy and Finance Committee will meet at 2:30 p.m. Members of the VFSB will partake in a group dinner - No VFSB/public business will be discussed.

**Contact:** Christy L. King, Policy, Planning, and Legislative Affairs Manager, Department of Fire Services, 101 N. 14th St., 18th Floor, Richmond, Virginia 23219, telephone (804) 371-0220, FAX (804) 371-0219, e-mail cking@vdfp.state.va.us.

**December 3, 2004 - 9 a.m.** -- Open Meeting  
Prince William County CPAT Facility, 8494 Kao Circle, Manassas, Virginia.  (Interpreter for the deaf provided upon request)

For more information please contact Christy King at 804/371-0220

**Contact:** Christy L. King, Policy, Planning, and Legislative Affairs Manager, Department of Fire Services, 101 N. 14th St., 18th Floor, Richmond, VA 23219, telephone (804) 371-0220, FAX (804) 371-0219, e-mail cking@vdfp.state.va.us.

## CHARITABLE GAMING BOARD

**December 7, 2004 - 10 a.m.** -- Open Meeting  
Science Museum of Virginia, RFandP Forum Room, 2500 West Broad Street, Richmond, Virginia. 

A regular quarterly meeting.

**Contact:** Clyde Cristman, Director, Department of Charitable Gaming, 101 N 14th St., 17th Floor, Richmond, VA 23219, telephone (804) 786-1681, FAX (804) 786-1079, e-mail clyde.cristman@dcg.virginia.gov.

## BOARD FOR GEOLOGY

**January 5, 2005 - 9 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A regular meeting.

**Contact:** David E. Dick, Executive Director, Board for Geology, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8507, FAX (804) 367-6128, (804) 367-9753/TTY , e-mail geology@dpor.virginia.gov.

## STATE BOARD OF HEALTH

**December 3, 2004** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Health intends to amend regulations entitled **12 VAC 5-230, State Medical Facilities Plan** and to repeal regulations entitled **12 VAC 5-240, General Acute Care Services; 12 VAC 5-250, Perinatal Services; 12 VAC 5-260, Cardiac Services; 12 VAC 5-270, General Surgical Services; 12 VAC 5-280, Organ Transplantation Services; 12 VAC 5-290, Psychiatric and Substance Abuse Treatment Services; 12 VAC 5-300, Mental Retardation Services; 12 VAC 5-310, Medical Rehabilitation Services; 12 VAC 5-320, Diagnostic Imaging Services; 12 VAC 5-330, Lithotripsy Services; 12 VAC 5-340, Radiation Therapy Services; 12 VAC 5-350, Miscellaneous Capital Expenditures; and 12 VAC 5-360, Nursing Home Services.** The purpose of the proposed action is to update the criteria and standards in the SMFP to reflect current national and health care industry standards, remove archaic language and ambiguities, and consolidate all portions of the SMFP into one comprehensive document.

Statutory Authority: §§ 32.1-11 and 32.1-12 of the Code of Virginia.

**Contact:** Carrie Eddy, Senior Policy Analyst, Department of Health, Center for Quality Health Care Services, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2157, FAX (804) 367-2149 or e-mail carrie.eddy@vdh.virginia.gov.

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**† January 28, 2005** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Health intends to amend regulations entitled **12 VAC 5-410, Rules and Regulations for the Licensure of Hospitals.** The purpose of the proposed action is to extend the storage time of breastmilk from 24 to 48 hours and to reformat section 440 of the regulations.

Statutory Authority: § 32.1-127 of the Code of Virginia.

**Contact:** Carrie Eddy, Senior Policy Analyst, Department of Health, Center for Quality Health Care Services, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2157, FAX (804) 367-2149 or e-mail carrie.eddy@vdh.virginia.gov.

## DEPARTMENT OF HEALTH

**November 29, 2004 - 10 a.m.** -- Open Meeting  
Department of Health, 109 Governor Street, 5th Floor Conference Room, Richmond, Virginia.

A meeting of the Sewage Handling and Disposal Regulations Advisory Committee to make recommendations to the commissioner regarding sewage handling and disposal policies, procedures and programs of the

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## Calendar of Events

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department. This is a continuation of the meeting held September 16.

**Contact:** Donna Tiller, Executive Secretary, Department of Health, 109 Governor St., 5th Floor Richmond, VA 23219, telephone (804) 864-7470, FAX (804) 864-7476, e-mail donna.tiller@vdh.virginia.gov.

† **December 2, 2004 - 2 p.m.** -- Public Hearing  
McCoart Government Building, Potomac Room, 1 County Complex Court, Occoquan, Virginia. ♿

† **December 3, 2004 - 3 p.m.** -- Public Hearing  
Heritage Public Library, Route 60 at Route 155, Providence Forge, Virginia. ♿

† **December 6, 2004 - 2 p.m.** -- Public Hearing  
Virginia Baptist, Rivermont Avenue, Classroom A, Lynchburg, Virginia. ♿

Public hearings regarding Ryan White Care Act Title II Funding to solicit comments as to what citizens would like to see in the statewide grant application that will be submitted to the U.S. government. Those who may be interested include Virginia Consortia subcontractors, health service providers, HIV infected/affected individuals and other interested persons.

**Contact:** Michelle Baker, Department of Health, 109 Governor St., Richmond, VA 23219, telephone (804) 864-8020, FAX (804) 864-8050, e-mail michelle.baker@vdh.virginia.gov.

**December 3, 2004 - 10:30 a.m.** -- Open Meeting  
Virginia Center for Health Affairs, 4200 Innslake Drive, Conference Room, Glen Allen, Virginia. ♿

A quarterly meeting of the Advisory Committee for the Virginia Early Hearing Detection and Intervention Program.

**Contact:** Pat T. Dewey, Program Manager, Department of Health, 109 Governor St., 8th Floor, Richmond, VA 23219, telephone (804) 864-7713, FAX (804) 864-7721, toll-free (866) 493-1090, (804) 828-1120/TTY ♿, e-mail pat.dewey@vdh.virginia.gov.

**December 6, 2004 - 1 p.m.** -- Public Hearing  
Department of Health, 109 Governor Street, Room 715, Richmond, Virginia.

A public hearing for the Fiscal Year 2005 Preventive Health and Health Service (PHHS) Block Grant. All interested individuals and groups are invited to participate at the public hearing on the PHHS Block Grant. In accordance with Title XIX, Section 1905 of the Public Health Service Act, the Commonwealth of Virginia hereby gives notice that VDH will: apply for FY 2005 PHHS Block Grant funds and submit a State Plan for programs addressing the following Healthy People 2010 National Health Objectives: reduce the overall cancer death rate; increase community health promotion; reduce coronary heart disease deaths; reduce deaths caused by unintentional injury; reduce the rate of physical assault by current or former intimate partners; reduce the annual rate of rape or attempted rape; reduce the proportion of children and adolescents who have dental caries experience in their primary teeth; increase the proportion of

the U.S. population served by community water systems with optimally fluoridated water; increase public access to information and surveillance data; and increase the proportion of data for leading health indicators, health status indicators and priority data needs at state and local levels. The State Plan is available on the agency's website at www.vahealth.org. Public comment on the Plan can be made at the public hearing and written comments can be addressed to Robin Buskey, Office of Family Health Services, P.O. Box 2448, Room 721, Richmond, VA 23218.

**Contact:** Robin Buskey, Grants Coordinator, Department of Health, 109 Governor St., Room 721, Richmond, VA 23218, telephone (804) 864-7663, FAX (804) 864-7647, e-mail robin.buskey@vdh.virginia.gov.

### Sewage Handling and Disposal Appeal Review Board

**January 19, 2005 - 10 a.m.** -- Open Meeting

† **February 23, 2005 - 10 a.m.** -- Open Meeting  
County of Henrico, 8600 Dixon Powers Drive, Human Services Board Room, 2nd Floor, Richmond, Virginia ♿

A meeting to hear appeals of health department denials of septic tank permits and/or Indemnification Fund Claim requests.

**Contact:** Susan Sherertz, Secretary to the Board, Department of Health, 109 Governor St., 5th Floor, Richmond, VA 23219, telephone (804) 864-7464, FAX (804) 864-7475, e-mail susan.sherertz@vdh.virginia.gov.

### DEPARTMENT OF HEALTH PROFESSIONS

**December 3, 2004** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Health Professions intends to adopt regulations entitled **18 VAC 76-20, Regulations Governing the Prescription Monitoring Program**. The purpose of the proposed action is to eliminate the requirement for a prescriber to submit a copy of a patient's consent form in order to query the monitoring system.

Statutory Authority: §§ 54.1-2505 and 54.1-2520 of the Code of Virginia.

Public comments may be submitted until December 3, 2004, to Robert A. Nebiker, Director, Department of Health Professions, 6603 West Broad Street, Richmond, VA 23230-1712.

**Contact:** Elaine J. Yeatts, Regulatory Coordinator, Department of Health Professions, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9918, FAX (804) 662-9114, (804) 662-7197/TTY ♿, e-mail elaine.yeatts@dhp.virginia.gov.

**December 10, 2004 - 9 a.m.** -- Open Meeting  
Department of Health Professions, Alcoa Building, 6603 West Broad Street, 5th Floor, Conference Room 3, Richmond, Virginia. 

A meeting of the Intervention Program Committee for the Health Practitioners' Intervention Program (HPIP).

**Contact:** Donna P. Whitney, Intervention Program Manager, Department of Health Professions, 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9424, FAX (804) 662-7358, e-mail donna.whitney@dhp.virginia.gov.

**December 15, 2004 - 11 a.m.** -- Open Meeting  
NOTE: CHANGE IN MEETING LOCATION  
Clarion Hotel Roanoke Airport, 3315 Ordway Drive, Roanoke, Virginia. 

A working meeting of the Advisory Committee Prescription Monitoring Program for the purpose of reviewing data collected for the Program Evaluation Workplan. Public comments will be received during this meeting.

**Contact:** Ralph Orr, Program Manager, Department of Health Professions, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9129, FAX (804) 662-9240.

## BOARD FOR HEARING AID SPECIALISTS

† **January 19, 2005 - 10 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Room 453, Richmond, Virginia. 

An informal fact-finding conference.

**Contact:** William H. Ferguson, II, Executive Director, Board for Hearing Aid Specialists, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8590, FAX (804) 367-6295, (804) 367-9753/TTY , e-mail hearingaidspec@dpor.virginia.gov.

## DEPARTMENT OF HISTORIC RESOURCES

### Historic Resources Board and State Review Board

† **December 1, 2004 - 10 a.m.** -- Open Meeting  
Virginia Historical Society, 428 North Boulevard, Halsey Lecture Hall, Richmond, Virginia. 

The Historic Resources Board will consider and vote on proposed nominations to the Virginia Landmarks Register, proposed Historic Highway Markers, and proposed Historic Preservation Easements. The State Review Board will consider and make recommendations on proposed nominations to the National Register of Historic Places, and they will have an informal consideration of preliminary proposals for the National Register of Historic Places.

**Contact:** Marc C. Wagner, National Register Manager, Department of Historic Resources, 2801 Kensington Ave, Richmond, VA 23228, telephone (804) 367-2323, FAX (804) 367-2391, (804) 367-2386/TTY , e-mail marc.wagner@dhr.virginia.gov.

## VIRGINIA INFORMATION TECHNOLOGIES AGENCY

### Information Technology Investment Board

† **December 7, 2004 - 2 p.m.** -- Open Meeting  
VITA Operations Center, Richmond Plaza Building, 110 South 7th Street, 3rd Floor, Executive Conference Room, Richmond, Virginia. 

A meeting of the Legislative Review Committee. Public comment will be heard at the conclusion of the meeting.

**Contact:** Roz Witherspoon, ITIB, Executive Director, Virginia Information Technologies Agency, 411 E. Franklin St., Richmond, VA 23219, telephone (804) 343-9057, FAX (804) 343-9015, e-mail roz.witherspoon@vita.virginia.gov.

† **December 8, 2004 - 8:30 a.m.** -- Open Meeting  
VITA Operations Center, Richmond Plaza Building, 110 South 7th Street, 3rd Floor, Richmond, Virginia. 

The following committees will meet:

8:30 a.m. - Investment CIO Evaluation Committee - Executive Conference Room  
9:30 a.m. - IT Project Review Committee - Training Room  
1 p.m. - Investment Board - 4th Floor, Auditorium

Public comment will be heard at the conclusion of the meeting.

**Contact:** Roz Witherspoon, Executive Director, Virginia Information Technologies Agency, 411 East Franklin Street, telephone (804) 343-9057, FAX (804) 343-9015, e-mail roz.witherspoon@vita.virginia.gov, homepage <http://www.vita.virginia.gov>.

## JAMESTOWN-YORKTOWN FOUNDATION

**December 1, 2004 - 2 p.m.** -- Open Meeting  
McGuireWoods, One James Center, 901 East Cary Street, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular meeting of the Jamestown 2007 Executive Committee.

**Contact:** Stacy Ruckman, Administrative Office Manager, Jamestown-Yorktown Foundation, P.O. Box 1607, Williamsburg, VA 23187, telephone (757) 253-4253, FAX (757) 253-5299, (757) 253-5110/TTY , e-mail sruckman@jyf.state.va.us.

## DEPARTMENT OF LABOR AND INDUSTRY

### Virginia Apprenticeship Council

NOTE: CHANGE IN MEETING TIME

**December 9, 2004 - 10 a.m.** -- Open Meeting  
Confederate Hills Recreation Building, 302 Lee Avenue, Highland Springs, Virginia.  (Interpreter for the deaf provided upon request)

A general meeting of the board.

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# Calendar of Events

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**Contact:** Beverley Donati, Program Director, Department of Labor and Industry, Powers-Taylor Bldg., 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-2382, FAX (804) 786-8418, (804) 786-2376/TTY ☎, e-mail [bgd@doli.virginia.gov](mailto:bgd@doli.virginia.gov).

## Safety and Health Codes Board

† **December 14, 2004 - 10 a.m.** -- Open Meeting  
State Corporation Commission, Tyler Building, 1300 East Main Street, Courtroom B, 2nd Floor, Richmond, Virginia. ♿  
(Interpreter for the deaf provided upon request)

A regular meeting.

**Contact:** Regina P. Cobb, Agency Management Analyst Senior, Department of Labor and Industry, Powers-Taylor Bldg., 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-0610, FAX (804) 786-8418, (804) 786-2376/TTY ☎, e-mail [rlc@doli.state.va.us](mailto:rlc@doli.state.va.us).

## STATE LIBRARY BOARD

**January 27, 2005 - 8:15 a.m.** -- Open Meeting  
The Library of Virginia, 800 East Broad Street, Richmond, Virginia. ♿

Meetings of the board to discuss matters pertaining to the Library of Virginia and the board. Committees of the board will meet as follows:

8:15 a.m. - Public Library Development Committee, Orientation Room  
Publications and Educational Services Committee, Conference Room B  
Records Management Committee, Conference Room C

9:30 a.m. - Archival and Information Services Committee, Orientation Room  
Collection Management Services Committee, Conference Room B  
Legislative and Finance Committee, Conference Room C

10:30 a.m. - Library Board, Conference Room, 2M

**Contact:** Jean H. Taylor, Executive Secretary to the Librarian, The Library of Virginia, 800 E. Broad St., Richmond, VA 23219-2000, telephone (804) 692-3535, FAX (804) 692-3594, (804) 692-3976/TTY ☎, e-mail [jtaylor@lva.lib.va.us](mailto:jtaylor@lva.lib.va.us).

## LONGWOOD UNIVERSITY

† **December 10, 2004 - 9 a.m.** -- Open Meeting  
Longwood University, The Stallard Board Room, Lancaster 102, 201 High Street, Farmville, Virginia. ♿

Routine business meetings of the following committees:

9 a.m. - Administration, Finance and Facilities  
11 a.m. - University Advancement  
1 p.m. - Audit  
1:15 p.m. - Academic and Student Affairs

**Contact:** Jeanne Hayden, Longwood University, Office of the President, 201 High St., Farmville, VA 23909, telephone (434) 395-2004, e-mail [haydenjs@longwood.edu](mailto:haydenjs@longwood.edu).

† **December 11, 2004 - 9 a.m.** -- Open Meeting  
Longwood University, 201 High Street, The Stallard Board Room, Lancaster 102, Farmville, Virginia. ♿

A meeting to conduct routine business of the Board of Visitors.

**Contact:** Jeanne S. Hayden, Longwood University, Office of the President, 201 High St., Farmville, VA 23909, telephone (434) 395-2004, e-mail [haydenjs@longwood.edu](mailto:haydenjs@longwood.edu).

## MARINE RESOURCES COMMISSION

**December 21, 2004 - 9:30 a.m.** -- Open Meeting  
Virginia Marine Resources Commission, 2600 Washington Avenue, 4th Floor, Newport News, Virginia. ♿ (Interpreter for the deaf provided upon request)

A monthly meeting.

**Contact:** Jane McCroskey, Commission Secretary, Marine Resources Commission, 2600 Washington Ave., 3rd Floor, Newport News, VA 23607, telephone (757) 247-2215, FAX (757) 247-8101, toll-free (800) 541-4646, (757) 247-2292/TTY ☎, e-mail [jane.mccroskey@mrc.virginia.gov](mailto:jane.mccroskey@mrc.virginia.gov)

## BOARD OF MEDICAL ASSISTANCE SERVICES

**December 14, 2004 - 10 a.m.** -- Open Meeting  
Department of Medical Assistance Services, 600 East Broad Street, 13th Floor Conference Room, Richmond, Virginia. ♿

A routine quarterly meeting required in the BMAS by-laws.

**Contact:** Nancy Malczewski, Board Liaison, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-8096, FAX (804) 371-4981, (800) 343-0634/TTY ☎, e-mail [nancy.malczewski@dmas.virginia.gov](mailto:nancy.malczewski@dmas.virginia.gov).

## DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

† **December 8, 2004 - 9 a.m.** -- Open Meeting  
Department of Medical Assistance Services, 600 East Broad Street, 13th Floor, Richmond, Virginia. ♿

A meeting of the Pharmacy and Therapeutics Committee to review antidepressants and antianxiety medications.

**Contact:** Katina Goodwyn, Pharmacy Contract Manager, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 371-0428, FAX (804) 786-0973, (800) 343-0634/TTY ☎, e-mail [katina.goodwyn@dmas.virginia.gov](mailto:katina.goodwyn@dmas.virginia.gov).

**January 5, 2005 - 1 p.m.** -- Open Meeting  
Department of Medical Assistance Services, 600 East Broad Street, Board Room, Suite 1300, Richmond, Virginia. ♿

A meeting of the Medicaid Transportation Advisory Committee to discuss issues and problems in Medicaid transportation with the advisory committee and community.

**Contact:** Robert Knox, Transportation Manager, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-8854, FAX (804) 786-5799, (800) 343-0634/TTY ☎, e-mail robert.knox@dmas.virginia.gov.

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† **January 28, 2005** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to amend regulations entitled **12 VAC 30-141, Family Access to Medical Insurance Security Plan**. The purpose of the proposed action is to implement a program of retrospective and prospective utilization review of pharmacy services for noninstitutionalized fee-for-service and PCCM FAMIS enrollees who are prescribed more than nine unique prescriptions within a 180-day period.

Statutory Authority: § 32.1-351 of the Code of Virginia; Item 324 H of Chapter 1042 of the 2003 Acts of Assembly.

**Contact:** Linda Nablo, Director, Child Health Insurance Programs, FAMIS Division, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 225-4212, FAX (804) 786-1680 or e-mail Linda.Nablo@dmas.virginia.gov.

## BOARD OF MEDICINE

**December 1, 2004 - 9:15 a.m.** -- Open Meeting  
Holiday Inn Select, 2801 Plank Road, Fredericksburg, Virginia.

**December 7, 2004 - 9:15 a.m.** -- Open Meeting  
Clarion Hotel, 3315 Ordiway Drive, Roanoke, Virginia.

† **December 8, 2004 - 9:15 a.m.** -- Open Meeting  
Williamsburg Marriott, 50 Kingsmill Road, Williamsburg, Virginia.

An informal conference committee will convene informal conferences to inquire into allegations that certain practitioners(s) may have violated laws and regulations governing the practice of medicine and other healing arts in Virginia. Further, the committee may review cases with staff for case disposition including consideration of consent orders for settlement. The committee will meet in open and closed sessions pursuant to the Code of Virginia. Public comment will not be received.

**Contact:** Peggy Sadler/Renee Dixon, Staff, Board of Medicine, 6603 W. Broad St., Richmond, VA, telephone (804) 662-7332, FAX (804) 662-9517, (804) 662-7197/TTY ☎, e-mail peggy.sadler@dhp.virginia.gov.

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† **January 21, 2005 - 8:15 a.m.** -- Public Hearing

Department of Health Professions, 6603 West Broad Street, 5th Floor, Board Room 2, Richmond, Virginia.

† **January 28, 2005** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled:

**18 VAC 85-20. Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, and Chiropractic;**

**18 VAC 85-40. Regulations Governing the Practice of Respiratory Care Practitioners;**

**18 VAC 85-50. Regulations Governing the Practice of Physician Assistants;**

**18 VAC 85-80. Regulations for Licensure of Occupational Therapists;**

**18 VAC 85-101. Regulations Governing the Licensure of Radiologic Technologists and Radiologic Technologists Limited;**

**18 VAC 85-110. Regulations Governing the Practice of Licensed Acupuncturists;**

**18 VAC 85-120. Regulations Governing the Certification of Athletic Trainers.**

The purpose of the proposed action is to establish or amend standards for professional conduct, to include, but not be limited to, retention and release of patient records; patient confidentiality; practitioner-patient communication and termination of that relationship; sexual contact; and practitioner responsibilities.

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

Public comments may be submitted until January 28, 2005, to William L. Harp, M.D., Executive Director, Board of Medicine, 6603 West Broad Street, Richmond, VA 23230.

**Contact:** Elaine J. Yeatts, Regulatory Coordinator, Department of Health Professions, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9918, FAX (804) 662-9114, (804) 662-7197/TTY ☎, e-mail elaine.yeatts@dhp.virginia.gov.

## DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

**December 2, 2004 - 9:30 a.m.** -- Open Meeting

**January 6, 2005 - 9:30 a.m.** -- Open Meeting  
Henrico County Training Center, 7701 Parham Road, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A monthly meeting of the State and Local Advisory Team pursuant to §§ 2.2-5201 through 2.2-5203 of the Code of Virginia. A public comment period is scheduled.

**Contact:** Pamela Fitzgerald-Cooper, Director of Child and Adolescent Services, Department of Mental Health, Mental

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## Calendar of Events

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Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 371-2183, FAX (804) 786-1587.

### STATE MILK COMMISSION

**December 15, 2004 - 10:30 a.m.** -- Open Meeting  
Department of Forestry, 900 Natural Resource Drive, Room 2063, Charlottesville, Virginia.

A regular meeting to consider industry distributor licensing, base transfers and reports from staff. The commission offers anyone in attendance an opportunity to speak at the conclusion of the agenda. Those persons requiring special accommodations should notify Edward C. Wilson at least five working days prior to the meeting date so that suitable arrangements can be made.

**Contact:** Edward C. Wilson, Jr., Deputy Administrator, State Milk Commission, Washington Bldg., 1100 Bank St., Suite 1019, Richmond, VA 23218, telephone (804) 786-2013, FAX (804) 786-3779, e-mail ewilson@smc.state.va.us.

### VIRGINIA MUSEUM OF FINE ARTS

**December 7, 2004 - 8 a.m.** -- Open Meeting  
**January 4, 2005 - 8 a.m.** -- Open Meeting  
**February 1, 2005 - 8 a.m.** -- Open Meeting  
Virginia Museum of Fine Arts, Main Lobby Conference Room, 200 North Boulevard, Richmond, Virginia. ♿

A meeting for staff to update the Executive Committee. Public comment will not be received.

**Contact:** Suzanne Broyles, Secretary of the Museum, Virginia Museum of Fine Arts, 200 N. Boulevard, Richmond, VA 23220-4007, telephone (804) 340-1503, FAX (804) 340-1502, (804) 340-1401/TTY ☎, e-mail sbroyles@vmfa.state.va.us.

### BOARD OF NURSING

**December 2, 2004 - 9 a.m.** -- Open Meeting  
**December 7, 2004 - 9 a.m.** -- Open Meeting  
**December 8, 2004 - 9 a.m.** -- Open Meeting  
**December 9, 2004 - 9 a.m.** -- Open Meeting  
Department of Health Professions, 6603 West Broad Street, 5th Floor, Conference Room 3, Richmond, Virginia. ♿

A Special Conference Committee comprised of two or three members of the Virginia Board of Nursing will conduct informal conferences with licensees and certificate holders. Public comment will not be received.

**Contact:** Jay P. Douglas, R.N., M.S.M., C.S.A.C., Executive Director, Board of Nursing, 6603 West Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY ☎, e-mail nursebd@dhp.virginia.gov.

### JOINT BOARDS OF NURSING AND MEDICINE

**December 15, 2004 - 9 a.m.** -- Open Meeting  
Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, Virginia. ♿

A meeting of the Joint Boards of Nursing and Medicine.

**Contact:** Jay P. Douglas, R.N., M.S.M., C.S.A.C., Executive Director, Board of Nursing, 6603 W. Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, e-mail nursebd@dhp.virginia.gov.

### BOARD OF NURSING HOME ADMINISTRATORS

**November 30, 2004 - 10 a.m.** -- Open Meeting  
Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, Virginia. ♿

A meeting to discuss education requirements for licensure and qualifications for preceptors. There will be a 15 minute public comment period at the beginning of the meeting.

**Contact:** Sandra Reen, Executive Director, Board of Nursing Home Administrators, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-7457, FAX (804) 662-9943, (804) 662-7197/TTY ☎, e-mail sandra.reen@dhp.virginia.gov.

### OLD DOMINION UNIVERSITY

**December 10, 2004 - 1 p.m.** -- Open Meeting  
Webb University Center, Old Dominion University, Norfolk, Virginia. ♿

A quarterly meeting of the governing board of the institution to discuss business of the board and the institution as determined by the Rector and the President.

**Contact:** Donna Meeks, Executive Secretary to the Board of Visitors, Old Dominion University, 204 Koch Hall, Norfolk, VA 23529, telephone (757) 683-3072, FAX (757) 683-5679, e-mail dmeeks@odu.edu.

**February 15, 2005 - 3 p.m.** -- Open Meeting  
Webb University Center, Old Dominion University, Norfolk, Virginia. ♿

A regular meeting of the Board of Visitors' Executive Committee to discuss business of the board and the institution as determined by the Rector and the President.

**Contact:** Donna Meeks, Executive Secretary to the Board of Visitors, Old Dominion University, 204 Koch Hall, Old Dominion University, Norfolk, VA 23529, telephone (757) 683-3072, FAX (757) 683-5679, e-mail dmeeks@odu.edu.

### OLMSTEAD ADVISORY COMMITTEE

**December 21, 2004 - 1 p.m.** -- Open Meeting  
Virginia Housing and Development Authority, 601 South Belvidere Street, Richmond, Virginia. ♿

A meeting of the Olmstead Community Integration Implementation Team.

**Contact:** Viktoria Glenn, Administrative Assistant, Department of Rehabilitative Services, 8004 Franklin Farms Dr., P.O. Box K-300, Richmond, VA 23288, telephone (804) 662-7069, FAX (804) 662-7662, e-mail glennvh@dps.state.va.us.

## BOARD OF OPTOMETRY

**December 1, 2004** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 54.1-3223 of the Code of Virginia that the Board of Optometry intends to amend regulations entitled **18 VAC 105-20, Regulations Governing the Practice of Optometry**. The purpose of the repropounded action is to amend the treatment guidelines and formulary of therapeutic pharmaceutical agents that can be prescribed or administered by a qualified optometrist.

Statutory Authority: § 54.1-3223 of the Code of Virginia.

Public comments may be submitted until December 1, 2004, to Elizabeth A. Carter, Ph.D., Executive Director, Board of Optometry, 6603 W. Broad St., Richmond, VA 23230.

**Contact:** Elaine J. Yeatts, Regulatory Coordinator, Department of Health Professions, 6603 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.virginia.gov.

† **December 7, 2004 - 9 a.m.** -- Open Meeting  
Department of Health Professions, 6603 West Broad Street, 5th Floor, Room 4, Richmond, Virginia. 

The board will consider the adoption of amendments to the TPA formulary and treatment guidelines. The current treatment guidelines and TPA formulary found in 18 VAC 105-30 are being repealed and replaced with the addition of 18 VAC 105-20-46 and 18 VAC 105-20-47 in 18 VAC 105-20. The board will also conduct any other general business as required. Public comment will be received at the beginning of the meeting.

**Contact:** Elizabeth A. Carter, Ph.D., Executive Director, Board of Optometry, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9910, FAX (804) 662-7098, (804) 662-7197/TTY , e-mail elizabeth.carter@dhp.virginia.gov.

† **December 7, 2004 - 10 a.m.** -- Open Meeting  
Department of Health Professions, 6603 West Broad Street, 5th Floor, Conference Room 4, Richmond, Virginia. 

A special conference hearing. This is a public meeting; however, public comment will not be received.

**Contact:** Elizabeth Carter, Ph.D., Executive Director, Board of Optometry, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9910, FAX (804) 662-7098, e-mail elizabeth.carter@dhp.state.va.us.

## BOARD OF PHARMACY

† **December 1, 2004 - 9 a.m.** -- Open Meeting  
Department of Health Professions, 6603 West Broad Street, Fifth Floor, Conference Room 3, Richmond, Virginia.

† **December 9, 2004 - 9 a.m.** -- Open Meeting  
Department of Health Professions, 6603 West Broad Street, Fifth Floor, Conference Room 4, Richmond, Virginia.

A Special Conference Committee will discuss disciplinary matters. Public comments will not be received.

**Contact:** Elizabeth Scott Russell, Executive Director, Board of Pharmacy, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9911, FAX (804) 662-9313.

**December 10, 2004 - 9 a.m.** -- Open Meeting  
Department of Health Professions, 6603 West Broad Street, Fifth Floor, Conference Room 2, Richmond, Virginia.

A meeting of the board to consider such regulatory and disciplinary matters as may be presented on the agenda. Public comment will be received at the beginning of the meeting.

**Contact:** Elizabeth Scott Russell, RPh, Executive Director, Board of Pharmacy, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9911, FAX (804) 662-9313, (804) 662-7197/TTY , e-mail scottirussell@dhp.virginia.gov.

## POLYGRAPH EXAMINERS ADVISORY BOARD

† **November 29, 2004 - 10 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Room 453, Richmond, Virginia. 

An informal fact-finding conference.

**Contact:** Karen W. O'Neal, Regulatory Programs Coordinator, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8537, FAX (804) 367-2475, (804) 367-9753/TTY , e-mail oneal@dpor.virginia.gov.

**December 2, 2004 - 10 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A meeting to conduct board business. The meeting is open to the public; however, a portion of the board's business may be discussed in closed session. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the department at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

**Contact:** Eric Olson, Executive Director, Polygraph Examiners Advisory Board, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY , e-mail olson@dpor.virginia.gov.

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# Calendar of Events

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## DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION

**December 17, 2004** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Professional and Occupational Regulation intends to amend regulations entitled **18 VAC 120-40, Virginia Professional Boxing and Wrestling Events Regulations**. The purpose of the proposed action is to adjust fees to comply with the Callahan Act (§ 54.1-113 of the Code of Virginia).

Statutory Authority: § 54.1-831 of the Code of Virginia.

**Contact:** Karen W. O'Neal, Deputy Director for Licensing and Regulation, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8537, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail karen.oneal@dpor.virginia.gov.

## BOARD OF PSYCHOLOGY

**January 11, 2005 - 9:30 a.m.** -- Open Meeting  
Department of Health Professions, 6603 W. Broad Street, 5th Floor, Richmond, Virginia. ♿

A business meeting to include reports from standing committees and any other disciplinary or regulatory matters as may be presented on the agenda. Public comment will be received at the beginning of the meeting.

**Contact:** Evelyn B. Brown, Executive Director, Board of Psychology, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9913, FAX (804) 662-9943, (804) 662-7197/TTY ☎, e-mail evelyn.brown@dhp.virginia.gov.

## VIRGINIA PUBLIC GUARDIAN AND CONSERVATOR ADVISORY BOARD

**December 9, 2004 - 10 a.m.** -- Open Meeting  
1610 Forest Avenue, Suite 100, Richmond, Virginia. ♿

A quarterly meeting.

**Contact:** Terry Raney, Guardianship Coordinator, Virginia Public Guardian and Conservator Advisory Board, 1610 Forest Ave., Suite 100, Richmond, VA 23229, telephone (804) 662-7049, FAX (804) 662-9354, toll-free (800) 552-3402, (804) 662-9333/TTY ☎, e-mail traney@vda.virginia.gov.

## REAL ESTATE BOARD

**November 30, 2004 - 11 a.m.** -- Open Meeting  
Fairfax County Government Center Complex, Herrity Building, 12055 Government Center Parkway, Room 122, Fairfax, Virginia.

**December 2, 2004 - 9 a.m.** -- Open Meeting  
**December 8, 2004 - 9 a.m.** -- Open Meeting  
**† December 9, 2004 - 9 a.m.** -- Open Meeting  
**December 16, 2004 - 9 a.m.** -- Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Room 453, Richmond, Virginia. ♿

An informal fact-finding conference.

**Contact:** Karen W. O'Neal, Regulatory Programs Coordinator, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8537, FAX (804) 367-2475, (804) 367-9753/TTY ☎, e-mail karen.oneal@dpor.virginia.gov.

## VIRGINIA RECYCLING MARKETS DEVELOPMENT COUNCIL

**† December 15, 2004 - 10:30 a.m.** -- Open Meeting  
Piedmont Virginia Community College, 501 College Drive, Board Room, Room 814, Charlottesville, Virginia. ♿

A regular quarterly meeting.

**Contact:** Philip F. Abraham, Chairman, Virginia Recycling Markets Development Council, 411 E. Franklin St., Suite 602, Richmond, VA 23219, telephone (804) 644-6600, FAX (804) 644-6628, e-mail pabraham@vectrecorp.com.

## DEPARTMENT OF REHABILITATIVE SERVICES

**December 2, 2004 - 3 p.m.** -- Public Hearing  
Portsmouth DRS Office, 3248 Academy Avenue, Suites 22-26 Portsmouth, Virginia. ♿ (Interpreter for the deaf provided upon request)

**December 8, 2004 - 3 p.m.** -- Public Hearing  
Fairfax DRS Office, 11150 Main Street, Suite 300, Fairfax, Virginia.

**December 14, 2004 - 3 p.m.** -- Public Hearing  
Mount Rogers Community Mental Health and Mental Retardation Board, 770 West Ridge Road, Wytheville, Virginia.

**January 10, 2005 - 3 p.m.** -- Public Hearing  
Department of Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A meeting to provide the public the opportunity to discuss the annual DRS State Plan. The December 14 hearing will be in videoconference format and broadcasted from Richmond.

**Contact:** Elizabeth Smith, Policy and Planning Director, Department of Rehabilitative Services, 8004 Franklin Farms Dr., P.O. Box K-300, Richmond, VA 23288-0300, telephone (804) 662-7071, FAX (804) 662-7696, toll-free (800) 552-5019, (800) 464-9950/TTY ☎, e-mail smithee@drs.virginia.gov.

## Commonwealth Neurotrauma Initiative Trust Fund Advisory Board

**January 20, 2005 - 10 a.m.** -- Open Meeting  
Department of Rehabilitative Services, 8004 Franklin Farms Drive, 1st Floor Conference Rooms, Richmond, Virginia.   
(Interpreter for the deaf provided upon request)

A quarterly meeting.

**Contact:** Kristie Chamberlain, CNI Program Administrator, Department of Rehabilitative Services, 8004 Franklin Farms Dr., Richmond, VA 23229, telephone (804) 662-7154, FAX (804) 662-7663, toll-free (800) 552-5019, (804) 464-9950/TTY , e-mail [kristie.chamberlain@drs.virginia.gov](mailto:kristie.chamberlain@drs.virginia.gov).

## VIRGINIA RESOURCES AUTHORITY

**December 14, 2004 - 9 a.m.** -- Open Meeting  
Eighth and Main Building, 707 East Main Street, 2nd Floor, Richmond, Virginia. 

A regular meeting of the Board of Directors to (i) review and, if appropriate, approve the minutes from the most recent monthly meeting; (ii) review the authority's operations for the prior month; (iii) review applications for loans submitted to the authority for approval; (iv) consider loan commitments for approval and ratification under its various programs; (v) approve the issuance of any bonds; (vi) review the results of any bond sales; and (vii) consider such other matters and take such other actions as it may deem appropriate. Various committees of the Board of Directors may also meet immediately before or after the regular meeting and consider matters within their purview. The planned agenda of the meeting and any committee meetings will be available at the offices of the authority one week prior to the date of the meeting. Any person who needs any accommodation in order to participate in the meeting should contact the authority at least 10 days before the meeting so that suitable arrangements can be made.

**Contact:** Bonnie R. C. McRae, Executive Assistant, Virginia Resources Authority, 707 E. Main St., Richmond, VA 23219, telephone (804) 644-3100, FAX (804) 644-3109, e-mail [bmcrac@vra.state.va.us](mailto:bmcrac@vra.state.va.us).

## VIRGINIA SMALL BUSINESS FINANCING AUTHORITY

† **December 15, 2004 - Noon** -- Open Meeting  
Department of Business Assistance, 707 East Main Street, 3rd Floor Board Room, Richmond, Virginia. 

A meeting to review applications for loans submitted to the authority for approval and general business of the board. The meeting time is subject to change depending upon the board's agenda.

**Contact:** Scott E. Parsons, Executive Director, Department of Business Assistance, P.O. Box 446, Richmond, VA 23218-0446, telephone (804) 371-8256, FAX (804) 225-3384, toll-free (866) 248-8814, e-mail [scott.parsons@dba.virginia.gov](mailto:scott.parsons@dba.virginia.gov).

## STATE BOARD OF SOCIAL SERVICES

**December 15, 2004 - 9 a.m.** -- Open Meeting  
Department of Social Services, 608 Jackson Street, Fredericksburg, Virginia.

A work session from 9 a.m. until noon, followed by a full board meeting at 1:30 p.m. Public comment will be received at 1:30 p.m.

**Contact:** Pat Rengnerth, Board Liaison, Department of Social Services, Office of Legislative and Regulatory Affairs, 7 N. 8th St., Room 5214, Richmond, VA 23219, telephone (804) 726-7905, FAX (804) 726-7906, (800) 828-1120/TTY , e-mail [patricia.rengnerth@dss.virginia.gov](mailto:patricia.rengnerth@dss.virginia.gov).

**December 16, 2004 - 9 a.m.** -- Open Meeting  
Department of Social Services, 608 Jackson Street, Fredericksburg, Virginia.

A board meeting.

**Contact:** Pat Rengnerth, Board Liaison, Department of Social Services, Office of Legislative and Regulatory Affairs, 7 N. 8th St., Room 5214, Richmond, VA 23219, telephone (804) 726-7905, FAX (804) 726-7906, (800) 828-1120/TTY , e-mail [patricia.rengnerth@dss.virginia.gov](mailto:patricia.rengnerth@dss.virginia.gov).

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† **January 28, 2005** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Social Services intends to amend regulations entitled **22 VAC 40-325, Fraud Reduction/Elimination Effort**. The purpose of the proposed action is to amend the criteria for local departments of social services to receive full reimbursement for program costs, expand the responsibilities of local departments of social services' fraud units and enhance the definitions section of the regulation.

Statutory Authority: §§ 63.2-217 and 63.2-526 of the Code of Virginia.

**Contact:** S. Michelle Lauter, Manager, Division of Fraud Management, 7 N. 8th St., Richmond, VA 23219, telephone (804) 726-7679, FAX (804) 726-7669 or e-mail [michelle.lauter@dss.virginia.gov](mailto:michelle.lauter@dss.virginia.gov).

## DEPARTMENT OF SOCIAL SERVICES

### Family and Children's Trust Fund Board

† **December 6, 2004 - 3:30 p.m.** -- Open Meeting  
† **December 7, 2004 - 9 a.m.** -- Open Meeting  
2412 Langhorne Road, Lynchburg, Virginia.   
(Interpreter for the deaf provided upon request)

A regular business meeting.

**Contact:** Nan McKenney, Executive Director, Family and Children's Trust Fund Board, 7 N. 8th St., Richmond, VA 23219, telephone (804) 726-7604, toll-free (800) 726-7015.

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# Calendar of Events

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## BOARD FOR PROFESSIONAL SOIL SCIENTISTS AND WETLAND PROFESSIONALS

**December 1, 2004 - 10 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation,  
3600 West Broad Street, 4th Floor, Room 453, Richmond,  
Virginia. 

An informal fact-finding conference.

**Contact:** Mark N. Courtney, Executive Director, Board for Professional Soil Scientists and Wetland Professionals, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8514, FAX (804) 367-2475, (804) 367-9753/TTY , e-mail soilscientist@dpor.virginia.gov.

## VIRGINIA TOBACCO SETTLEMENT FOUNDATION

† **November 30, 2004 - 3 p.m.** -- Open Meeting  
Crowne Plaza, 555 East Canal Street, Salon B, Richmond,  
Virginia. 

A meeting for marketing campaign results.

**Contact:** Eloise Burke, Sr. Executive Assistant, Virginia Tobacco Settlement Foundation, 701 E. Franklin St., Richmond, VA 23219, telephone (804) 786-2523, FAX (804) 225-2272, e-mail eburke@tsf.state.va.us.

## BOARD OF VETERAN SERVICES

† **December 13, 2004 - 1 p.m.** -- Public Hearing  
American Legion Department of Virginia, 1708  
Commonwealth Avenue, Richmond, Virginia. 

A regular board meeting. Public comment will be received.

**Contact:** Steven Combs, Assistant to Commissioner, Department of Veterans Services, 900 E. Main St., Richmond, VA 23219, telephone (804) 786-0294, e-mail steven.combs@dvs.virginia.gov.

## DEPARTMENT OF VETERANS SERVICES

### Veteran Services Foundation Board

† **December 15, 2004 - 11:30 a.m.** -- Open Meeting  
American Legion Department of Virginia, 1708  
Commonwealth Avenue, Richmond, Virginia. 

A meeting of the Board of Trustees. Public comment will be received.

**Contact:** Steven Combs, Assistant to the Commissioner, Department of Veterans Services, 900 E. Main St., Richmond, VA 23219, telephone (804) 786-0294, e-mail steven.combs@dvs.virginia.gov.

## Joint Leadership Council of Veterans Service Organizations

**December 7, 2004 - 1 p.m.** -- Open Meeting  
American Legion Department of Virginia, 1708  
Commonwealth Avenue, Richmond, Virginia. 

A meeting of the Joint Leadership Council of Veterans Service Organizations. A public comment period will begin at approximately 3 p.m.

**Contact:** Steven Combs, Assistant to the Commissioner, Department of Veterans Services, 900 E. Main St., Richmond, Virginia 23219, telephone (804) 786-0294, e-mail steven.combs@dvs.virginia.gov.

## VIRGINIA WASTE MANAGEMENT BOARD

**January 11, 2005 - 1:30 p.m.** -- Public Hearing  
Department of Environmental Quality, Piedmont Regional  
Office, 4949-A Cox Road, Glen Allen, Virginia.

**January 28, 2005** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Virginia Waste Management Board intends to amend regulations entitled **9 VAC 20-80, Solid Waste Management Regulations**. The purpose of the proposed action is to establish an expedited process for permitting waste piles.

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

**Contact:** Michael Dieter, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4146, FAX (804) 698-4327 or e-mail mjdieter@deq.virginia.gov.

## STATE WATER CONTROL BOARD

**November 30, 2004 - 4 p.m.** -- Public Hearing  
Department of Environmental Quality, Tidewater Regional  
Office, 5635 Southern Boulevard, Virginia Beach, Virginia.

**December 1, 2004 - 2 p.m.** -- Public Hearing  
Department of Environmental Quality, Piedmont Regional  
Office, 4949-A Cox Road, Glen Allen, Virginia.

**December 6, 2004 - 7 p.m.** -- Public Hearing  
Department of Environmental Quality, Valley Regional Office,  
4411 Early Road, Harrisonburg, Virginia.

**December 7, 2004 - 2 p.m.** -- Public Hearing  
Department of Environmental Quality, Northern Regional  
Office, 13901 Crown Court, Woodbridge, Virginia.

**January 31, 2005** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Water Control Board intends to amend regulations entitled **9 VAC 25-260, Water Quality Standards**. The purpose of the proposed action is to include updated numerical and narrative criteria to protect designated uses from the impacts of nutrients and

sedimentation. The rulemaking will also include new and revised use designations for the Chesapeake Bay and its tidal tributaries.

Statutory Authority: § 62.1-44.15 of the Code of Virginia.

**Contact:** Eleanore M. Daub, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4111, FAX (804) 698-4522 or e-mail emdaub@deq.virginia.gov.

**December 2, 2004 - 9:30 a.m.** -- Open Meeting  
General Assembly Building, 9th and Broad Streets, House Room C, Richmond, Virginia. ♿

A regular board meeting.

**Contact:** Cindy Berndt, Regulatory Coordinator, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4378, FAX (804) 698-4346, e-mail cmberndt@deq.virginia.gov.

## BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS

**December 8, 2004 - 8:30 a.m.** -- Open Meeting  
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting to conduct board business.

**Contact:** David E. Dick, Executive Director, Board for Waterworks and Wastewater Works Operators, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8507, FAX (804) 367-6128, (804) 367-9753/TTY ♿, e-mail waterwasteoper@dpor.virginia.gov.

## INDEPENDENT

### STATE LOTTERY BOARD

† **December 15, 2004 - 9:30 a.m.** -- Open Meeting  
Virginia Lottery, 900 East Main Street, 13th Floor, Richmond, Virginia. ♿

A regular business meeting. There will be an opportunity for public comment shortly after the meeting is convened.

**Contact:** Frank S. Ferguson, Director, Legislative and Regulatory Affairs, State Lottery Department, 900 E. Main St., Richmond, VA 23219, telephone (804) 692-7901, FAX (804) 692-7905, e-mail fferguson@valottery.state.va.us.

### VIRGINIA RETIREMENT SYSTEM

**December 15, 2004 - 3 p.m.** -- Open Meeting  
† **February 16, 2005 - 11 a.m.** -- Open Meeting  
Bank of America, 1111 East Main Street, Virginia Retirement System Investment Department, Pavilion, 4th Floor, Richmond, Virginia. ♿

A regular meeting of the Investment Advisory Committee. No public comment will be received at the meeting.

**Contact:** Phyllis Henderson, Executive Assistant, Virginia Retirement System, 1200 E. Main St., Richmond, VA 23219, telephone (804) 697-6675, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY ♿, e-mail lking@vrs.state.va.us.

**December 16, 2004 - 9 a.m.** -- Open Meeting  
† **February 17, 2005 - 9 a.m.** -- Open Meeting  
Virginia Retirement System Headquarters Building, 1200 East Main Street, Richmond, Virginia. ♿

A regular meeting of the Board of Trustees. No public comment will be received at the meeting.

**Contact:** LaShaunda B. King, Executive Assistant, Virginia Retirement System, 1200 E. Main Street, Richmond, VA 23219, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY ♿, or e-mail lking@vrs.state.va.us.

**February 15, 2005 - Noon** -- Open Meeting  
Virginia Retirement System Headquarters Building, 1200 East Main Street, Richmond, Virginia. ♿

A meeting of the Optional Retirement Plan Advisory Committee. No public comment will be received.

**Contact:** LaShaunda B. King, Executive Assistant, Virginia Retirement System, 1200 E. Main St., Richmond, VA 23219, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY ♿, e-mail lking@vrs.state.va.us.

† **February 16, 2005 - 2:30 p.m.** -- Open Meeting  
Virginia Retirement System Headquarters Building, 1200 East Main Street, Richmond, Virginia. ♿

Meetings of the following committees:

2:30 p.m. - Benefits and Actuarial

4 p.m. - Audit and Compliance

4 p.m. - Administration and Personnel

No public comment will be received.

**Contact:** LaShaunda B. King, Executive Assistant, Virginia Retirement System, 1200 E. Main St., Richmond, VA 23219, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY ♿, e-mail lking@vrs.state.va.us.

## LEGISLATIVE

### VIRGINIA CODE COMMISSION

**December 15, 2004 - 10 a.m.** -- Open Meeting  
General Assembly Building, 9th and Broad Streets, 6th Floor, Speaker's Conference Room, Richmond, Virginia. ♿

A meeting to continue with the revisions of Titles 1, 3.1 and 37.1 and to conduct any other business that may come before the commission. A brief public comment period is scheduled at the end of the meeting.

**Contact:** Jane Chaffin, Registrar of Regulations, Virginia Code Commission, General Assembly Bldg., 910 Capitol St.,

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# Calendar of Events

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2nd Floor, Richmond, VA 23219, telephone (804) 786-3591, FAX (804) 692-0625, e-mail [jchaffin@leg.state.va.us](mailto:jchaffin@leg.state.va.us).

## VIRGINIA FREEDOM OF INFORMATION ADVISORY COUNCIL

**December 2, 2004 - 2 p.m.** -- Open Meeting  
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia. 

A regular meeting.

**Contact:** Lynda Waddill, Administrative Assistant, Virginia Freedom of Information Advisory Council, 910 Capitol St., 2nd Floor, Richmond, VA 23219, telephone (804) 225-3056, FAX (804) 371-0169, toll-free (866) 448-4100, e-mail [foiacouncil@leg.state.va.us](mailto:foiacouncil@leg.state.va.us).

## JOINT COMMISSION ON TECHNOLOGY AND SCIENCE

**December 1, 2004 - 9:30 a.m.** -- Open Meeting  
General Assembly Building, 9th and Broad Streets, House Room D, Richmond, Virginia. 

A full commission meeting to discuss 2005 legislative proposals.

**Contact:** Mitchell Goldstein, Director, Joint Commission on Technology and Science, General Assembly Bldg., 910 Capitol St., 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591, FAX (804) 371-0169, e-mail [jcots@leg.state.va.us](mailto:jcots@leg.state.va.us).

## CHRONOLOGICAL LIST

### OPEN MEETINGS

#### November 29

Health, Department of  
† Polygraph Examiners Advisory Board

#### November 30

Contractors, Board for  
Nursing Home Administrators, Board of  
Real Estate Board  
† Tobacco Settlement Foundation, Virginia

#### December 1

Emergency Planning Committee, Local - Winchester  
Fire Services Board, Virginia  
† Historic Resources, Department of  
Jamestown-Yorktown Foundation  
Medicine, Board of  
† Pharmacy, Board of  
Soil Scientists and Wetland Professionals, Board for  
Technology and Science, Joint Commission on

#### December 2

Aging, Commonwealth Council on  
Agriculture and Consumer Services, Department of  
- Virginia Soybean Board  
† Arts, Virginia Commission for the  
Asbestos, Lead and Home Inspectors, Virginia Board for  
Contractors, Board for

Elections, State Board of  
Fire Services Board, Virginia  
Freedom of Information Advisory Council, Virginia  
Mental Health, Mental Retardation and Substance Abuse  
Services, Department of  
Nursing, Board of  
Polygraph Examiners Advisory Board  
Real Estate Board  
Water Control Board, State

#### December 3

Accountancy, Board of  
Art and Architectural Review Board  
Dentistry, Board of  
Fire Services Board, Virginia  
Health, Department of

#### December 6

Alcoholic Beverage Control Board  
† Social Services, Department of

#### December 7

Agriculture and Consumer Services, Department of  
- Virginia Corn Board  
Alzheimer's Disease and Related Disorders Commission  
Auctioneers Board  
† Contractors, Board for  
† Gaming Board, Charitable  
† Information Technologies Agency, Virginia  
Medicine, Board of  
Museum of Fine Arts, Virginia  
Nursing, Board of  
† Optometry, Board of  
† Social Services, Department of  
Veterans Services, Department of  
- Joint Leadership Council of Veterans Service  
Organizations

#### December 8

Conservation and Recreation, Department of  
- Virginia Soil and Water Conservation Board  
† Contractors, Board for  
† Information Technologies Agency, Virginia  
† Medical Assistance Services, Department of  
† Medicine, Board of  
Nursing, Board of  
Real Estate Board  
Waterworks and Wastewater Works Operators, Board for

#### December 9

Agriculture and Consumer Services, Board of  
Architects, Professional Engineers, Land Surveyors,  
Certified Interior Designers and Landscape Architects,  
Board for  
† Contractors, Board for  
Criminal Justice Services Board  
Environmental, Department of  
Labor and Industry, Department of  
- Virginia Apprenticeship Council  
Nursing, Board of  
† Pharmacy, Board of  
Public Guardian and Conservator Advisory Board, Virginia  
† Real Estate Board

#### December 10

Dentistry, Board of  
Health Professions, Department of  
† Longwood University

Old Dominion University  
Pharmacy, Board of

**December 11**

† Longwood University

**December 13**

† Business Assistance, Department of  
- Small Business Advisory Board  
† Chesapeake Bay Local Assistance Board  
† Veterans Services, Board of

**December 14**

Architects, Professional Engineers, Land Surveyors,  
Certified Interior Designers and Landscape Architects,  
Board for  
† Aviation Board, Virginia  
Contractors, Board for  
† Labor and Industry, Department of  
- Safety and Health Codes Board  
Medical Assistance Services, Board of  
Resources Authority, Virginia

**December 15**

† Aviation Board, Virginia  
Code Commission, Virginia  
Compensation Board  
† Criminal Justice Services Board  
- Private Security Services Advisory Board  
Health Professions, Department of  
† Lottery Board, State  
Milk Commission, State  
Nursing and Medicine, Joint Boards of  
† Recycling Markets Development Council, Virginia  
Retirement System, Virginia  
† Small Business Financing Authority, Virginia  
Social Services, State Board of  
† Veterans Services, Department of  
- Veteran Services Foundation Board

**December 16**

Contractors, Board for  
Design-Build/Construction Management Review Board  
Real Estate Board  
Retirement System, Virginia  
Social Services, State Board of

**December 17**

Dentistry, Board of

**December 20**

Alcoholic Beverage Control Board

**December 21**

Marine Resources Commission  
Olmstead Advisory Committee

**January 4, 2005**

Museum of Fine Arts, Virginia

**January 5**

† Air Pollution Control Board, State  
Geology, Board for  
Medical Assistance Services, Department of  
- Medicaid Transportation Advisory Committee

**January 6**

Mental Health, Mental Retardation and Substance Abuse  
Services, Department of

**January 11**

† Child Fatality Review Team, State  
Psychology, Board of

**January 12**

Education, Board of

**January 18**

Contractors, Board for

**January 19**

Community Colleges, State Board for  
Health, Department of  
- Sewage Handling and Disposal Appeal Review Board  
† Hearing Aid Specialists, Board for

**January 20**

Community Colleges, State Board for  
Education, Board of  
Rehabilitative Services, Department of  
- Commonwealth Neurotrauma Initiative Trust Fund  
Advisory Board

**January 21**

Education, Board of

**January 24**

Education, Board of

**January 25**

Agriculture and Consumer Services, Department of  
- Virginia Marine Products Board

**January 27**

Library Board, State

**February 1**

Museum of Fine Arts, Virginia

**February 15**

Old Dominion University  
Retirement System, Virginia

**February 16**

† Asbestos, Lead, and Home Inspectors, Virginia Board for  
† Retirement System, Virginia

**February 17**

† Retirement System, Virginia

**February 23**

† Contractors, Board for  
† Education, Board of  
† Health, Department of  
- Sewage Handling and Disposal Appeal Review Board

## PUBLIC HEARINGS

**November 30**

Water Control Board, State

**December 1**

Water Control Board, State

**December 2**

† Health, Department of  
Rehabilitative Services, Department of

**December 3**

† Health, Department of

**December 6**

† Health, Department of  
Water Control Board, State

**December 7**

Water Control Board, State

**December 8**

Rehabilitative Services, Department of

**December 9**

Criminal Justice Services Board

**December 14**

Rehabilitative Services, Department of

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## Calendar of Events

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**December 15**

† Air Pollution Control Board, State

**January 10**

Rehabilitative Services, Department of

**January 11**

† Waste Management Board, Virginia

**January 21**

† Dentistry, Board of

† Medicine, Board of