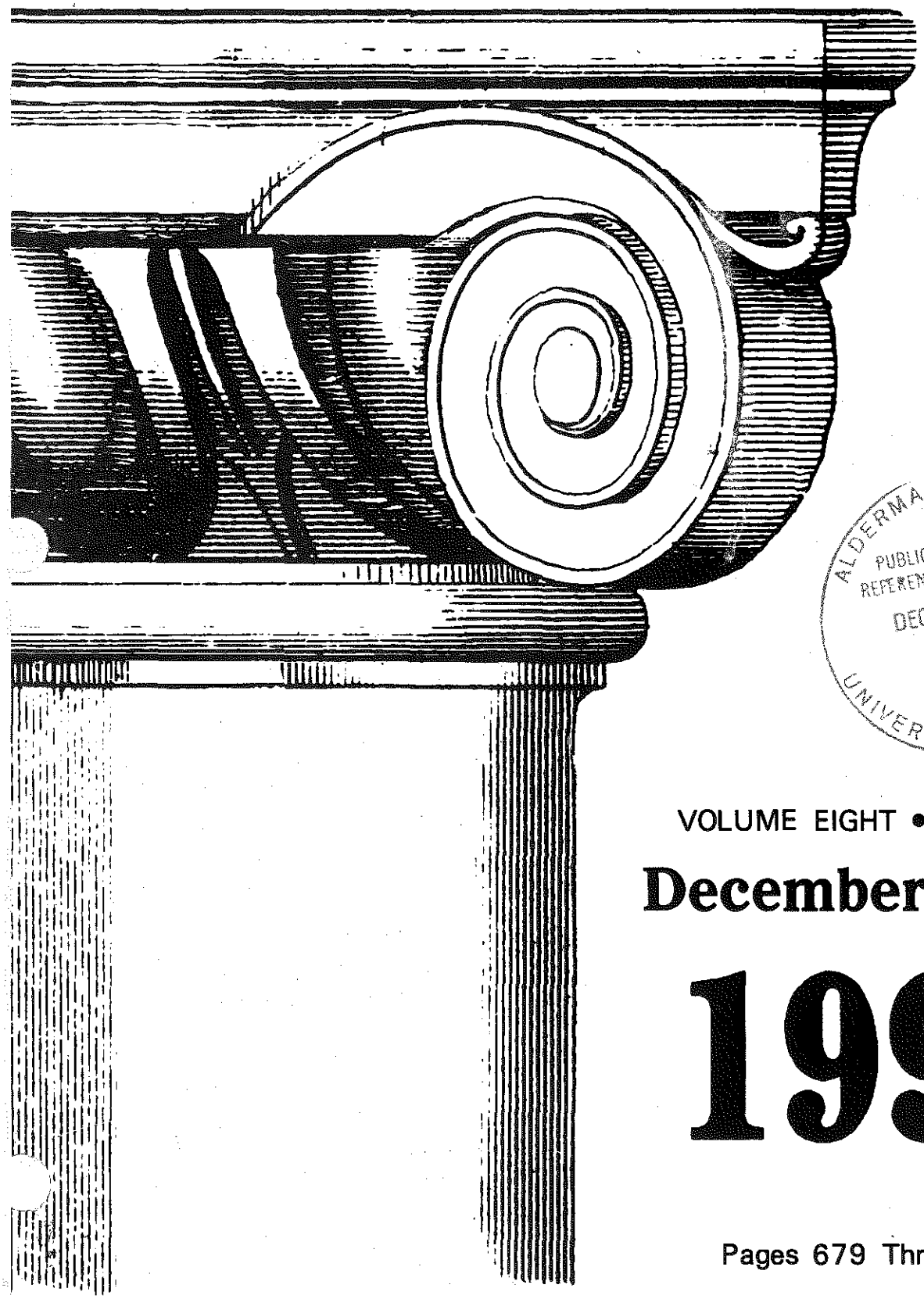
THE VIRGINIA REGISTER

OF REGULATIONS



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December 2, 1991

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VIRGINIA REGISTER

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

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

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

ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS

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

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

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

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

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

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

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

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

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

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

EMERGENCY REGULATIONS

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

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

STATEMENT

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

CITATION TO THE VIRGINIA REGISTER

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

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VIRGINIA REGISTER OF REGULATIONS

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July 1991 though September 1992

MATERIAL SUBMITTED BY Noon Wednesday	PUBLICATION DATE
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July 10	July 29
July 24	Aug. 12
Aug. 7	Aug. 26
Aug. 21	Sept. 9
Sept. 4	Sept. 23
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Oct. 2	Oct. 21
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† Indicates entries since last publication of the Virginia Register

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES (BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Agriculture and Consumer Services intends to consider amending regulations entitled: **VR 115-04-14. Rules and Regulations for Enforcement of the Virginia Pest Law - Cotton Boll Weevil Quarantine.** The purpose of the proposed action is to review the regulation for effectiveness and continued need. Among the matters that need to be reviewed are current penalties, reporting and filing dates, and the grounds for exemptions from the various requirements.

Statutory Authority: §§ 3.1-188.21 and 3.1-188.23 of the Code of Virginia.

Written comments may be submitted until December 8, 1991.

Contact: John R. Tate, Agriculture Biologist Supervisor, P.O. Box 1163, 1100 Bank Street, Room 703, Washington Building, Richmond, VA 23209, telephone (804) 786-3515.

STATE AIR POLLUTION CONTROL BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Air Pollution Control Board intends to consider amending regulations entitled: **VR 120-01. Regulations for the Control and Abatement of Air Pollution.** The purpose of the proposed amendment to Part VIII is to require the owner of the proposed new or expanded facility to provide such information as may be needed to enable the agency to conduct a preconstruction review in order to determine compliance with applicable new source performance standards and to assess the impact of the emissions from the facility on air quality. The amendment also provides the basis for the agency's final action (approval or disapproval) on the permit depending upon the results of the preconstruction review.

A public meeting will be held on December 10, 1991, at 10 a.m. in House Committee Room 1, State Capitol Building, Richmond, Virginia, to receive input on the development of the proposed regulation.

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

Written comments may be submitted until December 10, 1991, to Director of Program Development, Department of Air Pollution Control, P. O. Box 10089, Richmond, VA 23240.

Contact: Nancy S. Saylor, Policy Analyst, Department of Air Pollution Control, P. O. Box 10089, Richmond, VA 23240, telephone (804) 786-1249.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Air Pollution Control Board intends to consider amending regulations entitled: **VR 120-01. Regulations for the Control and Abatement of Air Pollution.** The purpose of the proposed amendment to Rule 4-37 is to require the owner/operator of a petroleum liquid storage and transfer facility to install and operate a vapor control and recovery system for VOC emissions, such that resultant ozone concentrations in the ambient air may be reduced to levels which are necessary for the protection of public health and welfare.

A public meeting will be held on December 11, 1991, at 10 a.m. in House Committee Room 1, State Capitol Building, Richmond, Virginia, to receive input on the development of the proposed regulation.

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

Written comments may be submitted until December 11, 1991, to Director of Program Development, Department of Air Pollution Control, P. O. Box 10089, Richmond, VA 23240.

Contact: Ellen P. Snyder, Policy Analyst, Division of Program Development, Department of Air Pollution Control, P. O. Box 10089, Richmond, VA 23240, telephone (804) 786-0177.

BOARD OF AVIATION

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Aviation intends to consider repealing existing regulations and promulgating new regulations entitled: **Regulations of the Department of Aviation.** The purpose of the proposed action is to solicit public comments and update current aviation regulations as to their effectiveness.

Statutory Authority: § 5.1-2.15 of the Code of Virginia.

Written comments may be submitted until December 22, 1991.

Contact: Keith F. McCrea, AICP, Aviation Planner, Department of Aviation, 4508 S. Laburnum Avenue, Richmond, VA 23231-2422, telephone (804) 786-1365 or toll-free 1-800-292-1034.

BOARD FOR CONTRACTORS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board for Contractors intends to consider amending regulations entitled: **VR 220-01-2. Board for Contractors Licensing Regulations.** The purpose of the proposed action is to solicit public comment on all existing regulations as to their effectiveness, efficiency, clarity and necessity.

Statutory Authority: § 54.1-1102 of the Code of Virginia.

Written comments may be submitted until December 20, 1991.

Contact: Martha LeMond, Assistant Director, 3600 West Broad Street, Richmond, Virginia 23230, telephone (804) 367-8557.

DEPARTMENT FOR THE DEAF AND HARD OF HEARING

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department for the Deaf and Hard of Hearing intends to consider amending regulations entitled: **VR 245-03-01. Regulations Governing Interpreter Services for the Hearing Impaired.** The purpose of the proposed action is to amend current regulations to incorporate guidelines for administration of a Cued Speech Assessment within the section of the regulations related to the Quality Assurance Screening.

Statutory Authority: § 63.1-85.4 of the Code of Virginia.

Written comments may be submitted until January 2, 1992.

Contact: Kathy E. Vesley, Deputy Director, Department for the Deaf and Hard of Hearing, Washington Building, Capitol Square, 1100 Bank Street, 12th Floor, Richmond, Virginia 23219, telephone (804) 225-2570/Voice/TDD ☎ or toll-free 1-800-552-7917/Voice/TDD ☎

DEPARTMENT OF EDUCATION (STATE BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Education intends to consider amending regulations entitled: **VR 270-01-0012. Standards for Accrediting Public Schools in Virginia.** The purpose of the proposed action is to provide minimum standards to give guidance and direction to assist schools in their continuing efforts to offer educational programs to meet the needs, interests, and aspirations of all students. The amendments are necessary to reflect changes in the missions of the Board of Education and the Department of Education. The board is also adopting new goals as part of the Standards of Quality.

Statutory Authority: §§ 22.1-19 and 22.1-253.13:3 (B) of the Code of Virginia.

Written comments may be submitted until December 30, 1991.

Contact: Ms. Lin Corbin-Howerton, Lead Policy Analysts, Virginia Department of Education, P.O. Box 6Q, Richmond, Virginia 23216, telephone (804) 225-2092, (804) 225-2543 or toll-free 1-800-292-3820.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Funeral Directors and Embalmers intends to consider amending regulations entitled: **Regulations of the Board of Funeral Directors and Embalmers.** The purpose of the proposed action is to delete all references to the resident trainee program which have now been included in their entirety in the regulations entitled "Resident Trainee Regulations for Funeral Services."

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

Written comments may be submitted until December 18, 1991.

Contact: Meredyth P. Partridge, Executive Director, Board of Funeral Directors and Embalmers, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-7390 or SCATS (804) 662-9907.

* * * * * * * * *

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Funeral Directors and Embalmers intends to consider amending regulations entitled: **Resident Trainee Program for Funeral Services.** The purpose of the proposed action is

to add additional language which places a maximum limit on the time a trainee can remain in the trainee program.

Statutory Authority: § 54.1-2817 of the Code of Virginia.

Written comments may be submitted until December 18, 1991.

Contact: Meredyth P. Partridge, Executive Director, Board of Funeral Directors and Embalmers, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-7390 or SCATS (804) 662-9907.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

DEPARTMENT OF HEALTH (STATE BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **Regulations Governing Eligibility Standards and Charges for Medical Care Services.** The purpose of the proposed action is to revise current regulations to more closely conform to eligibility guidelines of other state agencies.

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

Written comments may be submitted until December 12, 1991.

Contact: Dave Burkett, Health Administrator, P.O. Box 2448, Room 237, Richmond, VA 23218, telephone (804) 786-4089.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-30-01. Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.** The purpose of the proposed action is to amend the existing Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations so that the regulations are consistent with the amended law.

Statutory Authority: §§ 32.1-12 and 32.1-102.1 et seq. of the Code of Virginia.

Written comments may be submitted until December 5, 1991.

Contact: Paul Parker, Director, Division of Resources Development, Virginia Department of Health, 1500 East Main Street, Suite 105, Richmond, VA 23219, telephone (804) 786-7463.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-35-200. Sanitary Regulations for Hotels.** The purpose of the proposed action is to specify requirements for hotels to protect public health.

Statutory Authority: §§ 32.1-12, 35.1-11 and 35.1-13 of the Code of Virginia.

Written comments may be submitted until December 31, 1991.

Contact: John Benko, Director, Bureau of Food and General Environmental Services, Virginia Department of Health, P.O. Box 2448, Suite 144, Richmond, VA 23218, telephone (804) 786-3559.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-35-300. Sanitary Regulations for Summer Camps.** The purpose of the proposed action is to specify the requirements for summer camps to protect the public health.

Statutory Authority: §§ 32.1-12, 35.1-11 and 35.1-16 of the Code of Virginia.

Written comments may be submitted until December 31, 1991.

Contact: John Benko, Director, Bureau of Food and General Environmental Services, Virginia Department of Health, P.O. Box 2448, Suite 144, Richmond, VA 23218, telephone (804) 786-3559.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-35-400. Sanitary Regulations for Campgrounds.** The purpose of the proposed action is to specify the requirements for campgrounds to protect the public health.

Statutory Authority: §§ 32.1-12, 35.1-11 and 35.1-17 of the Code of Virginia.

Written comments may be submitted until December 31, 1991.

Contact: John Benko, Director, Bureau of Food and General Environmental Services, Virginia Department of

Health, P.O. Box 2448, Suite 144, Richmond, VA 23218, telephone (804) 786-3559.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-35-500. Regulations Governing Swimming Pools at Hotels, Motels, Campgrounds, Summer Camps and Related Facilities.** The purpose of the proposed action is to specify the requirements for the operation and maintenance of swimming pools at hotels, motels, campgrounds, summer camps and related facilities to protect public health.

Statutory Authority: §§ 32.1-12, 35.1-13, 35.1-16 and 35.1-17 of the Code of Virginia.

Written comments may be submitted until December 31, 1991.

Contact: John Benko, Director, Bureau of Food and General Environmental Services, Virginia Department of Health, P.O. Box 2448, Suite 144, Richmond, VA 23218, telephone (804) 786-3559.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider promulgating regulations entitled: **VR 355-35-700. Swimming Pool Regulations Governing the Posting of Water Quality Test Results.** The purpose of the proposed action is to ensure that all public swimming pools are maintained in a manner which does not adversely affect the public health, welfare and safety.

Statutory Authority: § 32.1-248.1 of the Code of Virginia.

Written comments may be submitted until December 31, 1991.

Contact: John Benko, Director, Bureau of Food and General Environmental Services, Virginia Department of Health, P.O. Box 2448, Suite 144, Richmond, VA 23218, telephone (804) 786-3559.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider promulgating regulations entitled: **Alternative Discharging Sewage Treatment System Regulations for Individual Single Family Dwellings.** The purpose of the proposed action is to regulate the installation, operation and maintenance of discharging sewage systems (aerobic treatment units, sandfilters, etc.) serving single family dwellings with flows less than 1,000 GPD. These regulations will replace the emergency discharging regulations which will expire on July 29, 1992.

Statutory Authority: §§ 32.1-12 and 32.1-164 of the Code of Virginia.

Written comments may be submitted until January 2, 1992.

Contact: Donald J. Alexander, Director, Bureau of Sewage and Water Services, Division of Sanitarian Services, 1500 E. Main Street, Suite 144, Richmond, VA 23219, telephone (804) 786-1750.

BOARD OF MEDICINE

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medicine intends to consider amending regulations entitled: **VR 465-08-01. Regulations for Certification of Occupational Therapists.** The purpose of the proposed action is to (i) define the Test of English as a Foreign Language; (ii) correct a technical error of reference in § 2.2. C and interchange subsections B and C; (iii) establish the Test of English as a requirement for certification for foreign-trained occupational therapists; and (iv) grammatically correct § 2.3 F.

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

Written comments may be submitted until January 2, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Drive, Richmond, Virginia 23229.

Contact: Eugenia K. Dorson, Deputy Executive Director of Licensure, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9923.

BOARD OF PROFESSIONAL COUNSELORS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Professional Counselors intends to consider amending regulations entitled: **VR 560-01-02. Regulations Governing the Practice of Professional Counseling.** The purpose of the proposed action is to consider the deletion of oral examinations and invite public comment.

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

Written comments may be submitted until December 31, 1991.

Contact: Evelyn B. Brown, Executive Director, Board of Professional Counselors, 1601 Rolling Hills Drive,

Richmond, VA 23229, telephone (804) 662-9912.

DEPARTMENT OF SOCIAL SERVICES (STATE BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Social Services intends to consider amending regulations entitled: **Child Support Enforcement Program.** The purpose of the proposed action is to change the basis of a default obligation from the ADC grant amount to a higher figure that will be based on poverty level.

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

Written comments may be submitted until December 20, 1991, to Penny Pellow, Policy Unit, 8007 Discovery Drive, Richmond, Virginia 23229.

Contact: Margaret J. Friedenberg, Legislative Analyst, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Social Services intends to consider repealing existing regulations and promulgating new regulations entitled: **VR 615-25-01. Minimum Standards for Licensed Group Family Day Care Homes.** The purpose of the proposed action is to repeal the existing Minimum Standards Licensed Family Day Care Homes while concurrently promulgating Minimum Standards for Licensed Group Family Day Care Homes.

Statutory Authority: § 63.1-202 of the Code of Virginia.

Written comments may be submitted until January 2, 1992, to Gayle Turner, Department of Social Serices, 8007 Discovery Drive, Richmond, Virginia 23229.

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

DEPARTMENT OF THE TREASURY (STATE TREASURER)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Treasurer intends to consider promulgating regulations entitled: **VR 640-04. Escheats Generally Statute Regulations.** The purpose of the proposed action is to adopt necessary rules and regulations to carry out the provisions of the Escheats Generally Statutes.

Statutory Authority: § 55-200.1 of the Code of Virginia.

Written comments may be submitted until January 2, 1992.

Contact: Robert S. Young, Director of Financial Policy, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-3131.

DEPARTMENT OF WASTE MANAGEMENT (VIRGINIA WASTE MANAGEMENT BOARD)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Virginia Waste Management Board intends to consider amending regulations entitled: **VR 672-30-1. Virginia Regulations Governing the Transportation of Hazardous Materials.** The purpose of the proposed action is to incorporate by reference changes that were made to Title 49, Code of Federal Regulations, from July 1, 1990, to June 30, 1991.

Statutory Authority: §§ 10.1-1402 and 10.1-1450 of the Code of Virginia.

Written comments may be submitted until December 4, 1991, to William F. Gilley, Department of Waste Management, 11th Floor, Monroe Building, Richmond, VA 23219.

Contact: C. Ronald Smith, Hazardous Waste Enforcement Chief, 11th Floor, Monroe Building, 101 N. 14th Street, Richmond, VA 23219, telephone (804) 225-4761 or toll-free 1-800-552-2075.

For information concerning Proposed Regulations, see information page.

Symbol Key

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

DEPARTMENT OF CRIMINAL JUSTICE SERVICES (BOARD OF)

Title of Regulation: **VR 240-04-3. Rules Relating to the Court-Appointed Special Advocate Program (CASA).**

Statutory Authority: § 9-173.6, 9-173.7 and 9-173.8 of the Code of Virginia.

Public Hearing Date: March 6, 1992 - 1 p.m.
(See Calendar of Events section for additional information)

Summary:

The proposed rules outline the policies and procedures that local Court-Appointed Special Advocate Programs will be required to follow. These include (i) guidelines on the selection and training of volunteer advocates, (ii) policies governing program and volunteer administration, and (iii) record keeping responsibilities.

It is intended that final regulations will become effective on July 1, 1992.

VR 240-04-3. Rules Relating to the Court-Appointed Special Advocate Program (CASA).

PART I.
GENERAL DEFINITIONS.

§ 1.1. Definitions.

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

"CASA" means court-appointed special advocate.

"CASA program" means any locally operated program which utilizes court-appointed volunteers to assist in judicial proceedings involving allegations that a child is abused, neglected, in need of services or in need of supervision.

"DCJS" means the Department of Criminal Justice Services.

"Program director" means the director or coordinator of a local CASA program.

"Volunteer" means the court-appointed special advocate.

PART II.
PROGRAM ADMINISTRATION.

§ 2.1. Advisory boards.

A. Although advisory boards are not mandated, CASA advisory boards are recommended.

B. The composition of local CASA advisory boards should include persons having knowledge of or an interest in court matters, child welfare and juvenile justice issues from both public and private sectors.

§ 2.2. Record keeping and monitoring.

A. CASA programs are required to maintain records of the activities of the CASA program.

B. CASA programs will provide quarterly reports on the operation of the CASA program to the Department of Criminal Justice Services in a format provided by the department. The CASA quarterly reports (Appendix A) will cover the following periods: July-September; October-December; January-March; April-June. These reports are due by the 20th day of the month following the end of each quarter.

C. The quarterly reports will include the following:

1. The number of volunteers who completed training during the quarter, the number currently assigned to cases, and the number of inactive or unassigned volunteers;

2. The number of volunteer hours and a dollar equivalency for volunteer services for the quarter as prescribed by DCJS;

3. The number of cases served during the quarter including cases opened, closed and continued from previous quarters to ensure unduplicated numbers;

4. Average number of cases per volunteer;

5. Breakdown of the types of cases handled during the quarter;

6. Breakdown of the age, sex, and race of children served at the time of case assignment;

7. For cases closed during the quarter, the average length of time each case was assigned to the program;

8. For cases closed during the quarter, the average

length of time each child was in out-of-home placement while assigned to the program; and

9. The number of new cases referred during the quarter awaiting assignment of a CASA volunteer or denied service due to lack of a CASA volunteer.

D. The April-June quarterly report may also serve as an annual report. In addition to the quarterly statistical, the annual report will include, but not be limited to, the following:

1. An annual statistical summary;

2. A program budget which contains expenditure and income projections and the sources and amounts of income from each source;

3. A narrative detailing the program's accomplishments, major changes in program policy or operation during the past year;

4. A letter from the CASA program's fiscal agent or accountant identifying who is responsible for maintaining the fiscal records, stating where the fiscal records are routinely kept and a statement, prepared in accordance with generally accepted accounting practices, showing the total cash receipts and disbursements for the CASA program for the past year.

§ 2.3. Program and personnel policies.

A. Programs will ensure that an attorney is available for CASA program directors and boards to provide legal consultation in matters pertaining to administration of the programs.

B. Programs will not employ as paid staff any individual who concurrently supervises children-in-need of services or juvenile offender cases, either for the courts or any child serving agencies.

C. Programs shall write policies on the following and make those written policies available to the respective court:

1. The maximum number of cases to which a volunteer may be assigned at any one time. If that number is larger than three active cases, a rationale must be provided to DCJS.

2. The maximum number of volunteers to be supervised by each staff person. Consideration should be given to the exact number of hours each staff person spends in supervision (as opposed to administrative or other duties). In no case should the staff-to-volunteer ratio exceed either one staff to 30 volunteers or one staff to 30 assigned CASA cases.

3. A policy for the review, investigation and handling of any complaints that may be received concerning CASA volunteers, including procedures for the removal of CASA program to accept and prioritize cases for assignment to CASA volunteers.

4. Policies shall be developed identifying the specific factors to be used by the CASA program to accept and prioritize cases for assignment to CASA volunteers.

5. A policy emphasizing the confidentiality of the records and information to which CASA volunteers will have access, and training volunteers on the importance of confidentiality.

6. A policy identifying the objectives, standards, and conduct for CASA volunteers and the procedures that the CASA program has implemented to evaluate the performance of its volunteers in order to ensure that volunteers are meeting CASA's objectives and standards of conduct.

7. A policy and procedure for CASA volunteers to report incidents of suspected child abuse and neglect.

8. A policy and procedure concerning CASA investigations, CASA's role and responsibility in assisting the guardian ad litem, and monitoring court order compliance.

D. CASA programs shall provide staff capable of managing effective and efficient program operations. The following job descriptions provide for essential CASA program management:

1. The program director is responsible for accomplishing organizational goals and all managerial functions. This staff position requires a degree or equivalent experience in child welfare, public administration, counseling, human services, and experience with community organization and volunteer program management. Generally the duties and responsibilities of the program director will include:

a. Conducting or overseeing the recruitment, screening, training, supervision and evaluation of the program volunteers and staff;

b. Developing and maintaining procedures for case record keeping; supervising staff and volunteers in completing record-keeping tasks;

c. Serving as a liaison to the court and local agency and DCJS personnel;

d. Planning program growth and development, including special projects, budgets, annual workplans, and analysis of trends in program services;

e. Representing the program to networks of service providers, and community coalitions dealing with child welfare issues;

f. Providing liaison and support to an advisory board; and

g. Supervising program operations.

2. Program volunteer coordinator. Depending on program size, it may be necessary to designate a staff person having knowledge of or interest in court matters, child welfare and juvenile justice issues who will focus exclusively on volunteer recruitment, screening, training and case assignment. Generally, the duties and responsibilities of the program volunteer coordinator will include:

a. Developing and distributing volunteer recruitment materials, and conducting presentations on the CASA program for the purpose of recruiting volunteers and increasing community awareness;

b. Screening volunteer applications and conducting interviews to determine suitability of the applicant for the CASA program;

c. Arranging training for CASA volunteers;

d. Recommending trained volunteers for acceptance into the CASA program;

e. Planning volunteer recognition events;

f. Evaluating effectiveness of volunteer recruitment, training, assignment, and recognition efforts; and

g. Conducting annual written evaluations of each CASA volunteer.

PART III.
VOLUNTEER ADMINISTRATION.

§ 3.1. Case assignment.

A. The CASA program director shall be responsible for all decisions pertaining to the assignment or removal of specific volunteers to specific cases.

B. A CASA volunteer will not be assigned to a case involving any professional connection or close personal relationship with the child client or family.

§ 3.2. CASA volunteer duties and responsibilities.

A. Volunteers shall follow specific policies regarding the nature of assistance:

1. Provided to the guardian ad litem;

2. Relating to his investigative role; and

3. Relating to monitoring compliance with court orders.

B. The CASA's investigation involves fact-finding via professional reports, observation of family and social interactions, and observation of the child's environment.

C. The CASA's investigation involves the observation of the child's current and ongoing circumstances; CASAs are specifically prohibited from actively seeking from the child information on the precipitating incident or allegation.

D. The CASA volunteer should encourage interdisciplinary coordination and cooperation, whenever possible, in an effort to develop a plan of action in conjunction with other local agencies and professionals.

§ 3.3. Confidentiality.

A. A CASA volunteer shall follow specific policies regarding the following:

1. Reporting suspected child abuse and neglect, and the procedure for making such reports;

2. Confidentiality of records and information which are collected by the volunteer as part of his duties; and

3. Contacting and interviewing persons involved in the case.

B. To the extent permitted by confidentiality regulations (both state and federal), CASA volunteers should share information gathered with other involved professionals whenever possible and practicable.

§ 3.4. Code of ethics.

A. CASA volunteers should conduct themselves in a professional manner, adhering to a code of ethics which is consistent with ethical principles established by local, state or national guidelines.

B. A CASA volunteer should not become inappropriately involved in the case of providing direct service delivery to any parties that could (i) lead to a conflict of interest or liability problems, or (ii) cause a child or family to become dependent on the CASA volunteer for services which should be provided by other agencies or organizations.

C. CASA volunteers should develop a general understanding of the code of ethics of other professionals with whom the CASA will be working.

PART IV.
QUALIFICATIONS OF VOLUNTEERS.

§ 4.1. Qualifications.

A. CASA volunteers must be 21 years of age.

B. CASA volunteers must have the ability to

communicate effectively, both orally and in writing, sufficient to prepare court reports and to provide testimony.

C. CASA volunteers must possess mature judgment, a high degree of responsibility and sufficient time to assist in advocating for the best interests of the child.

D. CASA volunteers must be able to relate to persons of different cultures, ethnic backgrounds and different socioeconomic status.

E. Knowledge of or experience in human services, with an emphasis in child welfare, is preferred.

§ 4.2. Screening.

A. CASA volunteers must successfully complete screening procedures which, at a minimum, shall consist of a written application and personal interview.

B. Pursuant to § 9-173.8 of the Code of Virginia, CASA programs shall conduct a formal security check of the volunteer applicant by screening criminal records through local and state law-enforcement agencies and the Central Child Abuse Registry. If the volunteer applicant has lived in another state within the past 12 months, the CASA program should also conduct criminal records checks in that area. An applicant should be rejected if he refuses to sign a release of information for appropriate law-enforcement checks.

C. CASA volunteers must have three references who will speak to their character, judgment and experience in working with children.

§ 4.3. Training.

CASA volunteers must successfully complete required training as set forth in § 5.1 of this regulation.

PART V.
TRAINING GUIDELINES FOR VOLUNTEERS.

§ 5.1. Training.

A. To ensure that volunteers are fully prepared to perform their role as a CASA and to assume the accompanying responsibilities, each volunteer must participate in a minimum of 25 hours of training prior to being accepted as a CASA and assigned cases. Credit may not be given (towards this 25 hours of training) for any previous training obtained by a volunteer prior to application to a CASA program.

B. The initial training curriculum for a CASA should, at a minimum, include instructions on:

1. The delineation of the roles and responsibilities of a CASA focusing on the rationale for family preservation/permanency planning, discussion of the basic principles of advocacy, distinction between the appropriate and inappropriate activities for a CASA, level of commitment required of a CASA involved in a case and the performance expectations, review of the case assignment process and procedures, differentiation between the role of the CASA and other system personnel, and a comprehensive list of resources available and when and how to utilize these resources;

2. The importance of confidentiality in the work of a CASA, proper record-keeping techniques, and the scope of state and federal statutes on the confidentiality of records;

3. The dynamics of cultural diversity and the development of cultural sensitivity by the CASA;

4. The nature of child abuse and neglect, the impact of drugs/alcohol on the incidence of abuse, identification of the family conditions and patterns which lead to and perpetuate abuse and neglect, and discussions of how social services respond to and assess reports of abuse and neglect;

5. The general principles and concepts of child and family development;

6. Permanency planning in the context of state law with consideration of the state's position on family preservation, family reunification and alternative permanent plans for a child who cannot be returned to the home. Through the critical use of these concepts, discussion of how a case plan is devised;

7. Basic communication and interview skills, with guidelines for dealing with sensitive issues and the interaction between the CASA and other parties to a case, and practice in conducting interviews and writing reports;

8. The juvenile court process which should include an outline of the various types of court events, what transpires at each event, the CASA's role at the event, who to contact when there is a question about the court process, a glossary of legal terminology, how to prepare for a hearing, and how to prepare a report for the court; and

9. The development of advocacy skills, such as negotiation and conflict management, and how they may be used by the CASA to improve the conditions for a child.

C. The initial training program should provide an opportunity for the volunteer to observe actual court proceedings similar to those in which he would be involved as a CASA volunteer. This observation is above and beyond the hours included in the initial training.

D. CASA volunteers in training should be provided an

opportunity to visit community agencies and institutions relevant to their work as a volunteer.

E. The CASA program should provide volunteers in training with the following written materials:

1. Copies of pertinent laws, regulations, and policies;

2. A statement of commitment form clearly stating the minimum expectations of the volunteer once trained; and

3. A training manual which is easy to update and revise.

F. Trainers and faculty for the initial training program and any ongoing training or continuing education should be persons with substantial knowledge, training and experience in the subject matter which they present and should also be competent in the provision of technical training to lay persons.

G. CASA program staff and others responsible for the initial training program should be attentive to the participation and progress of each trainee and be able to objectively evaluate his abilities according to criteria developed by the CASA program for that purpose. CASA directors should use the Comprehensive Training Curriculum for CASA from the National CASA Association and training curricula developed within the state as a reference in designing and developing their training program.

H. The CASA program should make available a minimum of 12 hours of continuing education annually for volunteers who are accepted into the program. These ongoing training programs should be designed and presented to maintain and improve the volunteer's level of knowledge and skill. Special attention shall be given to informing volunteers of changes in the law, local court procedures, the practices of other agencies involved, CASA program policies and developments in the fields of child development, child abuse and child advocacy. Ongoing training may be provided directly by the CASA program, in conjunction with another agency or agencies, or through an outside agency. All training provided by outside agencies must have been reviewed and approved by the CASA program director for its suitability for the continuing education of the CASA volunteers.

I. On an annual basis each CASA volunteer should participate in such continual education activities as determined by the program director.

APPENDIX A

CASA
Quarterly Case Summary

Program Name: _____
Localities Served: _____
Reporting Person: _____
Date: _____
Quarter: _____

Volunteer Activity This Quarter

Volunteers completing training: ____
Volunteers assigned to cases: ____
Volunteers inactive or unassigned: ____
Total volunteer hours: ____ X ____ per hour
Total volunteer $ equivalency: * ____

* Multiply the total number of volunteer hours this quarter by the hourly rate to arrive at the total volunteer $ equivalency.

Children Served This Quarter

AGE
0-24 mos.: ____
2-5 yrs.: ____
6-10 yrs.: ____
11-14 yrs.: ____
15+ yrs.: ____

SEX
Male: ____
Female: ____

RACE
Black: ____
White: ____
Hispanic: ____
Asian: ____
Native American: ____
Other: ____

Cases This Quarter

Holdover cases: ____ # Abuse/Neglect cases: ____
+ # New cases: ____ # Custody cases: ____
= # Total cases: * ____ # CHINS cases: ____

* Add the cases held over from last quarter to the new cases this quarter to arrive at the total number of active cases this quarter.

Total cases: ____ = # Cases per Volunteer: * ____
Volunteers: ____

* Divide the total number of active cases this quarter by the number of active volunteers this quarter to arrive at the average number of cases per volunteer.

New cases not yet assigned: ____
New cases denied (no available volunteer): ____

Closed Cases This Quarter

Total days assigned: ____ = Average assignment length: * ____
Cases closed: ____

* For cases closed this quarter, divide sum of the total duration of all closed cases by the number of closed cases to arrive at the average length of assignment.

Total days out-of-home: ____ = Average length of placement: * ____
Cases closed: ____

* For cases closed this quarter, divide sum of the total duration of out of home placements for all closed cases by the number of closed cases to arrive at the average length of out-of-home placement.

Completed forms should be returned to:
VA Department of Criminal Justice Services
805 E. Broad Street
Richmond, VA 23219
attn: CASA Program

DCJS

APPENDIX B

CASA
Annual Case Summary

Program Name: _____
Localities Served: _____
Reporting Person: _____
Date: _____
Quarter: _____

Volunteer Activity This Year

Volunteers completing training: ____
Volunteers assigned to cases: ____
Volunteers inactive or unassigned: ____
Total volunteer hours: ____ X ____ per hour
Total volunteer $ equivalency: * ____

* Multiply the total number of volunteer hours this year by the hourly rate to arrive at the total volunteer $ equivalency.

Children Served This Year

AGE
0-24 mos.: ____
2-5 yrs.: ____
6-10 yrs.: ____
11-14 yrs.: ____
15+ yrs.: ____

SEX
Male: ____
Female: ____

RACE
Black: ____
White: ____
Hispanic: ____
Asian: ____
Native American: ____
Other: ____

Cases This Year

Holdover cases: ____ # Abuse/Neglect cases: ____
+ # New cases: ____ # Custody cases: ____
= # Total cases: * ____ # CHINS cases: ____

* Add the cases held over from the previous year to the new cases this year to arrive at the total number of active cases this year.

Total cases: ____ = # Cases per Volunteer: * ____
Volunteers: ____

* Divide the total number of active cases this year by the number of active volunteers this quarter to arrive at the average number of cases per volunteer.

New cases not yet assigned: ____
New cases denied (no available volunteer): ____

Closed Cases This Year

Total days assigned: ____ = Average assignment length: * ____
Cases closed: ____

* For cases closed this year, divide sum of the total duration of all closed cases by the number of closed cases to arrive at the average length of assignment.

Total days out-of-home: ____ = Average length of placement: * ____
Cases closed: ____

* For cases closed this year, divide sum of the total duration of out of home placements for all closed cases by the number of closed cases to arrive at the average length of out-of-home placement.

Attach Narrative and Financial Status and return to:
VA Department of Criminal Justice Services
805 E. Broad Street
Richmond, VA 23219
attn: CASA Program

DCJS

APPENDIX C

Annual Case Summary Narrative Form

Program Name: _____

Localities Served: _____

Reporting Person: _____

Date: _____

Year: _____

Use this sheet to detail the program's accomplishments and major changes in program policy or operation during the past year.

Attach to Annual Case Summary Form and return to:
VA Department of Criminal Justice Services
805 E. Broad Street
Richmond, VA 23219
attn: CASA Program

APPENDIX D

Annual Financial Status

Program Name: _____

Localities Served: _____

Reporting Person: _____

Date: _____

Year: _____

Please attach a letter from program's fiscal agent or accountant identifying who is responsible for maintaining the fiscal records, stating where the fiscal records are routinely kept and a statement, prepared in accordance with generally accepted accounting practices, showing the total cash receipts and disbursements for the CASA Program for the past year.

Attach to Annual Case Summary Form and return to:
VA Department of Criminal Justice Services
805 E. Broad Street
Richmond, VA 23219
attn: CASA Program

DEPARTMENT FOR THE DEAF AND HARD-OF-HEARING

Title of Regulation: **VR 245-02-01. Regulations Governing Eligibility Standards and Application Procedures for the Distribution of Telecommunications Equipment.**

Statutory Authority: § 63.1-85.4 of the Code of Virginia.

Public Hearing Date: January 21, 1992 - 4 p.m.
(See Calendar of Events section for additional information)

Summary:

These regulations are used to screen applicants for the Telecommunications Assistance Program and to determine the applicant's contribution or payment towards the purchase of telecommunications equipment, if any. The amendments specifically exclude applicants from contributing towards purchase and retaining ownership of telecommunications equipment costing or having a value of $5,000 or more. Additionally, the amendments reflect experience gained with the Telecommunications Assistance Program since its inception.

VR 245-02-01. Regulations Governing Eligibility Standards and Application Procedures for the Distribution of Telecommunications Equipment.

PART I.
DEFINITIONS.

§ 1.1. Definitions.

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

~~"Amplified handset"~~ *"Amplification device"* means a ~~mechanical~~ device that amplifies either incoming sounds for ~~hearing-impaired persons~~ *individuals who have a hearing loss* or outgoing sounds for ~~speech-impaired persons~~ *individuals who have a speech disability* .

"Applicant" means a person who applies for telecommunications equipment.

"Application" means the TAP Application (VDDHH-TDD-1).

"Audiologist" means any person who accepts compensation for examining, testing, evaluating, treating or counseling persons having or suspected of having disorders or conditions affecting hearing and related communicative disorders or who assists persons in the perception of sound and is not authorized by another regulatory or health regulatory board to perform any such services.

"Braille ~~TDD~~ *text telephone*" means ~~an electrical~~ *a* device for use with a telephone *line* that utilizes a ~~keyboard, an acoustic coupler, a visual display and a braille display~~ *nonvoice terminal and braille keyboard and display* to transmit and receive messages.

"Completion date" means the date all supporting documentation for the application is received by the department.

"Coordinator" means the *Telecommunications Assistance Program* Coordinator ~~for Statewide Telecommunications Programs for the Deaf~~ of the Virginia Department for the Deaf and Hard-of-Hearing.

"Coupon" means a voucher which may be used by the ~~recipient~~ *applicant* as credit toward the purchase of approved telecommunications equipment from a contracted vendor.

"Deaf" means ~~the presence of a hearing impairment~~ *a hearing loss* that requires use of a ~~telecommunications device for the deaf~~ *text telephone* to communicate effectively on the telephone.

"Deaf-blind" means ~~the presence of a hearing impairment and a visual impairment~~ *a dual loss of hearing and vision* that requires use of a braille ~~or large print TDD~~ *text telephone* to communicate effectively on the telephone.

"Department" means the Virginia Department for the Deaf and Hard-of-Hearing.

"Director" means the Director of the Virginia Department for the Deaf and Hard-of-Hearing.

"Family" means the applicant, his dependents , ~~and~~ *or* any person legally required to support the applicant, including spouses.

"Gross income" means the income, total cash receipts before taxes from all sources of the applicant, his dependents , ~~and~~ *or* any person legally required to support the applicant including spouses.

"Hearing aid specialist/dealer" means a person who accepts compensation for evaluating hearing for the purpose of fitting appropriate hearing aids.

"Hearing-impaired/visually-impaired" means a dual loss of hearing and vision that requires use of large print text telephone or a braille text telephone to communicate effectively on the telephone.

"Manager" means the Telecommunications Programs Manager of the Virginia Department for the Deaf and Hard-of-Hearing.

"Minor" means a person less than 18 years of age whose parents are legally responsible for his support.

"Outreach specialist" means a person hired by the

department to provide outreach services and to assist the department in carrying out activities related to the Telecommunications Assistance Program on either a regional or local level.

"Physician" means a person who has a medical degree and a license to practice medicine in any one of the United States.

"Program" or *"TAP Program"* means Telecommunications Assistance Program for distributing telecommunications equipment to *individuals who are* deaf, severely hearing-impaired, *hearing-impaired/visually-impaired,* deaf-blind ~~and~~ *or* speech-impaired ~~persons~~ *and* who meet eligibility requirements through an application process.

"Public assistance" means and includes aid to dependent children; auxiliary grants to the aged, blind and disabled; medical assistance; food stamps; general relief; fuel assistance; and social services.

"Recipient" means a person who receives telecommunications equipment ~~or a coupon valid toward the purchase of the equipment~~ .

"Ring signal device" means a ~~mechanical~~ device that alerts ~~a~~ *an individual who is* deaf, severely hearing-impaired , *hearing impaired/visually-impaired* or deaf-blind ~~person~~ of an incoming call.

"Severely hearing-impaired" means a hearing loss that requires use of either a ~~Telecommunications Device for the Deaf~~ *text telephone* or an ~~amplified telephone handset~~ *amplification device* to communicate effectively on the telephone.

"Speech-impaired" means a loss of verbal communication ability which prohibits normal usage of a standard telephone handset.

"Speech pathologist" means any person who accepts compensation for examining, testing, evaluating, treating or counseling persons having or suspected of having disorders or conditions affecting speech, voice or language and is not authorized by another regulatory or health regulatory board to perform any such services.

~~"Telecommunications devices for the deaf, hereinafter called TDD" means an electrical device for use with a telephone that utilizes a keyboard, acoustic coupler and display screen to transmit and receive messages.~~

"Telecommunications equipment" means any ~~mechanical~~ adaptation for a telephone needed by ~~a~~ *individuals who are* deaf, ~~a~~ hearing-impaired , *hearing-impaired/visually-impaired, deaf-blind* or ~~a~~ speech-impaired ~~person~~ in order to use the telephone, including ~~amplified handsets~~ *amplification devices* , ring signaling devices, and braille, large-print or regular-print ~~TDDs~~ *TTs* .

"Text telephone" (hereinafter called TT) means a nonvoice terminal device used to transmit and receive messages via telephone. This includes, but is not limited to, telecommunications devices for the deaf (TDD/TTY) and computer modems.

PART II.
DETERMINING OWNERSHIP.

§ 2.1. Ownership guidelines.

A. Any telecommunications device or component distributed through the program is the property of the individual recipient except for any device which, individually, has a value or cost in excess of $5,000 at the date of acquisition.

B. The department shall retain ownership of any telecommunications device or component distributed through the program that costs $5,000 or more.

Where ownership of telecommunications devices or components is retained by the department, the department, in its discretion, may suspend part or all of the following regulations as deemed necessary.

PART ~~II~~ *III* .
PARTICIPATION OF APPLICANT.

§ ~~2.1.~~ *§ 3.1.* Eligibility requirements.

Upon request for telecommunications equipment by an applicant, the department will require information as to the family size, financial status, and other related data as described on the application. It is the applicant's responsibility to furnish the department with the correct financial data in order to be appropriately classified according to income level and to determine applicable charges for telecommunications equipment. Applicants eligible to participate in the program shall meet the following requirements:

1. The applicant must be certified as deaf, severely hearing-impaired, *hearing-impaired/visually-impaired,* deaf-blind, or speech-impaired by a licensed physician, audiologist, speech-language pathologist, vocational rehabilitation counselor employed by the Department of Rehabilitative Services or the Department for the Visually Handicapped, a Virginia School for the Deaf and Blind representative, *a Virginia Department for the Deaf and Hard-of-Hearing Outreach Specialist* or other appropriate agency or government representative.

2. The applicant shall reside in the Commonwealth of Virginia.

3. An applicant shall submit a completed *and signed* application.

§ ~~2.2.~~ *§ 3.2.* Charges for equipment.

Eligible applicants shall be granted program participation based on a first-come, first-served basis and the availability of program funds. The participation of applicants shall be by coupon. (See Part ~~IV~~ *V* .) The approved applicant may use his coupon in addition to his contribution, as defined in subdivisions A 1 and 2 ~~of~~ § ~~2.2~~ of ~~these regulations~~ *this section* , to purchase the approved equipment at the state contract rate.

A. Cost of the program to applicant.

If the individual or family monthly gross income is such that a charge for telecommunications equipment is required, an explanation of the charges shall be provided to the recipient.

1. An applicant shall not be required to participate in the cost of telecommunications equipment ~~if his individual or family monthly gross income is~~ :

a. If his individual or family monthly gross income is:

~~a.~~ *(1)* Obtained solely from, any one or combination of, public assistance, as defined in Part I of these regulations, earnings of minor children or gifts, or any combination thereof; or

~~b.~~ *(2)* Less than or equal to the Economic Needs Guidelines found in subdivision A 3 ~~of~~ § ~~2.2~~ of ~~these regulations~~ *this section* .

b. If ownership of telecommunications devices or components is retained by the department.

2. Any other applicant shall be required to participate in the cost of any telecommunications equipment distributed to the applicant. The portion paid by the applicant to the vendor shall be equal to the amount which his individual or family monthly gross income exceeds the following Economic Needs Guidelines. However, this amount shall not exceed the approved equipment total price or $75, whichever is lower.

3. Statewide Economic Needs Guidelines. The same formula used to determine the following sets of Economic Needs Guidelines shall be applied where the number of family members exceeds six.

	Monthly Gross Income	Annual Gross Income
Family of 1	$1,210	$14,520
Family of 2	1,583	18,996
Family of 3	1,995	23,940
Family of 4	2,327	27,924
Family of 5	2,699	32,388
Family of 6	3,072	36,864

a. Northern Virginia Economic Needs Guidelines. To be used for applicants residing in Arlington, Fairfax, Loudoun, and Prince William counties and the incorporated cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park.

	Monthly Gross Income	Annual Gross Income
Family of 1	$1,319	$15,828
Family of 2	1,726	20,712
Family of 3	2,175	26,100
Family of 4	2,537	30,444
Family of 5	2,942	35,304
Family of 6	3,349	40,188

b. If an applicant is paying monthly installments toward a debt(s), then the amount of one monthly installment will be subtracted from the applicant's expected contribution before the valid amount of the coupon is determined, under the following conditions:

~~1.~~ *(1)* The debt(s) is owed for nonpreventative medical or dental services; and

~~2.~~ *(2)* The debt(s) is owed by or for the applicant or individuals whom the applicant is legally responsible to support or is legally supported by.

§ ~~2.3.~~ *§ 3.3.* Type of equipment.

The applicant must choose the type(s) of equipment requested based upon the applicant's sensory loss. The equipment available through the program includes: ~~TDDs, braille TDDs, amplified handsets and ring signal devices.~~ *TTs, large print TTs, braille TTs, amplification devices and ring signal devices.*

PART ~~III~~ *IV* .
APPLICATION PROCEDURES.

§ ~~3.1.~~ *§ 4.1.* The application may be obtained from the department or the department's outreach specialists or other authorized distribution centers. Completed applications shall be forwarded to:

Virginia Department for the Deaf and Hard-of-Hearing
ATTN: TAP Program
Washington Building
Capitol Square
1100 Bank Street
12th Floor
Richmond, VA 23219-3640.

The VDDHH telephone number is 1-800-552-7917 (V/ ~~TDD~~ *TT*) or (804) 225-2570 (V/ ~~TDD~~ *TT*).

§ ~~3.2.~~ *§ 4.2.* Processing applications.

A. The coordinator shall approve all applications for which eligibility requirements defined in § ~~2.1~~ *§ 3.1* are satisfied, except as provided in subsections B ~~and~~ , C , *and D* of this regulation.

B. Original application shall not be approved:

1. When the applicant has already been issued a coupon which is still valid towards the purchase of telecommunications equipment under this program.

2. When the applicant has received a device from the TAP Program within the preceding four years.

C. Application for replacement equipment shall not be approved when:

1. A device previously issued by the department has been subjected to abuse, misuse or unauthorized repair by the recipient.

2. The recipient fails to provide a police report of a stolen device or refuses to cooperate with the police investigation or in the prosecution of the suspect, including the refusal to testify in court when requested to do so.

3. The recipient is found negligent in the police report, such as doors to the house or car left unlocked or unattended.

4. The recipient has lost the device.

5. The recipient has sold the device.

D. Replacement equipment may be given within a four-year period if telecommunications equipment is damaged through natural disasters, such as lightning, electrical storms, or floods. The recipient must first send damaged equipment to the vendor. If the vendor certifies to the department that the equipment, provided it is still under valid warranty, is unrepairable due to natural disaster, a replacement unit shall be issued to the recipient, upon reapplication, either free or up to $75, depending on eligibility criteria as outlined in § 3.2.

E. Exchange of equipment may be permitted only where the original equipment can no longer be used by a recipient due to deteriorating vision or hearing. A recipient must obtain a letter from a physician stating that the recipient has deteriorating vision or hearing and can no longer benefit from the equipment currently used by the recipient and that the recipient would benefit from another device available through TAP.

F. Eligibility requirements regarding financial data and family size shall not be required by the department if ownership of telecommunications devices or components is retained by the department.

§ ~~3.3.~~ *§ 4.3.* Notice of action on approved or denied applications.

The recipient shall be notified of a decision regarding an original application within 30 days of the completion date.

§ 4.4. If a recipient obtained telecommunications equipment under false premises or misrepresentation of facts on the TAP application, the department reserves the right to demand return of such equipment. Such a recipient may be prosecuted to the fullest extent of the law.

PART ~~IV~~ *V* .
COUPON SYSTEM.

§ ~~4.1.~~ *§ 5.1.* Coupons.

A coupon for purchase of telecommunications equipment based on an original application will be processed as follows:

1. The TAP Program Coordinator shall issue coupons varying in amount, but not exceeding the equipment's contracted price, for the purchase of approved equipment to persons determined to be eligible for the program. The coordinator will attach a list of contracted vendors who sell the approved telecommunications equipment.

Coupons shall not be issued if the department retains ownership of the telecommunications device or component.

2. The coupon shall entitle the ~~recipient~~ *applicant* to purchase the approved equipment at the state-contract rate.

3. The ~~recipient~~ *applicant* shall present or send the coupon to the vendor to make a purchase of approved equipment within ~~30 days of the coupon's issuance date~~ *the specified time period indicated on the coupon* .

4. The coupon shall have the signature and signature date of the ~~recipient~~ *applicant* . The signature date indicates the order date for approved equipment by the ~~recipient~~ *applicant* .

5. The vendor shall complete its section of the coupon, including signature and date, documenting the corresponding serial numbers for all approved equipment. The serial number for all equipment shall be required for reimbursement.

6. Within ~~30 days of the order date~~ *the specified time*

period on the coupon , the vendor shall forward the coupon to the Virginia Department for the Deaf and Hard-of-Hearing (VDDHH). An invoice for payment shall accompany the coupon for reimbursement. When submitting the coupon and invoice for payment, the vendor shall provide proof of delivery to the recipient's home address. This proof shall include a signature indicating receipt of the approved equipment.

7. Payment reimbursed from VDDHH to the vendor shall not exceed the valid amount, found in the upper right-hand corner, of the coupon.

8. The difference between the equipment's state-contracted price under the program and the value of the coupon will be collected by the vendor from the recipient.

9. Upon receipt of the authorized coupon, accompanying invoice, and confirmation of satisfactory delivery of the equipment, VDDHH will process an accounting voucher for the valid amount. The agency accounting voucher will be processed with an appropriate due date in accordance with the terms and conditions set forth in the Commonwealth's Prompt Payment Act.

~~§ 4.2. Ownership.~~

~~All telecommunications devices distributed through the program are the property of the recipient.~~

~~§ 4.3.~~ *§ 5.2.* Liability.

Recipients shall be responsible for any repairs to or loss of a device issued in the program , *except where the department retains ownership of the device* .

PART ~~V~~ *VI* .
CONFIDENTIALITY.

~~§ 5.1.~~ *§ 6.1.* Confidentiality.

All TAP applications and other client materials shall be kept confidential by department personnel and other persons authorized by the department to view such materials. An applicant's award shall also be confidential and shall not be released without the applicant's permission.

VDDHH
Virginia Department for the Deaf and Hard of Hearing

FOR OFFICE USE ONLY

Date Received	/	Date Complete	Region	City County	Application #

TELECOMMUNICATIONS ASSISTANCE PROGRAM (TAP)

All information is confidential.

ALL INFORMATION MUST BE FILLED IN.

1. NAME OF PERSON WHO WILL USE THIS EQUIPMENT: _____ (First / MI / Last)

2. THIS IS MY FIRST TAP APPLICATION: ___ YES ___ NO

3. BIRTHDATE: ___ / ___ / ___

4. APPLICANT IS: ☐ MARRIED ☐ SINGLE ☐ LEGALLY SEPARATED ☐ DIVORCED ☐ WIDOWED

5. SPOUSE NAME: _____ (First / MI / Last)

6A. HOME ADDRESS: (NO POST OFFICE BOXES!)

_____ (Number / Street Name / Apt. #)

_____ (City / State / Zip)

6C. _____ CITY/COUNTY APPLICANT LIVES IN

6B. IF APPROVED, WHERE DO YOU WANT YOUR EQUIPMENT SHIPPED TO? (MUST BE IN VIRGINIA ONLY)

☐ Home Address as Listed in 6A

☐ Other:

Name: _____ (First / MI / Last)

Street Address: _____ (Number / Street Name / Apt. #)

_____ (City / State / Zip)

7. YOUR TELEPHONE NUMBERS:

HOME: (___) _____ ___ TDD ___ Voice

WORK: (___) _____ ___ TDD ___ Voice

8. NAME OF PERSON ON HOME TELEPHONE BILL:

_____ (First / MI / Last)

9. YOUR WHOLE FAMILY MONTHLY INCOME (BEFORE TAXES):

$ _____

10. FAMILY SIZE (INCLUDE YOURSELF): _____

11. WHERE DO YOU GET YOUR INCOME? *(Use Instruction Codes on the back)*

_____

12. I AM:
- ☐ Deaf
- ☐ Severely Hearing-Impaired
- ☐ Deaf-Blind
- ☐ Hearing-Impaired/Visually-Impaired
- ☐ Speech-Impaired

13. EQUIPMENT:

GROUP 1 Check (✓) one box
- ☐ Electric-Powered In-Line Amplifier
- ☐ Battery-Powered In-Line Amplifier
- ☐ TDD (Telecommunications Device for the Deaf)
- ☐ Large Print TDD*
- ☐ Braille TDD*
- ☐ Speech Amplifier**
- ☐ Other _____

GROUP 2 Check (✓) one box
- ☐ Audible Ring Signaler
- ☐ Visual Ring Signaler
- ☐ Tactile Ring Signaler*
- ☐ Other _____

*FOR HEARING-IMPAIRED/VISUALLY-IMPAIRED OR DEAF-BLIND APPLICANTS ONLY.
**FOR SPEECH-IMPAIRED APPLICANTS ONLY.

14. DO YOU NEED TRAINING TO USE THIS EQUIPMENT? ☐ YES ☐ NO

15. **APPLICANT CERTIFICATION:**

I CERTIFY:
1 – All information on this application is true.
2 – I live in Virginia.
3 – I am hearing-impaired and/or speech-impaired.
4 – YOUR WHOLE FAMILY MONTHLY INCOME (Question #9) is the total gross monthly income my family earns in one month.

I UNDERSTAND:
1 – **If any information on this application is not true I will have to give all equipment back to VDDHH.**
2 – I accept responsibility for the machines.
3 – I accept responsibility for all repair and maintenance costs.
4 – I accept responsibility for all of my telephone bills.

APPLICANT SIGNATURE _____ Soc. Sec. # ___ / ___ / ___ Date: ___ / ___ / ___

PARENT OR GUARDIAN: _____ Soc. Sec. # ___ / ___ / ___ Date: ___ / ___ / ___

16. PROFESSIONAL CERTIFICATION (Take this application to one of the professionals listed below. They must fill out this section and return the application to you.)

- ☐ Doctor (licensed physician)
- ☐ Audiologist
- ☐ Speech Pathologist
- ☐ VDDHH Outreach Specialist
- ☐ Va. School for the Deaf Rep.
- ☐ DRS or DVH Rep.
- ☐ Other appropriate agency Rep. (check with VDDHH)

ABOVE CLIENT IS (please check one):
- ☐ Deaf
- ☐ Severely Hearing-Impaired
- ☐ Speech-Impaired
- ☐ Hearing-Impaired/Visually-Impaired
- ☐ Deaf-Blind
- ☐ Other _____

I Certify: That this applicant meets the definition of "Deaf," "Severely Hearing-Impaired," "Hearing-Impaired/Visually-Impaired," "Deaf-Blind" or "Speech-Impaired" given on the reverse side of this application. (Please see back of this form for a definition of each impairment and a description of each device.)

Name of Certifying Person: _____ Title: _____

Name of Agency: _____ State Lic. # (if applicable): _____

Address: _____ Day Phone Number: (___) _____

Signature: _____ Date: ___ / ___ / ___

Applicants for this program shall be afforded equal opportunity without regard to race, color, religion, national origin, political affiliation, handicap, sex or age.
Mail completed application to: VDDHH-TAP/Washington Building Capitol Square/1100 Bank Street, 12th Floor/Richmond, VA 23219-3640. For more information, call: 1-800-552-7917 TDD/V.

[VDDHH TDD-1 Revised 95]

TAP APPLICATION INSTRUCTIONS

ALL INFORMATION LISTED ON THE APPLICATION IS CONFIDENTIAL!

ALL QUESTIONS ARE TO BE ANSWERED BY THE PERSON WHO WILL BE USING THE EQUIPMENT. IF THE PERSON IS A MINOR, A PARENT OR GUARDIAN SHOULD LIST ANSWERS FOR THE MINOR (i.e. for question #2, put down the minor's name, not the parent's or guardian's name).

Important! Follow the directions carefully.

If any answers are incorrect, inconsistent or left blank, the application process will be delayed and you may have to fill out additional forms.

You must write an answer to every question on the TAP Application! (Do not write in the shaded areas.)

1. **Name of Person Who Will Use This Equipment**
   Print your full legal name; first name, middle initial and last name.
2. **This is My First TAP Application**
   Check (✓) "YES" if you have not received equipment through this program before.
3. **Birthdate**
   Use numbers. For example: August 11, 1956 = 8/11/56
4. **Applicant is:**
   Married Single Legally Separated Divorced Widowed
   Check the box that relates to the person who will use this equipment, not the parent.
5. **Spouse Name**
   Write the first name, middle initial and last name of the spouse of the person who will use this equipment, not the parent. If none, write "none" in the space.

6A. **Home Address**
Print your complete home (street) address. A P.O. Box is not acceptable.

6B. **Shipping Address**
If the address is different, print your complete mailing address (including P.O. Box, R.D. #, etc.). It must be a Virginia address.

6C. **City/County Applicant Lives In**
For example, you may live in Roanoke City or Roanoke County. If you live in Chatham, you should write Pittsylvania County.

7. **Telephone Numbers**
   Write your telephone numbers. If you don't have a telephone number, then write in "none."
8. **Name of Person Listed on Home Telephone Bill**
   Write the first name, middle initial and last name of the person as it appears on your monthly home telephone bill.
9. **Your Whole Family Monthly Income (Before Taxes)**
   Put down the TOTAL dollar amount that you, your spouse, your children (and anyone else that you are legally required to support or that you claimed on your most recent income tax return) made in one month before taxes or other deductions (for example, you make $1300 a month from work, your spouse gets $800 a month from a private pension plan and your child gets $100 a month from a trust fund: $1300 + $800 + $100 = $2200 per month). PUT DOWN ONLY THE TOTAL AMOUNT.
10. **Family Size (Include Yourself)**
    List the number of people that you are legally required to support or that you claimed on your most recent income tax return. BE SURE TO COUNT YOURSELF! (For example, you have a spouse and three children: 1 + 3 + yourself = 5.) If you did not fill out a tax return, count the number of relatives living with you.
11. **Where Do You Get Your Income?**
    Write in where the money in "Your Whole Family Monthly Income" comes from using the codes below. (Example: If your money comes from salary/wages, you would write an "A" in the space.) Use as many letters as you need to show where all your money comes from.

CODES FOR QUESTION 11.

A	Salary/ Wages	I	(Continued) Social Services (SSI and SSDI or SSA)—not regular Social Security retirement; Auxiliary Grants to the aged, blind or disabled; Medical Assistance (Medicaid); Food Stamps General Relief; and Fuel Assistance
B	Self-Employed (money after business deductions)		
C	Unemployment Compensation		
D	Worker's Compensation (if you were injured on the job)		
E	Veteran's Benefits		
F	Private Pension (Retirement)		
G	Government Employee Pension	J	Earnings of minor children
H	Alimony	K	Gifts
I	Public Assistance Includes: Aid to Dependent Children (ADC or AFDC);	L	Regular Social Security (Retirement); Medicare
		M	Other (Specify on application)

12. **Classification**
    Check only one box that describes you: Deaf, Severely Hearing-Impaired, Hearing-Impaired/Visually-Impaired, Deaf-Blind, or Speech-Impaired.
13. **Equipment**
    Check (✓) only one type of equipment in each group. The following lists are a guide to help you pick the right equipment:
    DEAF: must have a TDD to communicate on the telephone.
    SEVERELY HEARING-IMPAIRED: must have either a TDD or an in-line amplification device to communicate on the telephone.
    HEARING-IMPAIRED/VISUALLY-IMPAIRED: must have either a Large Print TDD or a Braille TDD to communicate on the telephone.
    DEAF-BLIND: must have a Braille TDD to communicate on the telephone.
    SPEECH-IMPAIRED: must have either a TDD or a speech amplification device to communicate on the telephone.
    OTHER: (only when new equipment is approved by VDDHH).
14. **Do You Need Training to Use This Equipment?**
    Check "yes" if you want to learn how to use the equipment.
15. **Applicant Certification**
    Read all statements in this section. If all is clearly explained to you and you agree and all of your information is true, then sign your name, social security number and today's date (use numbers).
    All applicants, regardless of age, must have their social security number on the application. Applicants who are 7 years old or older must also have their signature on the application.
    If the applicant is under 18 years old, then the mother, father or legal guardian must also sign the application, and put their social security number and today's date on the second line provided.
16. **Professional Certification**
    Take this application to any one of the kinds of professionals listed in this section. They must fill out the section, certify your impairment and give the application back to you.
    VDDHH must approve a person not listed in this section.

CHECK YOUR APPLICATION BEFORE MAILING IT!!
Did you sign your name?
Write your social security number?
Fill in today's date?
Check the equipment you want?
Have a doctor or other listed professional sign your application?

Mail This Application To: **Virginia Department for the Deaf and Hard of Hearing**
Washington Building, Capitol Square
1100 Bank Street, 12th Floor
Richmond, VA 23219-3640

If you do not get a telephone call or letter from VDDHH within six weeks, call: 1-800-552-7917 TDD/V.

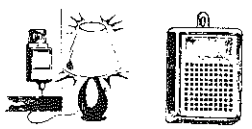
TDD

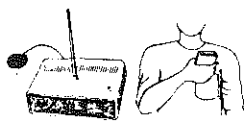
Telecommunications Device for the Deaf: A **TDD** is a machine that looks like a small typewriter. To use it you put your telephone handset on the TDD. The person you are talking to must also have a TDD.

Large Print TDDs are available for hearing-impaired/visually-impaired people.

Ring Signalers

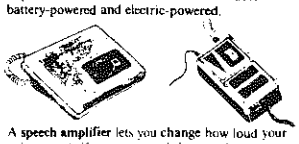
A Ring Signaler is a machine that helps you know when someone is calling you on the telephone. There are 3 kinds of Ring Signalers: **Visual** (light); **Audible** (loud); and **Tactile** (vibrating for Deaf-Blind).





Amplification Devices

A **volume amplifier** lets you control how loud the person you are talking to sounds if you are hearing-impaired. There are two kinds of in-line devices: battery-powered and electric-powered.



A **speech amplifier** lets you change how loud your voice sounds if you are speech-impaired.

Braille TDDs are available for Deaf-Blind people.

Virginia Department for the Deaf and Hard of Hearing

Telecommunications Assistance Program (TAP)
Equipment Coupon

Name
Street Address
City, State, Zip Code
#SSN

Coupon No.:

Recipient Must Redeem By:

Amount:

(This section must be completed by the recipient.)

( ) ___ - ____
HOME PHONE NUMBER

RECIPIENT'S SIGNATURE

__/__/__
DATE

(This section is for use by vendor and staff only. Vendor must complete required items for reimbursement.)

	SERIAL NUMBER	VERIFICATION	DATE
Type of Device			__/__/__
Vendor's Signature	__/__/__ Date	Coordinator's Signature	__/__/__ Date

Vendor Expiration Date:

(Please accompany this coupon with an invoice for payment)
[VDDHH-TDD2, 08/91]

VDDHH
Washington Building, Capitol Square
1100 Bank Street, 12th Floor
Richmond, VA 23219-3640
1-800-552-7917 [Voice/TDD]
(804) 225-2570 [Voice/TDD]

WARNING!!

Please check this coupon carefully to make sure that this is the equipment you want. Once you get your equipment, it can NOT be exchanged for another kind of equipment. If you don't want the equipment that is on the coupon, please return this coupon to us now and tell us what you want.

REMINDER!!

If you go to Potomac Technology to pick up your TDD, you MUST show a valid Virginia Driver's License or Virginia ID card.

DEPARTMENT OF GENERAL SERVICES

Title of Regulation: **VR 330-05-01. Regulations for the Approval of Field Tests for Detection of Drugs.**

Statutory Authority: §§ 2.1-424 and 19.2-188.1 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until January 31, 1992.
(See Calendar of Events section for additional information)

Summary:

Section 19.2-188.1. of the Code of Virginia (effective March 1, 1992) permits a law-enforcement officer to testify to the results of field tests performed on controlled substances, imitation controlled substances or marijuana, as defined in § 18.2-247, in any preliminary hearing on a violation of Article 1 (§ 18.2-247 et seq.) of Chapter 7 of Title 18.2. The Division of Forensic Science has been designated to approve such field tests. These regulations describe the requirements for application and approval of such field tests or field test kits.

The regulations also describe the approval authority, criteria for approval, the approval process and the publication of a list of approved field tests or field test kits in the Virginia Register of Regulations.

VR 330-05-01. Regulations for the Approval of Field Tests for Detection of Drugs.

§ 1. Definitions.

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

"Agency" means any law-enforcement officer or group of law-enforcement officers in the Commonwealth.

"Approval authority" means the Director of the Division of Forensic Science or designee.

"Division" means the Division of Forensic Science, Department of General Services.

"Drug" means any controlled substance, imitation controlled substance, or marijuana, as defined in § 18.2-247.

"Field test" means any presumptive chemical test unit used outside of a chemical laboratory environment to detect the presence of a drug.

"Field test kit" means a combination of individual field tests units.

"List of approved field tests" means a list of field tests or field test kits approved by the division for use by law-enforcement agencies in the Commonwealth and periodically published by the division in the Virginia Register of Regulations in accordance with § 19.2-188.1.

"Manufacturer" means any entity which provides field test units or field test kits to any law-enforcement officer or agency in the Commonwealth for the purpose of detecting a drug.

"Manufacturers instructions and claims" means those testing procedures, requirements, instructions, precautions and proposed conclusions which are published by the manufacturer and supplied with the field tests or field test kits.

"Street drug preparations" means any drug or combination of drugs and any other substance which has been encountered or is likely to be encountered by a law-enforcement officer as a purported drug in the Commonwealth.

§ 2. Regulations.

A. Section 19.2-188.1 of the Code of Virginia provides that the Division of Forensic Science shall approve field tests for use by law-enforcement officers to enable them to testify to the results obtained in any preliminary hearing regarding whether or not any substance the identity of which is at issue in such hearing is a controlled substance, imitation controlled substance, or marijuana, as defined in § 18.2-247.

B. Any manufacturer who wishes to have field tests or field test kits approved shall submit a written request for approval to the division director. Materials sufficient for at least 10 field tests shall be supplied for each drug for which the manufacturer requests approval. The materials shall include all instructions, precautions, color charts, flow charts and the like which are provided with the field test or field test kit and which describe the use and interpretation of the tests.

The manufacturer shall also include exact specifications as to the chemical composition of all chemicals or reagents used in the field tests. These shall include the volume or weight of the chemicals and the nature of their packaging.

This approval will require at least 120 days from the receipt of the written request and all needed materials from the manufacturer.

C. The division will use commonly encountered "street drug preparations" to examine those field tests for approval. In order to be approved, the field test must correctly react in a clearly observable fashion to the naked eye, and perform in accordance with manufacturers instructions and claims.

D. Upon completion of such testing and in concurrence with the approval authority, a list of approved field tests will be published forthwith by the division in the Virginia Register of Regulations in accordance with the Administrative Process Act. The division may, in addition, provide copies of its approval list to any agency subject to these regulations. The division may share any information or data developed from this testing with these agencies.

E. If any modifications are made to any field test by the manufacturer, the field test must be approved before it can be used in accordance with § 19.2-188.1. These changes shall include, but are not limited to any chemical, procedural or instructional modifications made to the field test.

F. The division assumes no liability as to the safety of these field tests or field test kits, any chemicals contained therein or the procedures and instructions by which they are used.

The division further assumes no responsibility for any incorrect results or interpretations obtained from these inherently tentative presumptive chemical tests.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: **State Plan for Medical Assistance Relating to Mortgage Debt Refinancing, Nursing Facility Rate Change, and Technical Language Changes. VR 460-03-4.1940:1. Nursing Home Payment System (PIRS)**

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

Public Hearing Date: N/A – Written comments may be submitted until January 31, 1992.
(See Calendar of Events section for additional information)

Summary:

The purpose of this proposal is to promulgate permanent regulations to supersede existing emergency regulations providing for mortgage debt refinancing incentive, nursing facility rate change, and technical language changes.

The sections of the State Plan for Medical Assistance which are affected by this proposed regulation are as follows: VR 460-03-4.1940:1: §§ 2.4, 2.7, and 2.8.1.

Section 2.4 of the NHPS methodology currently provides that mortgage refinancing is permitted where the refinancing would result in a cost savings from lower rates. In other words, refinancing is permitted when it benefits the Commonwealth, but the provider has been given no specific incentive to refinance.

A DMAS study found that 18 of the responding providers had existing mortgage rates of between 11% and 15%. Nine of these providers have rates that are capped by existing interest rate upper limit provisions of the NHPS. There are approximately nine facilities that could be affected by the amendment at this time.

Therefore, § 2.4 is being modified to encourage mortgage refinancing by providing incentive payments which will be made when the refinancing benefits both the Commonwealth and the provider, as mandated by the 1991 General Assembly. This provision was the subject of an earlier emergency regulation.

Section 2.7 contains the nursing facility reimbursement formula which provides for peer group ceilings. The peer group ceilings are derived from facilities' allowable operating rates. This amendment clarifies the phrase "from the effective date of such 'interim' ceilings" as contained in § 2.7 B 1. The phrase was intended to remove duplicative allowances for inflation during adjustment of peer group medians pursuant to § 2.7 A 5 c. For most providers, the calculation of the estimated reimbursement rate for FY '91 under § 2.7 A 5 a already has an inflation allowance forecasted in the providers' fiscal years extending into FY '92. For the remaining providers, there is a forecasted inflation allowance calculated in § 2.7 A 5 a for FY '91 which is partially duplicated by an historical inflation allowance calculated in § 2.7 A 5 b for FY '91. Without this amendment, the phrase in question could be interpreted as allowing both historical and forecasted inflation adjustments for the same period of time. This was never the intent of the methodology.

Section 2.8.1 provides for the overall reduction of nursing facility per diem operating cost rates. The amendment is being made to permit the Commonwealth of Virginia and concomitantly HCFA to participate in the benefits of cost management efficiencies achieved by NF's since 1982. DMAS is adjusting per diem operating cost rates effective on or after July 5, 1991, for all NF's to produce a projected reduction of $5 million during the period from July 1, 1991, through June 30, 1991. The proposed rate change will reduce projected NF reimbursement by approximately 1.2% during fiscal year 1992 and will result in operating cost rates which, for the majority of NFs, are still above the peer group operating cost medians.

VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).

PART I.
INTRODUCTION.

§ 1.1. Effective October 1, 1990, the payment methodology for Nursing Facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set

forth in the following document. The formula provides for incentive payments to efficiently operated NFs and contains payment limitations for those NFs operating less efficiently. A cost efficiency incentive encourages cost containment by allowing the provider to retain a percentage of the difference between the prospectively determined operating cost rate and the ceiling.

§ 1.2. Three separate cost components are used: plant cost, operating cost and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

§ 1.3. In determining the ceiling limitations, there shall be direct patient care medians established for NFs in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for NFs in the Virginia portion of the Washington DC-MD-VA MSA, and in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Health Care Financing Administration (HCFA). A NF located in a jurisdiction which HCFA adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

§ 1.4. Institutions for mental diseases providing nursing services for individuals age 65 and older shall be exempt from the prospective payment system as defined in §§ 2.6, 2.7, 2.8, 2.19, and 2.25, as are mental retardation facilities. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare and Medicaid principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

§ 1.5. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see VR 460-03-4.1941, Uniform Expense Classification) and must be identifiable and verified by contemporaneous documentation.

All matters of reimbursement which are part of the DMAS reimbursement system shall supercede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.

PART II.
RATE DETERMINATION PROCEDURES.

Article 1.
Plant Cost Component.

§ 2.1. Plant cost.

A. Plant cost shall include actual allowable depreciation, interest, rent or lease payments for buildings and equipment as well as property insurance, property taxes and debt financing costs allowable under Medicare principles of reimbursement or as defined herein.

B. To calculate the reimbursement rate, plant cost shall be converted to a per diem amount by dividing it by the greater of actual patient days or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.

C. For NFs of 30 beds or less, to calculate the reimbursement rate, the number of patient days will be computed as not less than 85% of the daily licensed bed complement.

D. Costs related to equipment and portions of a building/facility not available for patient care related activities are nonreimbursable plant costs.

§ 2.2. New nursing facilities and bed additions.

A. 1. Providers shall be required to obtain three competitive bids when (i) constructing a new physical plant or renovating a section of the plant when changing the licensed bed capacity, and (ii) purchasing fixed equipment or major movable equipment related to such projects.

2. All bids must be obtained in an open competitive market manner, and subject to disclosure to DMAS prior to initial rate setting. (Related parties see § 2.10.)

B. Reimbursable costs for building and fixed equipment shall be based upon the 3/4 (25% of the surveyed projects with costs above the median, 75% with costs below the median) square foot costs for NFs published annually in the R.S. Means Building Construction Cost Data as adjusted by the appropriate R.S. Means Square Foot Costs "Location Factor" for Virginia for the locality in which the NF is located. Where the specific location is not listed in the R.S. Means Square Foot Costs "Location Factor" for Virginia, the facility's zip code shall be used to determine the appropriate locality factor from the U.S. Postal Services National Five Digit Zip Code for Virginia and the R.S. Means Square Foot Costs "Location Factors." The provider shall have the option of selecting the construction cost limit which is effective on the date the Certificate of

Public Need (COPN) is issued or the date the NF is licensed. Total cost shall be calculated by multiplying the above 3/4 square foot cost by 385 square feet (the average per bed square footage). Total costs for building additions shall be calculated by multiplying the square footage of the project by the applicable components of the construction cost in the R.S. Means Square Foot Costs, not to exceed the total per bed cost for a new NF. Reasonable limits for renovations shall be determined by the appropriate costs in the R.S. Means Repair and Remodeling Cost Data, not to exceed the total R.S. Means Building Construction Cost Data 3/4 square foot costs for nursing homes.

C. New NFs and bed additions to existing NFs must have prior approval under the state's Certificate of Public Need Law and Licensure regulations in order to receive Medicaid reimbursement.

D. However in no case shall allowable reimbursed costs exceed 110% of the amounts approved in the original COPN, or 100% of the amounts approved in the original COPN as modified by any "significant change" COPN, where a provider has satisfied the requirements of the State Department of Health with respect to obtaining prior written approval for a "significant change" to a COPN which has previously been issued.

§ 2.3. Major capital expenditures.

A. Major capital expenditures include, but are not limited to, major renovations (without bed increase), additions, modernization, other renovations, upgrading to new standards, and equipment purchases. Major capital expenditures shall be any capital expenditures costing $100,000 or more each, in aggregate for like items, or in aggregate for a particular project. These include purchases of similar type equipment or like items within a one calendar year period (not necessarily the provider's reporting period).

B. Providers (including related organizations as defined in § 2.10) shall be required to obtain three competitive bids and if applicable, a Certificate of Public Need before initiating any major capital expenditures. All bids must be obtained in an open competitive manner, and subject to disclosure to the DMAS prior to initial rate setting. (Related parties see § 2.10.)

C. Useful life shall be determined by the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (AHA). If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

D. Major capital additions, modernization, renovations, and costs associated with upgrading the NF to new standards shall be subject to cost limitations based upon the applicable components of the construction cost limits determined in accordance with § 2.2 B.

§ 2.4. Financing.

A. The DMAS shall continue its policy to disallow cost increases due to the refinancing of a mortgage debt, except when required by the mortgage holder to finance expansions or renovations. Refinancing shall also be permitted in cases where refinancing would produce a lower interest rate and result in a cost savings. The total net aggregate allowable costs incurred for all cost reporting periods related to the refinancing cannot exceed the total net aggregate costs that would have been allowable had the refinancing not occurred.

1. Refinancing incentive. Effective July 1, 1991, for mortgages refinanced on or after that date, the DMAS will pay a refinancing incentive to encourage nursing facilities to refinance fixed-rate, fixed-term mortgage debt when such arrangements would benefit both the Commonwealth and the providers. The refinancing incentive payments will be made for the 10-year period following an allowable refinancing action, or through the end of the refinancing period should the loan be less than 10 years, subject to a savings being realized by application of the refinancing calculation for each of these years. The refinancing incentive payment shall be computed on the net savings from such refinancing applicable to each provider cost reporting period. Interest expense and amortization of loan costs on mortgage debt applicable to the cost report period for mortgage debt which is refinanced shall be compared to the interest expense and amortization of loan costs on the new mortgage debt for the cost reporting period.

2. Calculation of refinancing incentive. The incentive shall be computed by calculating two index numbers, the old debt financing index and the new debt financing index. The old debt financing index shall be computed by multiplying the term (months) which would have been remaining on the old debt at the end of the provider's cost report period by the interest rate for the old debt. The new debt index shall be computed by multiplying the remaining term (months) of the new debt at the end of the cost reporting period by the new interest rate. The new debt index shall be divided by the old debt index to achieve a savings ratio for the period. The savings ratio shall be subtracted from a factor of 1 to determine the refinancing incentive factor.

3. Calculation of net savings. The gross savings for the period shall be computed by subtracting the allowable new debt interest for the period from the allowable old debt interest for the period. The net savings for the period shall be computed by subtracting allowable new loan costs for the period from allowable gross savings applicable to the period. Any remaining unamortized old loan costs may be recovered in full to the extent of net savings produced for the period.

4. Calculation of incentive amount. The net savings for the period, after deduction of any unamortized old loan and debt cancellation costs, shall be multiplied by the refinancing incentive factor to determine the refinancing incentive amount. The result shall be the incentive payment for the cost reporting period, which shall be included in the cost report settlement, subject to per diem computations under § 2.1 B, 2.1 C, and 2.14 A.

5. Where a savings is produced by a provider refinancing his old mortgage for a longer time period, the DMAS shall calculate the refinancing incentive and payment in accordance with §§ 2.4 A 1 through 2.4 A 4 for the incentive period. Should the calculation produce both positive and negative incentives, the provider's total incentive payments shall not exceed any net positive amount for the entire incentive period. Where a savings is produced by refinancing with either a principal balloon payment at the end of the refinancing period, or a variable interest rate, no incentive payment will be made, since the true savings to the Commonwealth cannot be accurately computed.

6. All refinancings must be supported by adequate and verifiable documentation and allowable under DMAS regulations to receive the refinancing savings incentive.

B. Interest rate upper limit.

Financing for all NFs and expansions which require a COPN and all renovations and purchases shall be subject to the following limitations:

1. Interest expenses for debt financing which is exempt from federal income taxes shall be limited to:

The average weekly rates for Baa municipal rated bonds as published in Cragie Incorporated Municipal Finance Newsletter as published weekly (Representative reoffering from general obligation bonds), plus one percentage point (100 basis points), during the week in which commitment for construction financing or closing for permanent financing takes place.

2. a. Effective on and after July 1, 1990, the interest rate upper limit for debt financing by NFs that are subject to prospective reimbursement shall be the average of the rate for 10-year and 30-year U.S. Treasury Constant Maturities, as published in the weekly Federal Reserve Statistical Release (H.15), plus two percentage points (200 basis points).

This limit (i) shall apply only to debt financing which is not exempt from federal income tax, and (ii) shall not be available to NF's which are eligible for such tax exempt financing unless and until a NF has demonstrated to the DMAS that the NF failed, in a good faith effort, to obtain any available debt financing which is exempt from federal income tax. For construction financing, the limit shall be determined as of the date on which commitment takes place. For permanent financing, the limit shall be determined as of the date of closing. The limit shall apply to allowable interest expenses during the term of the financing.

b. The new interest rate upper limit shall also apply, effective July 1, 1990, to construction financing committed to or permanent financing closed after December 31, 1986, but before July 1, 1990, which is not exempt from federal income tax. The limit shall be determined as of July 1, 1990, and shall apply to allowable interest expenses for the term of the financing remaining on or after July 1, 1990.

3. Variable interest rate upper limit.

a. The limitation set forth in §§ 2.4 B 1 and 2.4 B 2 shall be applied to debt financing which bears a variable interest rate as follows. The interest rate upper limit shall be determined on the date on which commitment for construction financing or closing for permanent financing takes place, and shall apply to allowable interest expenses during the term of such financing as if a fixed interest rate for the financing period had been obtained. A "fixed rate loan amortization schedule" shall be created for the loan period, using the interest rate cap in effect on the date of commitment for construction financing or date of closing for permanent financing.

b. If the interest rate for any cost reporting period is below the limit determined in subdivision 3 a above, no adjustment will be made to the providers interest expense for that period, and a "carryover credit" to the extent of the amount allowable under the "fixed rate loan amortization schedule" will be created, but not paid. If the interest rate in a future cost reporting period is above the limit determined in subdivision 3 a above, the provider will be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or his actual cost, whichever is less.

c. The provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of interest claimed under the "carryover credit," and shall submit such a schedule with each cost report.

4. The limitation set forth in § 2.4 B 1, 2, and 3 shall be applicable to financing for land, buildings, fixed equipment, major movable equipment, working capital for construction and permanent financing.

5. Where bond issues are used as a source of financing, the date of sale shall be considered as the

date of closing.

6. The aggregate of the following costs shall be limited to 5.0% of the total allowable project costs:

a. Examination Fees

b. Guarantee Fees

c. Financing Expenses (service fees, placement fees, feasibility studies, etc.)

d. Underwriters Discounts

e. Loan Points

7. The aggregate of the following financing costs shall be limited to 2.0% of the total allowable project costs:

a. Legal Fees

b. Cost Certification Fees

c. Title and Recording Costs

d. Printing and Engraving Costs

e. Rating Agency Fees

C. DMAS shall allow costs associated with mortgage life insurance premiums in accordance with § 2130 of the HCFA-Pub. 15, Provider Reimbursement Manual (PRM-15).

D. Interest expense on a debt service reserve fund is an allowable expense if required by the terms of the financing agreement. However, interest income resulting from such fund shall be used by DMAS to offset interest expense.

§ 2.5. Purchases of nursing facilities (NF).

A. In the event of a sale of a NF, the purchaser must have a current license and certification to receive DMAS reimbursement as a provider.

B. The following reimbursement principles shall apply to the purchase of a NF:

1. The allowable cost of a bona fide sale of a facility (whether or not the parties to the sale were, are, or will be providers of Medicaid services) shall be the lowest of the sales price, the replacement cost value determined by independent appraisal, or the limitations of Part XVI - Revaluation of Assets. Revaluation of assets shall be permitted only when a bona fide sale of assets occurs.

2. Notwithstanding the provisions of § 2.10, where there is a sale between related parties (whether or not they were, are or will be providers of Medicaid services), the buyer's allowable cost basis for the nursing facility shall be the seller's allowable depreciated historical cost (net book value), as determined for Medicaid reimbursement.

3. For purposes of Medicaid reimbursement, a "bona fide" sale shall mean a transfer of title and possession for consideration between parties which are not related. Parties shall be deemed to be "related" if they are related by reasons of common ownership or control. If the parties are members of an immediate family, the sale shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control." See § 2.10 C for definitions of "common ownership," "control," "immediate family," and "significant ownership or control."

4. The useful life of the fixed assets of the facility shall be determined by AHA guidelines.

5. The buyer's basis in the purchased assets shall be reduced by the value of the depreciation recapture due the state by the provider-seller, until arrangements for repayment have been agreed upon by DMAS.

6. In the event the NF is owned by the seller for less than five years, the reimbursable cost basis of the purchased NF to the buyer, shall be the seller's allowable historical cost as determined by DMAS.

C. An appraisal expert shall be defined as an individual or a firm that is experienced and specializes in multi-purpose appraisals of plant assets involving the establishing or reconstructing of the historical cost of such assets. Such an appraisal expert employs a specially trained and supervised staff with a complete range of appraisal and cost construction techniques; is experienced in appraisals of plant assets used by providers, and demonstrates a knowledge and understanding of the regulations involving applicable reimbursement principles, particularly those pertinent to depreciation; and is unrelated to either the buyer or seller.

D. At a minimum, appraisals must include a breakdown by cost category as follows:

1. Building; fixed equipment; movable equipment; land; land improvements.

2. The estimated useful life computed in accordance with AHA guidelines of the three categories, building, fixed equipment, and movable equipment must be included in the appraisal. This information shall be utilized to compute depreciation schedules.

E. Depreciation recapture.

1. The provider-seller of the facility shall make a retrospective settlement with DMAS in instances where

a gain was made on disposition. The department shall recapture the depreciation paid to the provider by Medicaid for the period of participation in the Program to the extent there is gain realized on the sale of the depreciable assets. A final cost report and refund of depreciation expense, where applicable, shall be due within 30 days from the transfer of title (as defined below).

2. No depreciation adjustment shall be made in the event of a loss or abandonment.

F. Reimbursable depreciation.

1. For the purpose of this section, "sale or transfer" shall mean any agreement between the transferor and the transferee by which the former, in consideration of the payment or promise of payment of a certain price in money, transfers to the latter the title and possession of the property.

2. Upon the sale or transfer of the real and tangible personal property comprising a licensed nursing facility certified to provide services to DMAS, the transferor or other person liable therein shall reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing such services and subject to recapture under the provisions of the State Plan for Medical Assistance. The amount of reimbursable depreciation shall be paid to the Commonwealth within 30 days of the sale or transfer of the real property unless an alternative form of repayment, the term of which shall not exceed one year, is approved by the director.

3. Prior to the transfer, the transferor shall file a written request by certified or registered mail to the director for a letter of verification that he either does not owe the Commonwealth any amount for reimbursable depreciation or that he has repaid any amount owed the Commonwealth for reimbursable depreciation or that an alternative form of repayment has been approved by the director. The request for a letter of verification shall state:

a. That a sale or transfer is about to be made;

b. The location and general description of the property to be sold or transferred;

c. The names and addresses of the transferee and transferor and all such business names and addresses of the transferor for the last three years; and

d. Whether or not there is a debt owing to the Commonwealth for the amount of depreciation charges previously allowed and reimbursed as a reasonable cost to the transferor under the Virginia Medical Assistance Program.

4. Within 90 days after receipt of the request, the director shall determine whether or not there is an amount due to the Commonwealth by the nursing facility by reason of depreciation charges previously allowed and reimbursed as a reasonable cost under DMAS and shall notify the transferor of such sum, if any.

5. The transferor shall provide a copy of this section and a copy of his request for a letter of verification to the prospective transferee via certified mail at least 30 days prior to the transfer. However, whether or not the transferor provides a copy of this section and his request for verification to the prospective transferee as required herein, the transferee shall be deemed to be notified of the requirements of this law.

6. After the transferor has made arrangements satisfactory to the director to repay the amount due or if there is no amount due, the director shall issue a letter of verification to the transferor in recordable form stating that the transferor has complied with the provisions of this section and setting forth the term of any alternative repayment agreement. The failure of the transferor to reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing service to DMAS in a timely manner renders the transfer of the nursing facility ineffective as to the Commonwealth.

7. Upon a finding by the director that such sale or transfer is ineffective as to the Commonwealth, DMAS may collect any sum owing by any means available by law, including devising a schedule for reducing the Medicaid reimbursement to the transferee up to the amount owed the Commonwealth for reimbursable depreciation by the transferor or other person liable therein. Medicaid reimbursement to the transferee shall continue to be so reduced until repayment is made in full or the terms of the repayment are agreed to by the transferor or person liable therein.

8. In the event the transferor or other person liable therein defaults on any such repayment agreement the reductions of Medicaid reimbursement to the transferee may resume.

An action brought or initiated to reduce the transferee's Medicaid reimbursement or an action for attachment or levy shall not be brought or initiated more than six months after the date on which the sale or transfer has taken place unless the sale or transfer has been concealed or a letter of verification has not been obtained by the transferor or the transferor defaults on a repayment agreement approved by the director.

Article 2.
Operating Cost Component.

§ 2.6. Operating cost.

A. Operating cost shall be the total allowable inpatient cost less plant cost and NATCEPs costs. See Part VII for rate determination procedures for NATCEPs costs. To calculate the reimbursement rate, operating cost shall be converted to a per diem amount by dividing it by the greater of actual patient days, or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.

B. For NFs of 30 beds or less, to calculate the reimbursement rate the number of patient days will continue to be computed as not less than 85% of the daily licensed bed complement.

§ 2.7. Nursing facility reimbursement formula.

A. Effective on and after October 1, 1990, all NFs subject to the prospective payment system shall be reimbursed under a revised formula entitled "The Patient Intensity Rating System (PIRS)." PIRS is a patient based methodology which links NF's per diem rates to the intensity of services required by a NF's patient mix. Three classes were developed which group patients together based on similar functional characteristics and service needs.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.

2. In accordance with § 1.3, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in VR 460-03-1491. Indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA and for the rest of the state. Indirect patient care operating costs shall include all other operating costs, not defined in VR 460-03-4.1941 as direct patient care operating costs and NATCEPs costs.

3. Each NF's Service Intensity Index (SII) shall be calculated for each semiannual period of a NF's fiscal year based upon data reported by that NF and entered into DMAS' Long Term Care Information System (LTCIS). Data will be reported on the multidimensional assessment form prescribed by DMAS (now DMAS-95) at the time of admission and then twice a year for every Medicaid recipient in a NF. The NF's SII, derived from the assessment data, will be normalized by dividing it by the average for all NF's in the state.

See VR 460-03-4.1944 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NF's facility score and the methodology of computing the NF's semiannual SIIs.

4. The normalized SII shall be used to calculate the initial direct patient care operating cost peer group medians. It shall also be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NF's subsequent fiscal years.

a. The normalized SII, as determined during the quarter ended September 30, 1990, shall be used to calculate the initial direct patient care operating cost peer group medians.

b. A NF's direct patient care operating cost prospective ceiling shall be the product of the NF's peer group direct patient care ceiling and the NF's normalized SII for the previous semiannual period. A NF's direct patient care operating cost prospective ceiling will be calculated semiannually.

c. An SSI rate adjustment, if any, shall be applied to a NF's prospective direct patient care operating cost base rate for each semiannual period of a NF's fiscal year. The SII determined in the second semiannual period of the previous fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the first semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate. The SII determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the second semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate.

d. See VR 460-03-4.1944 for an illustration of how the SII is used to adjust direct patient care operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate.

5. An adjustment factor shall be applied to both the direct patient care and indirect patient care peer group medians to determine the appropriate initial peer group ceilings.

a. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during fiscal year 1991 under the prospective payment system in effect through September 30, 1990, as modified to incorporate the estimated additional NF reimbursement mandated by the provisions of § 1902(a)(13)(A) of the Social Security Act as amended by § 4211(b)(1) of the Omnibus Budget Reconciliation Act of 1987.

b. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during FY 1991 under the PIRS

prospective payment system.

c. The DMAS shall determine the differential between a and b above and shall adjust the peer group medians within the PIRS as appropriate to reduce the differential to zero.

d. The adjusted PIRS peer group medians shall become the initial peer group ceilings.

B. The allowance for inflation shall be based on the percentage of change in the moving average of the Skilled Nursing Facility Market basket of Routine Service Costs, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the quarter in which the NF's most recent fiscal year ended. NFs shall have their prospective operating cost ceilings and prospective operating cost rates established in accordance with the following methodology:

1. The initial peer group ceilings established under § 2.7 A shall be the final peer group ceilings for a NF's first full or partial fiscal year under PIRS and shall be considered as the initial "interim ceilings" for calculating the subsequent fiscal year's peer group ceilings. Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the ~~most recent~~ *initial* "interim" ceilings ~~for 100% of historical inflation, from the effective date of such "interim" ceilings to the beginning of the NF's next fiscal year to obtain new "interim" ceilings, and 50% of the forecasted inflation to the end of the NF's next fiscal year~~ *by a "percentage factor" which shall eliminate any allowances for inflation after September 30, 1990, calculated in both §§ 2.7 A 5 a and 2.7 A 5 c. The adjusted initial "interim" ceilings shall be considered as the final "interim ceiling." Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the final "interim" ceiling, as determined above, by 100% of historical inflation from October 1, 1990, to the beginning of the NFs next fiscal year to obtain new "interim" ceilings, and 50% of the forecasted inflation to the end of the NFs next fiscal year .*

2. A NF's average allowable operating cost rates, as determined from its most recent fiscal year's cost report, shall be adjusted by 50% of historical inflation and 50% of the forecasted inflation to calculate its prospective operating cost base rates.

C. The PIRS method shall still require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost rates or prospective operating ceilings.

D. Nonoperating costs.

1. Allowable plant costs shall be reimbursed in accordance with Part II, Article 1. Plant costs shall not include the component of cost related to making or producing a supply or service.

2. NATCEPs cost shall be reimbursed in accordance with Part VII.

E. The prospective rate for each NF shall be based upon operating cost and plant cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of nonreimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of nonreimbursable plant costs and NATCEPs costs shall be reflected in the year in which the nonreimbursable costs are included.

F. For those NFs whose operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable operating cost rates and the peer group ceilings under the PIRS.

1. The table below presents four incentive examples under the PIRS:

Peer Group Ceilings	Allowable Cost Per Day		Difference % of Ceiling	Sliding Scale	Scale % Difference
$30.00	$27.00	$3.00	10%	$ .30	10%
30.00	22.50	7.50	25%	1.88	25%
30.00	20.00	10.00	33%	2.50	25%
30.00	30.00	0		0	

2. Separate efficiency incentives shall be calculated for both the direct and indirect patient care operating ceilings and costs.

G. Quality of care requirement.

A cost efficiency incentive shall not be paid to a NF for the prorated period of time that it is not in conformance with substantive, nonwaived life, safety, or quality of care standards.

H. Sale of facility.

In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

I. Public notice.

To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

§ 2.8. Phase-in period.

A. To assist NFs in converting to the PIRS methodology,

a phase-in period shall be provided until June 30, 1992.

B. From October 1, 1990, through June 30, 1991, a NF's prospective operating cost rate shall be a blended rate calculated at 33% of the PIRS operating cost rates determined by § 2.7 above and 67% of the "current" operating rate determined by subsection D below.

C. From July 1, 1991, through June 30, 1992, a NF's prospective operating cost rate shall be a blended rate calculated at 67% of the PIRS operating cost rates determined by § 2.7 above and 33% of the "current" operating rate determined by subsection D below.

D. The following methodology shall be applied to calculate a NF's "current" operating rate:

1. Each NF shall receive as its base "current" operating rate, the weighted average prospective operating cost per diems and efficiency incentive per diems if applicable, calculated by DMAS to be effective September 30, 1990.

2. The base "current" operating rate established above shall be the "current" operating rate for the NF's first partial fiscal year under PIRS. The base "current" operating rate shall be adjusted by appropriate allowance for historical inflation and 50% of the forecasted inflation based on the methodology contained in § 2.7 B at the beginning of each of the NF's fiscal years which starts during the phase-in period, October 1, 1990, through June 30, 1992, to determine the NF's prospective "current" operating rate. See VR 460-03-4.1944 for example calculations.

§ 2.8.1. Nursing facility rate change.

For the period beginning July 1, 1991, and ending June 30, 1992, the per diem operating rate for each NF shall be adjusted. This shall be accomplished by applying a uniform adjustment factor to the rate of each NF.

Article 3.
Allowable Cost Identification.

§ 2.9. Allowable costs.

Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see VR 460-03-4.1941, Uniform Expense Classification).

A. Certification.

The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.

B. Operating costs.

1. Direct patient care operating costs shall be defined in VR 460-03-4.1941.

2. Allowable direct patient care operating costs shall exclude (i) personal physician fees, and (ii) pharmacy services and prescribed legend and nonlegend drugs provided by nursing facilities which operate licensed in-house pharmacies. These services shall be billed directly to DMAS through separate provider agreements and DMAS shall pay directly in accordance with subsections e and f of Attachment 4.19 B of the State Plan for Medical Assistance (VR 460-02-4.1920).

3. Indirect patient care operating costs include all other operating costs, not identified as direct patient care operating costs and NATCEPs costs in VR 460-03-4.1941, which are allowable under the Medicare principles of reimbursement, except as specifically modified herein and as may be subject to individual cost or ceiling limitations.

C. Allowances/goodwill.

Bad debts, goodwill, charity, courtesy, and all other contractual allowances shall not be recognized as an allowable cost.

§ 2.10. Purchases/related organizations.

A. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization, provided that such costs do not exceed the price of comparable services, facilities or supplies. Purchases of existing NFs by related parties shall be governed by the provisions of § 2.5 B 2.

Allowable cost applicable to management services furnished to the provider by organizations related to the provider by common ownership or control shall be lesser of the cost to the related organization or the per patient day ceiling limitation established for management services cost. (See VR 460-03-4.1943, Cost Reimbursement Limitations.)

B. Related to the provider shall mean that the provider is related by reasons of common ownership or control by the organization furnishing the services, facilities, or supplies.

C. Common ownership exists when an individual or individuals or entity or entities possess significant ownership or equity in the parties to the transaction. Control exists where an individual or individuals or entity

or entities have the power, directly or indirectly, significantly to influence or direct the actions or policies of the parties to the transaction. Significant ownership or control shall be deemed to exist where an individual is a "person with an ownership or control interest" within the meaning of 42 CFR 455.101. If the parties to the transaction are members of an immediate family, as defined below, the transaction shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control," as set forth above. Immediate family shall be defined to include, but not be limited to, the following: (i) husband and wife, (ii) natural parent, child and sibling, (iii) adopted child and adoptive parent, (iv) step-parent, step-child, step-sister, and step-brother, (v) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law, and (vi) grandparent and grandchild.

D. Exception to the related organization principle.

1. Effective with cost reports having fiscal years beginning on or after July 1, 1986, an exception to the related organization principle shall be allowed. Under this exception, charges by a related organization to a provider for goods or services shall be allowable cost to the provider if all four of the conditions set out below are met.

2. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of DMAS that the following criteria have been met:

a. The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the provider organization.

b. A substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of goods or services furnished by the organization. In determining whether the activities are of similar type, it is important to also consider the scope of the activity.

For example, a full service management contract would not be considered the same type of business activity as a minor data processing contract. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arms-length bargaining by well informed buyers and sellers.

c. The goods or services shall be those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions. This requirement means that institutions such as the provider typically obtain the good or services from outside sources rather than producing the item internally.

d. The charge to the provider is in line with the charge for such services, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such goods or services. The phrase "open market" takes the same meaning as "open, competitive market" in subdivision b above.

3. Where all of the conditions of this exception are met, the charges by the supplier to the provider for such goods or services shall be allowable as costs.

4. This exception does not apply to the purchase, lease or construction of assets such as property, buildings, fixed equipment or major movable equipment. The terms "goods and services" may not be interpreted or construed to mean capital costs associated with such purchases, leases, or construction.

E. Three competitive bids shall not be required for the building and fixed equipment components of a construction project outlined in § 2.2. Reimbursement shall be in accordance with § 2.10 A with the limitations stated in § 2.2 B.

§ 2.11. Administrator/owner compensation.

A. Administrators' compensation, whether administrators are owners or non-owners, shall be based on a schedule adopted by DMAS and varied according to facility bed size. The compensation schedule shall be adjusted annually to reflect cost-of-living increases and shall be published and distributed to providers annually. The administrator's compensation schedule covers only the position of administrator and assistants and does not include the compensation of owners employed in capacities other than the NF administrator (see VR 460-03-4.1943, Cost Reimbursement Limitations).

B. Administrator compensation shall mean remuneration paid regardless of the form in which it is paid. This includes, but shall not be limited to, salaries, professional fees, insurance premiums (if the benefits accrue to the employer/owner or his beneficiary) director fees, personal use of automobiles, consultant fees, management fees, travel allowances, relocation expenses in excess of IRS guidelines, meal allowances, bonuses, pension plan costs, and deferred compensation plans. Management fees, consulting fees, and other services performed by owners shall be included in the total compensation if they are performing administrative duties regardless of how such services may be classified by the provider.

C. Compensation for all administrators (owner and

nonowner) shall be based upon a 40 hour week to determine reasonableness of compensation.

D. Owner/administrator employment documentation.

1. Owners who perform services for a NF as an administrator and also perform additional duties must maintain adequate documentation to show that the additional duties were performed beyond the normal 40 hour week as an administrator. The additional duties must be necessary for the operation of the NF and related to patient care.

2. Services provided by owners, whether in employee capacity, through management contracts, or through home office relationships shall be compared to the cost and services provided in arms-length transactions.

3. Compensation for such services shall be adjusted where such compensation exceeds that paid in such arms-length transaction or where there is a duplication of duties normally rendered by an administrator. No reimbursement shall be allowed for compensation where owner services cannot be documented and audited.

§ 2.12. Depreciation.

The allowance for depreciation shall be restricted to the straight line method with a useful life in compliance with AHA guidelines. If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

§ 2.13. Rent/Leases.

Rent or lease expenses shall be limited by the provisions of VR 460-03-4.1942, Leasing of Facilities.

§ 2.14. Provider payments.

A. Limitations.

1. Payments to providers, shall not exceed charges for covered services except for (i) public providers furnishing services free of charge or at a nominal charge (ii) nonpublic provider whose charges are 60% or less of the allowable reimbursement represented by the charges and that demonstrates its charges are less than allowable reimbursement because its customary practice is to charge patients based on their ability to pay. Nominal charge shall be defined as total charges that are 60% or less of the allowable reimbursement of services represented by these charges. Providers qualifying in this section shall receive allowable reimbursement as determined in this Plan.

2. Allowable reimbursement in excess of charges may be carried forward for payment in the two succeeding cost reporting periods. A new provider may carry forward unreimbursed allowable reimbursement in the five succeeding cost reporting periods.

3. Providers may be reimbursed the carry forward to a succeeding cost reporting period (i) if total charges for the services provided in that subsequent period exceed the total allowable reimbursement in that period (ii) to the extent that the accumulation of the carry forward and the allowable reimbursement in that subsequent period do not exceed the providers' direct and indirect care operating ceilings plus allowable plant cost.

B. Payment for service shall be based upon the rate in effect when the service was rendered.

C. An interim settlement shall be made by DMAS within 90 days after receipt and review of the cost report. The word "review," for purposes of interim settlement, shall include verification that all financial and other data specifically requested by DMAS is submitted with the cost report. Review shall also mean examination of the cost report and other required submission for obvious errors, inconsistency, inclusion of past disallowed costs, unresolved prior year cost adjustments and a complete signed cost report that conforms to the current DMAS requirements herein.

However, an interim settlement shall not be made when one of the following conditions exists.

1. Cost report filed by a terminated provider;

2. Insolvency of the provider at the time the cost report is submitted;

3. Lack of a valid provider agreement and decertification;

4. Moneys owed to DMAS;

5. Errors or inconsistencies in the cost report; or

6. Incomplete/nonacceptable cost report.

§ 2.15. Legal fees/accounting.

A. Costs claimed for legal/accounting fees shall be limited to reasonable and customary fees for specific services rendered. Such costs must be related to patient care as defined by Medicare principles of reimbursement and subject to applicable regulations herein. Documentation for legal costs must be available at the time of audit.

B. Retainer fees shall be considered an allowable cost up to the limits established in VR 460-03-4.1943, Cost Reimbursement Limitations.

§ 2.16. Documentation.

Adequate documentation supporting cost claims must be

provided at the time of interim settlement, cost settlement, audit, and final settlement.

§ 2.17. Fraud and abuse.

Previously disallowed costs which are under appeal and affect more than one cost reporting period shall be disclosed in subsequent cost reports if the provider wishes to reserve appeal rights for such subsequent cost reports. The reimbursement effect of such appealed costs shall be computed by the provider and submitted to DMAS with the cost report. Where such disclosure is not made to DMAS, the inclusion of previously disallowed costs may be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General.

Article 4.
New Nursing Facilities.

§ 2.18. Interim rate.

A. For all new or expanded NFs the 95% occupancy requirement shall be waived for establishing the first cost reporting period interim rate. This first cost reporting period shall not exceed 12 months from the date of the NF's certification.

B. Upon a showing of good cause, and approval of the DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate, or being treated as a new NF.

C. The 95% occupancy requirement shall be applied to the first and subsequent cost reporting periods' actual costs for establishing such NF's second and future cost reporting periods' prospective reimbursement rates. The 95% occupancy requirement shall be considered as having been satisfied if the new NF achieved a 95% occupancy at any point in time during the first cost reporting period.

D. A new NF's interim rate for the first cost reporting period shall be determined based upon the lower of its anticipated allowable cost determined from a detailed budget (or pro forma cost report) prepared by the provider and accepted by the DMAS, or the appropriate operating ceilings or charges.

E. Any NF receiving reimbursement under new NF status shall not be eligible to receive the blended phase-in period rate under § 2.8.

F. During its first semiannual period of operation, a newly constructed or newly enrolled NF shall have an assigned SII based upon its peer group's average SII for direct patient care. An expanded NF receiving new NF treatment, shall receive the SII calculated for its last semiannual period prior to obtaining new NF status.

§ 2.19. Final rate.

The DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined above in § 2.18 A, C, E, and F.

Upon determination of the actual allowable operating cost for direct patient care and indirect patient care the per diem amounts shall be used to determine if the provider is below the peer group ceiling used to set its interim rate. If costs are below those ceilings, an efficiency incentive shall be paid at settlement of the first year cost report.

This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable operating cost and the peer group ceiling used to set the interim rate. (Refer to § 2.7 F.)

Article 5.
Cost Reports.

§ 2.20. Cost report submission.

A. Cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, it is considered delinquent. The cost report shall be deemed complete when DMAS has received all of the following:

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

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

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows. Multi-facility providers not having individual facility financial statements shall submit the "G" series schedules from the cost report plus a statement of changes in cash flow and corporate consolidated financial statements;

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

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

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

B. When cost reports are delinquent, the provider's interim rate shall be reduced by 20% the first month and an additional 20% of the original interim rate for each subsequent month the report has not been submitted. DMAS shall notify the provider of the schedule of

reductions which shall start on the first day of the following month. For example, for a September 30 fiscal year end, notification will be mailed in early January stating that payments will be reduced starting with the first payment in February.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

§ 2.21. Reporting form.

All cost reports shall be submitted on uniform reporting forms provided by the DMAS, or by Medicare if applicable. Such cost reports, subsequent to the initial cost report period, shall cover a 12-month period. Any exceptions must be approved by the DMAS.

§ 2.22. Accounting method.

The accrual method of accounting and cost reporting is mandated for all providers.

§ 2.23. Cost report extensions.

A. Extension for submission of a cost report may be granted if the provider can document extraordinary circumstances beyond its control.

B. Extraordinary circumstances do not include:

1. Absence or changes of chief finance officer, controller or bookkeeper;

2. Financial statements not completed;

3. Office or building renovations;

4. Home office cost report not completed;

5. Change of stock ownership;

6. Change of intermediary;

7. Conversion to computer; or

8. Use of reimbursement specialist.

§ 2.24. Fiscal year changes.

All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year.

Article 6.
Prospective Rates.

§ 2.25. Time frames.

A. A prospective rate shall be determined by DMAS within 90 days of the receipt of a complete cost report. (See § 2.20 A.) Rate adjustments shall be made retroactive to the first day of the provider's new cost reporting year. Where a field audit is necessary to set a prospective rate, the DMAS shall have an additional 90 days to determine any appropriate adjustments to the prospective rate as a result of such field audit. This time period shall be extended if delays are attributed to the provider.

B. Subsequent to establishing the prospective rate DMAS shall conclude the desk audit of a providers' cost report and determine if further field audit activity is necessary. The DMAS will seek repayment or make retroactive settlements when audit adjustments are made to costs claimed for reimbursement.

Article 7.
Retrospective rates.

§ 2.26. The retrospective method of reimbursement shall be used for Mental Health/Mental Retardation facilities.

§ 2.27. (reserved)

Article 8.
Record Retention.

§ 2.28. Time frames.

A. All of the NF's accounting and related records, including the general ledger, books of original entry, and statistical data must be maintained for a minimum of five years, or until all affected cost reports are final settled.

B. Certain information must be maintained for the duration of the provider's participation in the DMAS and until such time as all cost reports are settled. Examples of such information are set forth in § 2.29.

§ 2.29. Types of records to be maintained.

Information which must be maintained for the duration of the provider's participation in the DMAS includes, but is not limited to:

1. Real and tangible property records, including leases and the underlying cost of ownership;

2. Itemized depreciation schedules;

3. Mortgage documents, loan agreements, and amortization schedules;

4. Copies of all cost reports filed with the DMAS together with supporting financial statements.

§ 2.30. Record availability.

The records must be available for audits by DMAS staff. Where such records are not available, costs shall be

disallowed.

Article 9.
Audits.

§ 2.31. Audit overview.

Desk audits shall be performed to verify the completeness and accuracy of the cost report, and reasonableness of costs claimed for reimbursement. Field audits, as determined necessary by the DMAS, shall be performed on the records of each participating provider to determine that costs included for reimbursement were accurately determined and reasonable, and do not exceed the ceilings or other reimbursement limitations established by the DMAS.

§ 2.32. Scope of audit.

The scope of the audit includes, but shall not be limited to: trial balance verification, analysis of fixed assets, indebtedness, selected revenues, leases and the underlying cost of ownership, rentals and other contractual obligations, and costs to related organizations. The audit scope may also include various other analyses and studies relating to issues and questions unique to the NF and identified by the DMAS. Census and related statistics, patient trust funds, and billing procedures are also subject to audit.

§ 2.33. Field audit requirements.

Field audits shall be required as follows:

1. For the first cost report on all new NF's.

2. For the first cost report in which costs for bed additions or other expansions are included.

3. When a NF is sold, purchased, or leased.

4. As determined by DMAS desk audit.

§ 2.34. Provider notification.

The provider shall be notified in writing of all adjustments to be made to a cost report resulting from desk or field audit with stated reasons and references to the appropriate principles of reimbursement or other appropriate regulatory cites.

§ 2.35. Field audit exit conference.

A. The provider shall be offered an exit conference to be executed within 15 days following completion of the on-site audit activities, unless other time frames are mutually agreed to by the DMAS and provider. Where two or more providers are part of a chain organization or under common ownership, DMAS shall have up to 90 days after completion of all related on-site audit activities to offer an exit conference for all such NFs. The exit conference shall be conducted at the site of the audit or at a location mutually agreeable to the DMAS and the provider.

B. The purpose of the exit conference shall be to enable the DMAS auditor to discuss such matters as the auditor deems necessary, to review the proposed field audit adjustments, and to present supportive references. The provider will be given an opportunity during the exit conference to present additional documentation and agreement or disagreement with the audit adjustments.

C. All remaining adjustments, including those for which additional documentation is insufficient or not accepted by the DMAS, shall be applied to the applicable cost report(s) regardless of the provider's approval or disapproval.

D. The provider shall sign an exit conference form that acknowledges the review of proposed adjustments.

E. After the exit conference the DMAS shall perform a review of all remaining field audit adjustments. Within a reasonable time and after all documents have been submitted by the provider, the DMAS shall transmit in writing to the provider a final field audit adjustment report (FAAR), which will include all remaining adjustments not resolved during the exit conference. The provider shall have 15 days from the date of the letter which transmits the FAAR, to submit any additional documentation which may affect adjustments in the FAAR.

§ 2.36. Audit delay.

In the event the provider delays or refuses to permit an audit to occur or to continue or otherwise interferes with the audit process, payments to the provider shall be reduced as stated in § 2.20 B.

§ 2.37. Field audit time frames.

A. If a field audit is necessary after receipt of a complete cost report, such audit shall be initiated within three years following the date of the last notification of program reimbursement and the on site activities, including exit conferences, shall be concluded within 180 days from the date the field audit begins. Where audits are performed on cost reports for multiple years or providers, the time frames shall be reasonably extended for the benefit of the DMAS and subject to the provisions of § 2.35.

B. Documented delays on the part of the provider will automatically extend the above time frames to the extent of the time delayed.

C. Extensions of the time frames shall be granted to the department for good cause shown.

D. Disputes relating to the timeliness established in §§ 2.35 and 2.37, or to the grant of extensions to the DMAS, shall be resolved by application to the Director of the

DMAS or his designee.

PART III.
APPEALS.

§ 3.1. General.

A. NF's have the right to appeal the DMAS's interpretation and application of state and federal Medicaid and applicable Medicare principles of reimbursement in accordance with the Administrative Process Act, § 9-6.14.1 et seq. and § 32.1-325.1 of the Code of Virginia.

B. Nonappealable issues.

1. The use of state and federal Medicaid and applicable Medicare principles of reimbursement.

2. The organization of participating NF's into peer groups according to location as a proxy for cost variation across facilities with similar operating characteristics. The use of individual ceilings as a proxy for determining efficient operation within each peer group.

3. Calculation of the initial peer group ceilings using the most recent cost settled data available to DMAS that reflects NF operating costs inflated to September 30, 1990.

4. The use of the moving average of the Skilled Nursing Facility market basket of routine service costs, as developed by Data Resources, Incorporated, adjusted for Virginia, as the prospective escalator.

5. The establishment of separate ceilings for direct operating costs and indirect operating costs.

6. The use of Service Intensity Indexes to identify the resource needs of given NFs patient mix relative to the needs present in other NFs.

7. The development of Service Intensity Indexes based on:

a. Determination of resource indexes for each patient class that measures relative resource cost.

b. Determination of each NF's average relative resource cost index across all patients.

c. Standardizing the average relative resource cost indexes of each NF across all NF's.

8. The use of the DMAS Long Term Care Information System (LTCIS), assessment form (currently DMAS-95), Virginia Center on Aging Study, the State of Maryland Time and Motion Study of the Provision of Nursing Service in Long Term Care Facilities, and the KPMG Peat Marwick Survey of Virginia long-term care NF's nursing wages to determine the patient class system and resource indexes for each patient class.

9. The establishment of payment rates based on service intensity indexes.

§ 3.2. Conditions for appeal.

A. An appeal shall not be heard until the following conditions are met:

1. Where appeals result from desk or field audit adjustments, the provider shall have received a notification of program reimbursement (NPR) in writing from the DMAS.

2. Any and all moneys due to DMAS shall be paid in full, unless a repayment plan has been agreed to by the Director of the Division of Cost Settlement and Audit.

3. All first level appeal requests shall be filed in writing with the DMAS within 90 days following the receipt of a DMAS notice of program reimbursement that adjustments have been made to a specific cost report.

§ 3.3. Appeal procedure.

A. There shall be two levels of administrative appeal.

B. Informal appeals shall be decided by the Director o the Division of Cost Settlement and Audit after an informal fact finding conference is held. The decision of the Director of Cost Settlement and Audit shall be sent in writing to the provider within 30 days following conclusion of the informal fact finding conference.

C. If the provider disagrees with such initial decision the provider may, at its discretion, file a notice of appeal to the Director of the DMAS. Such notice shall be in writing and filed within 30 days of receipt of the initial decision.

D. Within 30 days of the receipt of such notice of appeal, the director shall appoint a hearing officer to conduct the proceedings, to review the issues and the evidence presented, and to make a written recommendation.

E. The director shall notify the provider of his final decision within 45 days of receipt of the appointed hearing officer's written recommendation, or after the parties have filed exceptions to the recommendations, whichever is later.

F. The director's final written decision shall conclude the provider's administrative appeal.

§ 3.4. Formal hearing procedures.

Formal hearing procedures, as developed by DMAS

shall control the conduct of the formal administrative proceedings.

§ 3.5. Appeals time frames.

Appeal time frames noted throughout this section may be extended for the following reasons;

A. The provider submits a written request prior to the due date requesting an extension for good cause and the DMAS approves the extension.

B. Delays on the part of the NF documented by the DMAS shall automatically extend DMAS's time frame to the extent of the time delayed.

C. Extensions of time frames shall be granted to the DMAS for good cause shown.

D. When appeals for multiple years are submitted by a NF or a chain organization or common owners are coordinating appeals for more than one NF, the time frames shall be reasonably extended for the benefit of the DMAS.

E. Disputes relating to the time lines established in § 3.3 B or to the grant of extensions to the DMAS shall be resolved by application to the Director of the DMAS or his designee.

PART IV.
INDIVIDUAL EXPENSE LIMITATION.

In addition to operating costs being subject to peer group ceilings, costs are further subject to maximum limitations as defined in VR 460-03-4.1943, Cost Reimbursement Limitations.

PART V.
COST REPORT PREPARATION INSTRUCTIONS.

Instructions for preparing NF cost reports will be provided by the DMAS.

PART VI.
STOCK TRANSACTIONS.

§ 6.1. Stock acquisition.

The acquisition of the capital stock of a provider does not constitute a basis for revaluation of the provider's assets. Any cost associated with such an acquisition shall not be an allowable cost. The provider selling its stock continues as a provider after the sale, and the purchaser is only a stockholder of the provider.

§ 6.2. Merger of unrelated parties.

A. In the case of a merger which combines two or more unrelated corporations under the regulations of the Code of Virginia, there will be only one surviving corporation. If the surviving corporation, which will own the assets and liabilities of the merged corporation, is not a provider, a Certificate of Public Need, if applicable, must be issued to the surviving corporation.

B. The nonsurviving corporation shall be subject to the policies applicable to terminated providers, including those relating to gain or loss on sales of NFs.

§ 6.3. Merger of related parties.

The statutory merger of two or more related parties or the consolidation of two or more related providers resulting in a new corporate entity shall be treated as a transaction between related parties. No revaluation shall be permitted for the surviving corporation.

PART VII.
NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM AND COMPETENCY EVALUATION PROGRAMS (NATCEPs).

§ 7.1. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) amended § 1903(a)(2)(B) of the Social Security Act to fund actual NATCEPs costs incurred by NFs separately from the NF's medical assistance services reimbursement rates.

§ 7.2. NATCEPs costs.

A. NATCEPs costs shall be as defined in VR 460-03-4.1941.

B. To calculate the reimbursement rate, NATCEPs costs contained in the most recently filed cost report shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days.

C. The NATCEPs interim reimbursement rate determined in § 7.2 B shall be added to the prospective operating cost and plant cost components or charges, whichever is lower, to determine the NF's prospective rate. The NATCEPs interim reimbursement rate shall not be adjusted for inflation.

D. Reimbursement of NF costs for training and competency evaluation of nurse aides must take into account the NF's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid shall not be charged for that portion of NATCEPs costs which are properly charged to Medicare or private pay services. The final retrospective reimbursement for NATCEPs costs shall be the reimbursement rate as calculated from the most recently filed cost report by the methodology in § 7.2 B times the Medicaid patient days from the DMAS MMR-240.

E. Disallowance of nonreimbursable NATCEPs costs shall be reflected in the year in which the nonreimbursable costs were claimed.

F. Payments to providers for allowable NATCEPs costs shall not be considered in the comparison of the lower allowable reimbursement or charges for covered services, as outlined in § 2.14 A.

PART VIII.
(Reserved)

PART IX.
USE OF MMR-240.

All providers must use the data from computer printout MMR-240 based upon a 60-day accrual period.

PART X.
COMMINGLED INVESTMENT INCOME.

DMAS shall treat funds commingled for investment purposes in accordance with PRM-15, § 202.6.

PART XI.
PROVIDER NOTIFICATION.

DMAS shall notify providers of State Plan changes affecting reimbursement 30 days prior to the enactment of such changes.

PART XII.
START-UP COSTS AND ORGANIZATIONAL COSTS.

§ 12.1. Start-up costs.

A. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they shall be capitalized as deferred charges and amortized over a 60-month time frame.

B. Start-up costs may include, but are not limited to, administrative and nursing salaries; heat, gas, and electricity; taxes, insurance; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as operating costs must be appropriately classified as such and excluded from start-up costs.

C. Start-up costs that are incurred immediately before a provider enters the Program and that are determined by the provider, subject to the DMAS approval, to be immaterial need not be capitalized but rather may be charged to operations in the first cost reporting period.

D. Where a provider incurs start-up costs while in the Program and these costs are determined by the provider, subject to the DMAS approval, to be immaterial, these costs shall not be capitalized but shall be charged to operations in the periods incurred.

§ 12.2. Applicability.

A. Start-up cost time frames.

1. Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient (whether Medicaid or non-Medicaid) is admitted for treatment, or where the start-up costs apply only to nonrevenue producing patient care functions or nonallowable functions, to the time the areas are used for their intended purposes.

2. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility shall be accumulated in a single deferred charge account and shall be amortized when the first patient is admitted for treatment.

3. If a provider intends to prepare portions of its facility on a piecemeal basis (i.e., preparation of a floor or wing of a provider's facility is delayed), start-up costs shall be capitalized and amortized separately for the portion or portions of the provider's facility prepared during different time periods.

4. Moreover, if a provider expands its NF by constructing or purchasing additional buildings or wings, start-up costs shall be capitalized and amortized separately for these areas.

B. Depreciation time frames.

1. Costs of the provider's facility and building equipment shall be depreciated using the straight line method over the lives of these assets starting with the month the first patient is admitted for treatment.

2. Where portions of the provider's NF are prepared for patient care services after the initial start-up period, those asset costs applicable to each portion shall be depreciated over the remaining lives of the applicable assets. If the portion of the NF is a nonrevenue-producing patient care area or nonallowable area, depreciation shall begin when the area is opened for its intended purpose. Costs of major movable equipment, however, shall be depreciated over the useful life of each item starting with the month the item is placed into operation.

§ 12.3. Organizational costs.

A. Organizational costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organizational costs extend over more than one accounting period and thus affect the costs of future periods of operations.

B. Allowable organizational costs shall include, but not

be limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders and fees paid to states for incorporation.

C. The following types of costs shall not be considered allowable organizational costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate state or federal authorities, stamp taxes, etc.

D. Allowable organization costs shall generally be capitalized by the organization. However, if DMAS concludes that these costs are not material when compared to total allowable costs, they may be included in allowable indirect operating costs for the initial cost reporting period. In all other circumstances, allowable organization costs shall be amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.

PART XIII.
DMAS AUTHORIZATION.

§ 13.1 Access to records.

A. DMAS shall be authorized to request and review, either through a desk or field audit, all information related to the provider's cost report that is necessary to ascertain the propriety and allocation of costs (in accordance with Medicare and Medicaid rules, regulations, and limitations) to patient care and nonpatient care activities.

B. Examples of such information shall include, but not be limited to, all accounting records, mortgages, deeds, contracts, meeting minutes, salary schedules, home office services, cost reports, and financial statements.

C. This access also applies to related organizations as defined in § 2.10 who provide assets and other goods and services to the provider.

PART XIV.
HOME OFFICE COSTS.

§ 14.1. General.

Home office costs shall be allowable to the extent they are reasonable, relate to patient care, and provide cost savings to the provider.

§ 14.2. Purchases.

Provider purchases from related organizations, whether for services, or supplies, shall be limited to the lower of the related organizations actual cost or the price of comparable purchases made elsewhere.

§ 14.3. Allocation of home office costs.

Home office costs shall be allocated in accordance with § 2150.3, PRM-15.

§ 14.4. Nonrelated management services.

Home office costs associated with providing management services to nonrelated entities shall not be recognized as allowable reimbursable cost.

§ 14.5. Allowable and nonallowable home office costs.

Allowable and nonallowable home office costs shall be recognized in accordance with § 2150.2, PRM-15.

§ 14.6. Equity capital.

Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

PART XV.
REFUND OF OVERPAYMENTS.

§ 15.1. Lump sum payment.

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

§ 15.2. Offset.

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

§ 15.3. Payment schedule.

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

B. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if

a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of DMAS may approve a repayment schedule of up to 36 months.

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

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

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

§ 15.4. Extension request documentation.

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

§ 15.5. Interest charge on extended repayment.

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

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

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

PART XVI.
REVALUATION OF ASSETS.

§ 16.1. Change of ownership.

A. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, reimbursement for capital upon the change of ownership of a NF is restricted to the lesser of:

1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year, or

2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

B. To comply with the provisions of COBRA 1985, effective October 1, 1986, the DMAS shall separately apply the following computations to the capital assets of each facility which has undergone a change of ownership:

1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index, or

2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U).

C. Change of ownership is deemed to have occurred only when there has been a bona fide sale of assets of a NF (See § 2.5 B 3 for the definition of "bona fide" sale).

D. Reimbursement for capital assets which have been revalued when a facility has undergone a change of ownership shall be limited to the lesser of:

1. The amounts computed in subsection B above;

2. Appraised replacement cost value; or

3. Purchase price.

* * *

NOTICE: The forms used in administering the above regulations are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Nursing Facility Uniform Cost Report Under Title XIX - Facility Description and Statistical Data (Schedule A)
Certification by Officer or Administrator of Provider (Schedule A-2)
Reclassification and Adjustment of Trial Balance of Expenses (Schedule B)
Classifications (Schedule B-1)
Analysis of Administrative and General - Other (Schedule B-2)
Adjustment to Expenses (Schedule B-4)
Cost Allocation - Employee Benefits (Schedule B-5)
Computation of Title XIX Direct Patient Care Ancillary Service Costs (Schedule C)
Statement of Cost of Services and Related Organizations (Schedule D)
Statement of Compensation of Owners (Schedule E)
Part II Statement of Compensation Administrators and/or Assistant Administrators (Schedule F)
Balance Sheet (Schedule G)
Statement of Patient Revenues (Schedule G-1)
Statement of Operations (Schedule G-2)
Computation of Title XIX (Medicaid) Base Costs and Prospective Rate/PIRS (Schedule H)
Computation of Prospective Direct and Indirect Patient Care Profit Incentive Rates (Schedule H-1)
Calculation of Medical Service Reimbursement Settlement (Schedule J)
Calculation of NATCEPs Reimbursement Settlement (Schedule J-1)
Debt and Interest Expenses (Schedule K)
Limitation on Federal Participation for Capital Expenditures Questionnaire (Schedule L)
Nurse Aide Training and Competency Evaluation Program Costs and Competency Evaluation Programs (NATCEPs) (Schedule N)
Certification by Officer or Administrator of Provider (Schedule A-1)
Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Statistical Data (Worksheet S-3)
Reclassification and Adjustment of Trial Balance of Expenses (Worksheet A)
Reclassification (Worksheet A-6)
Adjustments to Expenses (Worksheet A-8)
Statement of Costs of Services from Related Organizations (Supplemental Worksheet A-8)
Cost Allocation - General Service Costs (Worksheet B, Part I)
Cost Allocation - Statistical Basis (Worksheet B-1)
Allocation of Capital-Related Costs (Worksheet B, Part II)
Departmental Cost Distribution (Worksheet C)
Computation of Patient Intensity Reimbursement System Base Operating Costs (Schedule A-3)
Computation of Direct Patient Care Nursing Service Costs (Schedule A-4)

BOARD OF MEDICINE

Title of Regulation: **VR 465-03-01. Regulations Governing the Practice of Physical Therapy.**

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

Public Hearing Date: N/A - Written comments may be submitted until February 3, 1992.
(See Calendar of Events section for additional information)

Summary:

The proposed amendments to the current regulations are to more clearly define the physical therapist's supervisory responsibilities for specific practice settings, define the number of trainees the therapist may supervise in a traineeship program approved by the board, and further define on-site supervision of the physical therapist assistant in hospitals and other practice settings.

VR 465-03-01. Regulations Governing the Practice of Physical Therapy.

PART I.
GENERAL PROVISIONS.

§ 1.1. Definitions.

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

"Board" means the Virginia Board of Medicine.

"Advisory board" means the Advisory Board on Physical Therapy.

"Evaluation" means the carrying out by a physical therapist of the sequential process of assessing a patient, planning the patient's physical therapy treatment program, and appropriate documentation.

"Examination" means an examination approved and prescribed by the board for licensure as a physical therapist or physical therapist assistant.

"Physical therapist" means a person qualified by education and training to administer a physical therapy program under the direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery.

"Physical therapist assistant" means a person qualified by education and training to perform physical therapy functions under the supervision of and as directed by a physical therapist.

"Physical therapy aide" means any nonlicensed personnel performing patient care functions at the direction of a physical therapist or physical therapist assistant within the scope of these regulations.

"Referral and direction" means the referral of a patient by a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery to a physical therapist for a specific purpose and for consequent treatment that will be performed under the direction of and in continuing communication with the referring doctor or dentist.

"Trainee" means a person undergoing a traineeship.

1. *"Relicensure trainee"* means a physical therapist or physical therapist assistant who has been inactive for two years or more and who wishes to return to the practice of physical therapy.

2. *"Unlicensed graduate trainee"* means a graduate of an approved physical therapy or physical therapist assistant program who has not taken the state licensure examination or who has taken the examination but not yet received a license from the board or who has failed the examination three times as specified in § 3.3 A.

3. *"Foreign trained trainee"* means a physical therapist or physical therapist assistant who graduated from a school outside the United States, its territories, or the District of Columbia and who is seeking licensure to practice in Virginia.

"Traineeship" means a period of activity during which an unlicensed physical therapist or physical therapist assistant works under the direct supervision of a physical therapist approved by the board.

"Direct supervision" means a physical therapist is present and is fully responsible for the activities assigned to the trainee.

§ 1.2. A separate board regulation entitled VR 465-01-01, Public Participation Guidelines, which provides for involvement of the public in the development of all regulations of the Virginia State Board of Medicine, is incorporated by reference in these regulations.

PART II.
LICENSURE: GENERAL REQUIREMENTS AND LICENSURE BY EXAMINATION.

§ 2.1. Requirements, general.

A. No person shall practice as a physical therapist or physical therapist assistant in the Commonwealth of Virginia except as provided in these regulations.

B. Licensure by this board to practice as a physical therapist or physical therapist assistant shall be by examination or by endorsement, whichever is appropriate.

§ 2.2. Licensure by examination: Prerequisites to examination.

A. Every applicant for initial board licensure by examination shall:

1. Meet the age and character requirements of §§ 54.1-2947 and 54.1-2948 of the Code of Virginia;

2. Meet the educational requirements prescribed in § 2.3 or § 2.4 of these regulations;

3. Submit the required application and credentials to the board not less than 30 days prior to the date of examination; and

4. Submit, along with his application, the examination fee prescribed in § 9.1, Fees, of these regulations.

B. Every applicant shall take the examination at the time prescribed by the board.

§ 2.3. Education requirements: Graduates of American institutions or programs.

A. A graduate of an American institution who applies fo licensure as a physical therapist shall be a graduate of a school of physical therapy approved by the American Physical Therapy Association and shall submit to the board documented evidence of his graduation from such a school.

B. An applicant for licensure as a physical therapist assistant who attended an American institution shall be a graduate of a two-year college-level educational program for physical therapist assistants approved by the board and shall submit to the board documented evidence of his graduation from such a program.

§ 2.4. Educational requirement: Graduates of foreign institutions.

A. An applicant for licensure as a physical therapist or physical therapist assistant who graduated from a school outside the United States or Canada shall be a graduate of such a school which offers and requires courses in physical therapy acceptable to the board on the advice of the advisory board.

B. An applicant under this section for licensure as a physical therapist or physical therapist assistant, when filing his application and examination fee with the board, shall also:

1. Submit proof of proficiency in the English language

by passing with a grade of not less than 560, the Test of English as a Foreign Language (TOEFL); or an equivalent examination approved by the board. TOEFL may be waived upon evidence of English proficiency.

2. Submit a photostatic copy of the original certificate or diploma verifying his graduation from a physical therapy curriculum which has been certified as a true copy of the original by a notary public.

3. If such certificate or diploma is not in the English language, submit either:

a. A translation of such certificate or diploma by a qualified translator other than the applicant; or

b. An official certification from the school attesting to the applicant's attendance and graduation date.

4. Submit verification of the equivalency of the applicant's education to the following standards from a scholastic credentials service approved by the advisory board.

a. The minimum educational requirements in general and professional education for licensure as a physical therapist shall be 120 semester hours as follows:

(1) General education requirements. 40 or more semester hours in the following subjects: humanities, social sciences, natural sciences, biological sciences and electives.

(2) Professional education requirements. 60 or more semester hours; the course of professional study shall include: basic health sciences, clinical sciences, clinical education, and other electives.

b. The minimum requirements in general and professional education for licensure as a physical therapist assistant shall be 68 semester hours as follows:

(1) General education requirements: 24 or more semester hours in the following subjects: humanities, social sciences, natural sciences, biological sciences, and electives.

(2) Professional educational requirements: 44 or more semester hours in the following course of professional study: basic health sciences, clinical sciences, clinical education, and electives.

c. Education requirements of foreign trained physical therapists or physical therapist assistants shall be equivalent to the entry level degree of U.S. trained physical therapists or physical therapist assistants as established by the American Physical Therapy Association.

5. An applicant for licensure as a physical therapist shall submit verification of having successfully completed a full-time 1000 hour traineeship (approximately six months) under the direct supervision of a physical therapist licensed under § 54.1-2946 of the Code of Virginia. The initial 500 hours must be in an acute care facility treating both in and out patients and 500 hours may be in another type of physical therapy facility which is on the list approved by the advisory board.

6. An applicant for licensure as a physical therapist assistant shall submit verification of having successfully completed a full-time 500 hour traineeship in an acute care facility under the direct supervision of a physical therapist licensed under § 54.1-2946 of the Code of Virginia treating both inpatients and outpatients in a facility which meets the requirements of subdivision 7 below.

7. The traineeship must be completed in Virginia:

a. At a JCAH accredited hospital or other facility approved by the advisory board; and

b. At a facility that serves as a clinical education facility for students enrolled in an accredited program educating physical therapists or physical therapist assistants in Virginia.

8. It will be the responsibility of the trainee to make the necessary arrangements for his training with the Director of Physical Therapy, or the director's designee at the facility selected by the trainee.

9. The physical therapist supervising the trainee shall submit a progress report to the chairman of the advisory board at the end of 500 hours of training. A final report will be submitted at the end of the second 500 hours. These reports will be submitted on forms supplied by the advisory board.

10. If the trainee's performance is unsatisfactory, during the training period, the supervising therapist will notify, in writing, the chairman of the advisory board.

11. If the traineeship is not successfully completed at the end of the six-month period, the advisory board shall determine if the traineeship will be continued for a period not to exceed six months.

12. The traineeship requirements of this part may be waived, at the discretion of the advisory board, if the applicant for licensure can verify, in writing, the successful completion of one year of clinical practice in the United States, its territories or the District of Columbia.

13. A foreign trained physical therapist or physical therapist assistant licensed in another state who has

less than one year of clinical practice in the United States, its territories or the District of Columbia must comply with the traineeship requirement for licensure by endorsement.

PART III.
EXAMINATION.

§ 3.1. Conditions of examinations.

A. The licensure examinations for both physical therapists and physical therapist assistants shall be prepared and graded as prescribed and approved by the board.

B. The advisory board shall schedule and conduct the examinations at least once each fiscal year, the time and place to be determined by the advisory board.

C. The physical therapy examination shall be a one-part comprehensive examination approved by the board as prescribed in § 54.1-2947 of the Code of Virginia.

D. The physical therapy assistant examination shall be an examination approved by the board as prescribed in § 54.1-2948.

§ 3.2. Examination scores.

A. The minimum passing scores shall be:

1. For the physical therapy examination: the grade shall be established by the board.

2. For the physical therapist assistant examination: the grade shall be established by the board.

B. The scores shall be filed with the appropriate reporting service.

§ 3.3. Failure to pass.

An applicant who fails the examination after three attempts shall be required to satisfactorily complete a full time supervised traineeship approved by the chairman of the Advisory Board on Physical Therapy as prescribed in § 8.4, Traineeship, prior to being eligible for three additional attempts.

PART IV.
LICENSURE BY ENDORSEMENT.

§ 4.1. Endorsement.

A. A physical therapist or physical therapist assistant who has been licensed by another state or territory or the District of Columbia by examination equivalent to the Virginia examination at the time of licensure and who has met all other requirements of the board may, upon recommendation of the advisory board to the board, be licensed in Virginia by endorsement.

B. Any physical therapist or physical therapist assistant seeking endorsement or as described in § 7.2 B who has been inactive for a period of two years or more and who wishes to resume practice shall first successfully complete a traineeship.

PART V.
PRACTICE OF PHYSICAL THERAPY.

§ 5.1. General requirements.

All services rendered by a physical therapist shall be performed only upon medical referral by and under the direction of a doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery.

§ 5.2. Individual responsibilities to patients and to referring doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery.

A. The physical therapists' responsibilities are to evaluate a patient, plan the treatment program and administer and document treatment within the limit of his professional knowledge, judgment, and skills.

B. A physical therapist shall maintain continuing communication with and shall report the results of periodic evaluation of patients to the referring practitioner.

§ 5.3. Supervisory responsibilities.

A. A physical therapist shall supervise no more than three physical therapist assistants at any one time ~~participating in the treatment of patients~~ *per practice setting, but not to exceed a total of three practice settings* .

B. A physical therapist shall be responsible for any action of persons performing physical therapy functions under the physical therapist's supervision or direction.

C. A physical therapist may not delegate physical therapy treatments to physical therapy aides except those activities that are available without prescription in the public domain to include but not limited to hot packs, ice packs, massage and bandaging.

D. Supervision of a physical therapy aide means that a licensed physical therapist or licensed physical therapist assistant must be within the facility to give direction and instruction when procedures or activities are performed. Such nonlicensed personnel shall not perform those patient care functions that require professional judgment or discretion.

E. For patients assigned to a physical therapist assistant, the physical therapist shall make *on-site* visits to such patients jointly with the assistant at the frequency prescribed in § 6.1 of these regulations.

F. The advisory board may at its discretion approve the

utilization of more than three physical therapist assistants supervised by a single physical therapist in institutions under the supervision of the Department of Mental Health, Mental Retardation and Substance Abuse Services where the absence of physical therapy care would be detrimental to the welfare of the residents of the institution.

G. A physical therapist shall supervise no more than two trainees at any one time as established in § 2.4 and Part VIII of these regulations.

PART VI.
PRACTICE OF PHYSICAL THERAPIST ASSISTANTS.

§ 6.1. Scope of responsibility.

A. A physical therapist assistant is permitted to perform all physical therapy functions within his capabilities and training as directed by a physical therapist. The scope of such functions excludes initial evaluation of the patient, initiation of new treatments, and alteration of the plan of care of the patient.

B. Direction by the physical therapist shall be interpreted as follows:

1. The initial patient visit shall be made by the physical therapist for evaluation of the patient and establishment of a plan of care.

2. The physical therapist assistant's first visit to the patient shall be made jointly with the physical therapist.

3. The physical therapist shall provide on-site supervision ~~one of every five visits made to the patient by the physical therapist assistant during a 30-day period. Should there be fewer than five visits to the patient by the physical therapist assistant in a 30-day period, the assistant shall be supervised on-site at least once during that period by the physical therapist.~~ *according to the following schedules:*

a. For inpatients in hospitals, once a week.

b. For all other patients, one of 12 visits made to the patient during a 30-day period, or once every 30 days, whichever comes first.

4. Failure to abide by this regulation due to absence of the physical therapist in case of illness, vacation, or professional meeting, for a period not to exceed five consecutive days, will not constitute violation of the foregoing provisions.

PART VII.
RENEWAL OF LICENSURE; UPDATE FOR QUALIFICATIONS.

§ 7.1. Biennial renewal of license.

Every physical therapist and physical therapist assistant who intends to continue practice shall renew his license biennially during his birth month in each even numbered year and pay to the board the renewal fee prescribed in § 9.1 of these regulations.

A. A licensee whose license has not been renewed by the first day of the month following the month in which renewal is required shall be dropped from the registration roll.

B. An additional fee to cover administrative costs for processing a late application shall be imposed by the board. The additional fee for late renewal of licensure shall be $25 for each renewal cycle.

§ 7.2. Updates on professional activities.

A. The board shall require from physical therapists and physical therapist assistants licensed or applying for licensure in Virginia reports concerning their professional activities as shall be necessary to implement the provisions of these regulations.

B. A minimum of 320 hours of practice shall be required for licensure renewal for each biennium.

C. Any physical therapist or physical therapist assistant who fails to meet the requirements of subsection B of this section shall be considered to have been inactive since the professional activity requirement was last satisfied and the license shall be deemed to have expired and become invalid.

PART VIII.
TRAINEESHIP REQUIREMENTS.

§ 8.1. Traineeship required for relicensure.

A. Any physical therapist or physical therapist assistant who has been inactive as described in § 7.1 for a period of two years or more and who wishes to resume practice shall first successfully complete a traineeship.

B. The period of traineeship to be served by such person shall be:

1. A minimum of one month full time for those inactive for a period of two to six years.

2. A minimum of two months full time for those inactive for a period of seven to 10 years.

3. A minimum of three months full time for those inactive for a period exceeding 10 years.

C. The physical therapist who serves as the supervisor of a trainee under this section shall certify to the advisory board upon completion of the traineeship that the trainee's knowledge and skills meet current standards of the practice of physical therapy.

D. Upon receipt of a petition from a person seeking relicensure and declaring hardship, the advisory board may, at its discretion, recommend to the board that the traineeship provision be waived.

§ 8.2. Additional requirement for physical therapist examination.

In addition to the traineeship required in § 8.1, any physical therapist seeking relicensure who has been inactive for seven years or more shall take and pass the examination approved by the board and pay a fee as prescribed in § 9.1. If a trainee fails the examination three times, the trainee must appear before the advisory board prior to additional attempts.

§ 8.3. Exemption for physical therapist assistant.

A physical therapist assistant seeking relicensure who has been inactive shall be exempt from reexamination requirements but not from traineeship requirements.

§ 8.4. Traineeship required for unlicensed graduate scheduled to sit for the board's licensure examination as required by regulation in § 2.1.

A. Upon approval of the chairman of the advisory board, an unlicensed graduate trainee may be employed under the direct supervision of a physical therapist while awaiting the results of the next licensure examination.

B. The traineeship shall terminate upon receipt by the candidate of the licensure examination results.

C. A person not taking the licensure examination within three years after graduation shall successfully complete a full-time three-month traineeship before taking the licensure examination.

PART IX.
FEES.

§ 9.1. The following fees have been established by the board:

1. The fee for physical therapist examination shall be $200.

2. The fee for the physical therapist assistant examination shall be $200.

3. The fee for licensure by endorsement for the physical therapist shall be $225.

4. The fee for licensure by endorsement for the physical therapist assistant shall be $225.

5. The fees for taking the physical therapy or physical therapist assistant examination are nonrefundable. An applicant may, upon request 21 days prior to the scheduled exam, and payment of the $100 fee, reschedule for the next time such examination is given.

6. The fee for license renewal for a physical therapist assistant's license is $80 and shall be due in the licensee's birth month, in each even numbered year. An additional fee to cover administrative costs for processing a late application may be imposed by the board. The additional fee for late renewal of licensure shall be $25 for each renewal cycle.

7. The fee for license renewal for a physical therapy license is $125 and shall be due in the licensee's birth month, in each even numbered year. An additional fee to cover administrative costs for processing a late application may be imposed by the board. The additional fee for late renewal of licensure shall be $25 for each renewal cycle.

8. The examination fee for reinstatement of an inactive license as prescribed in § 8.2 shall be 200.

9. Lapsed license. The fee for reinstatement of a physical therapist or a physical therapist assistant license issued by the Board of Medicine pursuant to § 54.1-2904, which has expired for a period of two years or more, shall be $225 and must be submitted with an application for licensure reinstatement.

* * *

NOTICE: The forms used in administering the Physical Therapy Regulations are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Board of Medicine, 1601 Rolling Hills Drive, Suite 200, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Instructions for Licensure by Endorsement to Practice as a Physical Therapist/Physical Therapist Assistant (DHP-30-059), Revised 10/25/91
Instructions for Licensure by Endorsement to Practice as a Physical Therapist/Physical Therapist Assistant - Foreign Graduates (DHP-30-059), Revised 10/25/91
Instructions for Licensure by Examination to Practice as a Physical Therapist (DHP-30-059), Revised 10/25/91
Instructions for Licensure by Examination for Foreign Graduates to Practice as a Physical Therapist (DHP-30-059), Revised 10/25/91
Application for a License to Practice Physical Therapy
Quiz - Physical Therapy Practice Act, Revised 10/25/91
Physical Therapist Licensing, Physical Therapist Assistant Licensing, Revised 6/90
Professional Reporting Service (PRS)
Verification of Physical Therapy Practice (DHP-30-059), Revised 10/2/91
Verification of State Licensure (DHP-30-059), Revised 10/2/91
Licensure Registration

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Title of Regulation: **VR 465-05-1. Regulations Governing the Practice of Physicians' Assistants.**

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

Public Hearing Date: N/A – Written comments may be submitted until February 3, 1992.

Summary:

These regulations protect the health, safety, and welfare of the citizens of the Commonwealth by establishing requirements for license, license fees, and renewal of license.

The proposed amendments to the current regulations redefine the license renewal period to be biennial in each odd-numbered year in the birth month of the licensee; adjust the renewal fee to reflect the extended renewal period; and delete the term "certification" and insert the term "licensure" to comply with the recodification of Title 54.1 of the Code of Virginia.

VR 465-05-01. Regulations Governing the Practice of Physicians' Assistants.

PART I.
GENERAL PROVISIONS.

§ 1.1. Definitions.

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

"Assistant to a Doctor of Medicine, Osteopathy, or Podiatry," or *"Physician's Assistant,"* means an individual who is qualified as an auxiliary paramedical person by academic and clinical training and is functioning in a dependent-employee relationship with a doctor of medicine, osteopathy, or podiatry licensed by the board.

"Board" means the Virginia Board of Medicine.

"Committee" means the Advisory Committee on Physician's Assistants appointed by the president of the board to advise the board on matters relating to physician's assistants. The committee is composed of four members of the board, one supervising physician, and two physician's assistants.

"Group practice" means the practice of a group of two or more doctors of medicine, osteopathy, or podiatry licensed by the board who practice as a partnership or professional corporation.

"Institution" means a hospital, nursing home or other health care facility, community health center, public health center, industrial medicine or corporation clinic, a medical service facility, student health center, or other setting approved by the board.

"NCCPA" means the National Commission on Certification of Physician Assistants.

"Protocol" means a set of directions developed by the supervising physician that defines the supervisory relationship between the physician assistant and the physician and the circumstances under which the physician will see and evaluate the patient.

~~*"Supervising physician"* means a doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth of Virginia who has registered with the board and who has accepted responsibility for the supervision of the service that a physician's assistant renders.~~

"Supervision means" :

1. *"Alternate supervising physician"* means a member of the same group or professional corporation or partnership of any licensee, any hospital or any commercial enterprise with the supervising physician. Such alternating supervising physician shall be a physician licensed in the Commonwealth of Virginia who has registered with the board and who has accepted responsibility for the supervision of the service that a physician's assistant renders.

2. *"Direct supervision"* means the physician is in the room in which a procedure is being performed.

3. *"General supervision"* means the supervising physician is easily available and can be physically present within one hour.

4. *"Personal supervision"* means the supervising physician is within the facility in which the physician's assistant is functioning.

5. *"Supervising physician"* means the supervising physician who makes application to the board for licensure of the assistant.

6. *"Substitute supervising physician"* means a doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth of Virginia who has accepted responsibility for the supervision of the service that a physician's assistant renders in the absence of such assistant's supervising physician.

§ 1.2. Applicability.

These regulations apply to physician's assistants only, as defined in § 1.1.

§ 1.3. A separate board regulation, VR 465-01-01, entitled Public Participation Guidelines, which provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine, is

incorporated by reference in these regulations.

PART II.
REQUIREMENTS FOR PRACTICE AS A PHYSICIAN'S ASSISTANT.

§ 2.1. Requirements, general.

A. No person shall practice as a physician's assistant in the Commonwealth of Virginia except as provided in these regulations.

B. All services rendered by a physician's assistant shall be performed only under the supervision of a doctor of medicine, osteopathy, or podiatry licensed by this board to practice in the Commonwealth of Virginia.

§ 2.2. ~~Certification,~~ *Licensure:* Entry requirements and application.

A. A ~~certificate~~ *license* to practice as a physician's assistant shall be obtained from the board before such assistant begins to practice with a supervising doctor of medicine, osteopathy, or podiatry.

B. Entry requirements.

An applicant for ~~certification~~ *licensure* shall:

1. Possess the educational qualifications prescribed in § 2.3 of these regulations; and

2. Meet the requirements for examination prescribed in §§ 3.1 through 3.3 of these regulations.

C. Application for board approval of a physician's assistant shall be submitted to the board by the supervising physician under whom the assistant will work, and who will assume the responsibility for the assistant's performance. By submitting the application, the supervising physician attests to the general competence of the assistant. In a group or institutional practice setting, the supervising physician shall be the contact for the board regardless of whether the supervision has been delegated to an alternate or substitute supervising physician.

D. The application shall:

1. Be made on forms supplied by the board and completed in every detail;

2. Spell out the roles and functions of the assistant with a protocol acceptable to the board and any such protocols shall take into account such factors as the number of patients, the types of illness treated by the physician, the nature of the treatment, special procedures, and the nature of the physician's availability in ensuring direct physician involvement at an early stage and regularly thereafter;

The board may require, at its discretion, in a supplement to the application, information regarding the level of supervision, "direct," "personal" or "general," with which the supervising physician plans to supervise the physician's assistant for selected tasks. The board may also require the supervising physician to document the assistant's competence in performing such tasks.

3. Provide that, if for any reason the assistant discontinues working in the employment and under the supervision of the licensed practitioner who submitted the application:

a. Such assistant and the employing practitioner shall so inform the board and the assistant's approval shall terminate.

b. A new application shall be submitted to the board and approved by the board in order for the assistant either to be reemployed by the same practitioner or to accept new employment with another supervising physician.

E. The application fee prescribed in § 5.1 of these regulations shall be paid at the time the application is filed.

§ 2.3. Educational requirements.

An applicant for ~~certification~~ *licensure* shall:

1. Have successfully completed a prescribed curriculum of academic study in a school or institution accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association and accredited by the American Academy of Physician Assistants; and

2. Present documented evidence of eligibility for the NCCPA examination or completed ~~certification~~ *licensure* requirements.

PART III.
EXAMINATION.

§ 3.1. The proficiency examination of the NCCPA constitutes the board examination required of all applicants for ~~certification~~ *licensure* .

§ 3.2. Provisional registration.

An applicant who has met the requirements of the board at the time his initial application is submitted may be granted provisional registration by the board if he meets the provisions of § 54.1-2950 of the Code of Virginia and § 2.3 of these regulations. Such provisional ~~registration~~ *licensure* shall be subject to the following conditions:

A. The provisional ~~registration~~ *licensure* shall be valid until the applicant takes the next subsequent NCCPA examination and its results are reported, but this period of

validity shall not exceed 30 days following the reporting of the examination scores.

B. An applicant who fails the examination may be granted individual consideration by the board and granted an extension of the provisional ~~registration~~ *licensure* upon evidence that he is eligible for admission to the next scheduled board examination.

§ 3.3. Examination.

A. Every applicant shall take the NCCPA examination at the time scheduled by the NCCPA.

B. An applicant who fails the examination three consecutive times shall surrender his ~~certificate~~ *license* to practice until proof has been provided to the board that the standards of NCCPA have been met.

§ 3.4. Renewal of ~~certificate~~ *license* .

A. Every ~~certified~~ *licensed* physician's assistant intending to continue ~~his~~ *to* practice shall ~~annually on or before July 1~~ *biennially renew the license in each odd numbered year in the licensee's birth month* :

1. Register with the board for renewal of his ~~certificate~~ *license* ;

2. Present documented evidence of compliance with continuing medical education standards established by the NCCPA; and

3. Pay the ~~prescribed~~ renewal fee *as prescribed in § 5.1 B* at the time ~~he files for~~ *of filing the license* renewal.

B. Any physician's assistant who allows his NCCPA certification to lapse shall be considered not ~~certified~~ *licensed* by the board. Any such assistant who proposes to resume his practice shall make a new application for ~~certification~~ *licensure* .

PART IV.
INDIVIDUAL RESPONSIBILITIES.

§ 4.1. Individual responsibilities.

A supervising physician and the physician's assistants working with him shall observe the following division of responsibilities in the care of patients:

A. The supervising physician shall:

1. See and evaluate any patient who presents with the same complaint twice in a single episode of care and has failed to improve significantly. Such physician involvement shall occur not less frequently than every fourth visit for a continuing illness.

2. Review the record of services rendered the patient by the physician's assistant and sign such records within 24 hours after any such care was rendered by the assistant.

3. Be responsible for all invasive procedures. Under general supervision, a physician's assistant may insert a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow-directed catheter, and may perform minor suturing, venipucture, and subcutaneous intramuscular or intravenous injection.

All other invasive procedures not listed above must be performed under direct supervision unless, after directly supervising the performance of a specific invasive procedure three times or more, the supervising physician attests to the competence of the physician's assistant to perform the specific procedure without direct supervision by certifying to the board in writing the number of times the specific procedure has been performed and that the physician's assistant is competent to perform the specific procedure. After such certification has been accepted and approved by the board, the physician's assistant may perform the procedure under general supervision.

B. The physician's assistant shall not render independent health care. Such assistant:

1. Shall perform only those medical care services that are within the scope of the practice and proficiency of the supervising physician as prescribed in the physician's assistants protocol.

2. Shall not sign prescriptions.

3. Shall, during the course of performing his duties, wear identification showing clearly that he is a physician's assistant.

C. If the assistant is to perform duties away from the supervising physician, such supervising physician shall obtain board approval in advance for any such arrangement and shall establish written policies to protect the patient.

D. If, due to illness, vacation, or unexpected absence, the supervising physician is unable to supervise personally the activities of his assistant, such supervising physician may temporarily delegate the responsibility to another doctor of medicine, osteopathy, or podiatry. The employing supervising physician so delegating his responsibility shall report such arrangement for coverage, with the reason therefor, to the board office in writing, subject to the following provisions:

1. For planned absence, such notification shall be received at the board office at least one month prior to the supervising physician's absence.

2. For sudden illness or other unexpected absence, the

board office shall be notified as promptly as possible, but in no event later than one week.

3. Temporary coverage may not exceed four weeks unless special permission is granted by the board.

E. With respect to assistants employed by institutions, the following additional regulations shall apply:

1. No assistant may render care to a patient unless the physician responsible for that patient has signed an application to act as supervising physician for that assistant. The board shall make available appropriate forms for physicians to join the application for an assistant employed by an institution.

2. Any such application as described in subdivision 1 above shall delineate the duties which said physician authorizes the assistant to perform.

3. The assistant shall as soon as circumstances may dictate but, within an hour, report to the supervising physician concerning the examination of the patient. The assistant shall also record his findings in appropriate institutional records.

4. No physician assistant shall perform the initial evaluation, or institute treatment of a patient who presents to the emergency room or is admitted to the hospital for a life threatening illness or injury. In noncritical care areas, the physician assistant may perform the initial evaluation in an inpatient setting provided the supervising physician evaluates the patient within eight hours of the physician assistant's initial evaluation.

PART V.
FEES.

§ 5.1. The following fees are required:

A. The application fee, payable at the time application is filed, shall be $100.

B. The ~~annual~~ *biennial* fee for renewal of ~~registration,~~ *license shall be $80* payable ~~on~~ ~~or~~ ~~before~~ ~~July~~ ~~1,~~ ~~shall~~ ~~be~~ ~~$40~~ *in each odd numbered year in the birth month of the licensee* .

C. An additional fee to cover administrative costs for processing a late application may be imposed by the board. The additional fee for late renewal of licensure shall be $10 for each renewal cycle.

* * *

NOTICE: The forms used in administering the Physician's Assistants Regulations are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Board of Medicine, 1601 Rolling Hills Drive, Suite 200, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Instructions for Completing Physician Assistant Application
Application for Certification as a Physician's Assistant (DHP-30-056), Revised 8/91
Protocol of Physician's Assistant's Duties (Form #1)
Physician Assistant Invasive Procedures Protocol (Form #2)
Employment Verification (HRB-30-056) # B
License Verification (HRB-30-056) # C
Licensure Registration

For information concerning Final Regulations, see information page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates new text. Language which has been stricken indicates text to be deleted. [Bracketed language] indicates a substantial change from the proposed text of the regulations.

STATE AIR POLLUTION CONTROL BOARD

REGISTRAR'S NOTICE: This regulation is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially form those required by federal law or regulation. The State Air Pollution Control Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **VR 120-01. Regulations for the Control and Abatement of Air Pollution: Nonattainment Areas (Appendix K) and Prevention of Significant Deterioration Areas (Appendix L).**

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

Effective Date: January 1, 1992.

Summary:

The amendments (i) revise the geographic delineation of the nonattainment areas to correspond to the recent federal promulgation (Appendix K); and (ii) revise the geographic delineation of the prevention of significant deterioration areas to correspond to the recent federal promulgation (Appendix L).

VR 120-01. Regulations for the Control and Abatement of Air Pollution: Nonattainment Areas (Appendix K) and Prevention of Significant Deterioration Areas (Appendix L).

APPENDIX K.
NONATTAINMENT AREAS.

Nonattainment Areas are geographically defined below *by locality* for the ~~following~~ criteria pollutants *indicated* : . *Following the name of each nonattainment area, in parentheses, is the classification assigned pursuant to Section 181 (a) for ozone and Section 186 (a) for carbon monoxide of the Federal Clean Air Act.*

~~A. Particulate Matter~~

~~None~~

~~B. Sulfur Dioxide~~

~~None~~

~~C. Carbon Monoxide~~

~~1. Air Quality Control Regions 1 through 6~~	~~None~~
~~2. Air Quality Control Region 7~~	~~† Alexandria City~~ ~~† Arlington County~~

~~D. Ozone~~

~~1. Air Quality Control Region 1~~	~~None~~
~~2. Air Quality Control Region 2~~	~~None~~
~~3. Air Quality Control Region 3~~	~~None~~
~~4. Air Quality Control Region 4~~	~~None~~
~~5. Air Quality Control Region 5~~	~~† Richmond City~~ ~~† Chesterfield County~~ ~~† Henrico County~~
~~6. Air Quality Control Region 6~~	~~None~~
~~7. Air Quality Control Region 7~~	~~† Alexandria City~~ ~~† Fairfax City~~ ~~† Falls Church City~~ ~~† Manassas City~~ ~~† Manassas Park City~~ ~~† Arlington County~~ ~~† Fairfax County~~ ~~† Loudoun County~~ ~~† Prince William County~~

~~E. Nitrogen Oxides~~

~~None~~

~~F. Lead~~

~~None~~

~~† designates localities in nonattainment areas for which the control strategy does not demonstrate the attainment of the applicable ambient air quality by December 31, 1982. This designation is pertinent to the provisions of § 120-08-03 F 6.~~

A. Ozone.

1. Northern Virginia Ozone Nonattainment Area (serious).

Arlington County
Fairfax County
Loudoun County
Prince William County
Stafford County
Alexandria City
Fairfax City
Falls Church City
Manassas City
Manassas Park City

2. Richmond Ozone Nonattainment Area (moderate).

Charles City County
Chesterfield County
Hanover County
Henrico County
Colonial Heights City
Hopewell City
Richmond City

3. Hampton Roads Ozone Nonattainment Area (marginal).

James City County
York County
Chesapeake City
Hampton City
Newport News City
Norfolk City
Poquoson City
Portsmouth City
Suffolk City
Virginia Beach City
Williamsburg City

4. White Top Mountain Ozone Nonattainment Area (marginal - rural transport area). The portion above 4,500 feet elevation in Smyth County (located within the Jefferson National forest).

B. Carbon monoxide.

Northern Virginia Carbon Monoxide Nonattainm (moderate).

Arlington County
Alexandria City

APPENDIX L.
PREVENTION OF SIGNIFICANT DETERIORAT
AREAS.

I. Prevention of Significant Deterioration Area geographically defined below *by locality* for the fol criteria pollutants:

A. Particulate matter.

AQCR 1 through 7	All areas

B. Sulfur dioxide.

AQCR 1 through 7	All areas

C. Carbon monoxide.

1.	AQCR 1 through 6	All areas
2.	AQCR 7	All areas except Alexandria City Arlington County

D. Ozone (volatile organic compounds):

1.	AQCR 1	All areas *except the portion of White Top Mountain above 4,500 feet elevation located in Smyth County*
2.	AQCR 2	All areas
3.	AQCR 3	All areas
4.	AQCR 4	All areas *except Stafford County*
5.	AQCR 5	All areas except *Charles City County* Chesterfield County *Hanover County* Henrico County *Colonial Heights City Hopewell City* Richmond City
6.	AQCR 6	All areas *except James City County York County Chesapeake City*

Hampton City
Newport News City
Norfolk City
Poquoson City
Portsmouth City
Suffolk City
Virginia Beach City
Williamsburg City

7. AQCR 7 No area

E. Nitrogen oxides.
AQCR 1 through 7 All areas

F. Lead.
AQCR 1 through 7 All areas

II. All areas of the state are geographically defined as Prevention of Significant Deterioration Areas for the following pollutants:

Mercury

Beryllium

Asbestos

Fluorides

Sulfuric acid mist

Vinyl chloride

Total reduced sulfur:
Hydrogen sulfide
Methyl mercaptan
Dimethyl sulfide
Dimethyl disulfide

Reduced sulfur compounds:
Hydrogen sulfide
Carbon disulfide
Carbonyl sulfide

III. The classification of Prevention of Significant Deterioration Areas is as follows:

A. Class I.

1. Federal - James River Face Wilderness Area (located in AQCR 2) and Shenandoah National Park (located in AQCR 2 and AQCR 4).

2. State - None

B. Class II - All areas of the state not designated in Class I.

C. Class III - None.

IV. The area classification prescribed in Section III may be redesignated in accordance with 40 CFR 52.21(e), (g), (u) and (t).

COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

910 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-3591

November 13, 1991

Mr. Wallace N. Davis, Executive Director
Department of Air Pollution Control
Room 801, Ninth Street Office Building
Richmond, Virginia 23219

RE: VR 120-01 Regulations for the Control and Abatement of Air Pollution. Nonattainment Areas and Prevention of Significant Deterioration Areas.

Dear Mr. Davis:

This will acknowledge receipt of the above-referenced regulations from the Department of Air Pollution Control.

As required by § 9-6.14:4.1 C.4.(c). of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law.

Sincerely,

Joan W. Smith
Registrar of Regulations

JWS:jbc

DEPARTMENT OF GAME AND INLAND FISHERIES (BOARD OF)

NOTE: The Board of Game and Inland Fisheries is exempted from the Administrative Process Act (§ 9-6.14:4 of the Code of Virginia); however, it is required by § 9-6.14:22 to publish all proposed and final regulations.

Title of Regulation:

VR 325-01. Definitions and Miscellaneous.
VR 325-01-1. In General.
~~**VR 325-01-2. Importation, Possession, Sale, Etc., of Animals.**~~
VR 325-02. Game.
VR 325-02-27. Permits.
VR 325-03. Fish.
VR 325-03-1. Fishing Generally.
VR 325-03-2. Trout Fishing.
VR 325-03-3. Seines and Nets.
VR 325-03-4. Gigs, Grab Hooks, Trotlines, Snares, Etc.
VR 325-03-5. Aquatic Invertebrates, Amphibians, Reptiles and Nongame Fish.

Statutory Authority: §§ 29.1-501 and 29.1-502 of the Code of Virginia.

Effective Date: January 1, 1992.

Summary:

Summaries are not provided since, in most instances the summary would be as long or longer than the full text.

VR 325-01. DEFINITIONS AND MISCELLANEOUS.

VR 325-01-1. In General.

[~~*§ 5. Same—"Wild animal," "native animal," "naturalized animal," "non-native (exotic) animal" and "domestic animal."*~~

~~*In accordance with § 29.1-100 of the Code of Virginia, the following terms shall have the meanings ascribed to them by this section when used in the regulations of the board:*~~

~~*1. Definition of "wild animal."—The term "wild animal" means any member of the animal kingdom, except domestic animals, including without limitation any native, naturalized or non-native (exotic) mammal, fish, bird, amphibian, reptile, mollusk, crustacean, arthropod or other invertebrate, and includes any part, product, egg or offspring thereof, or the dead body or parts thereof.*~~

~~*2. Definition of "native animal."—The term "native animal" means those species and subspecies of animals naturally occurring in Virginia, as included in the department's 1991 official listing of "Native and Naturalized Species of Virginia," with copies available in the Richmond and regional offices of the department.*~~

~~*3. Definition of "naturalized animal."—The term "naturalized animal" means those species and subspecies of animals not originally native to Virginia which have established wild, self-sustaining populations, as included in the department's 1991 official listing of "Native and Naturalized Species of Virginia," with copies available in the Richmond and regional offices of the department.*~~

~~*4. Definition of "non-native (exotic) animal."—The term "non-native (exotic) animal" means those species and subspecies of animals not naturally occurring in Virginia, excluding domestic and naturalized species.*~~

~~*5. Definition of "domestic animal."—The term "domestic animal" means animals which, through extremely long association with humans, have been bred to a degree which has resulted in genetic changes affecting the temperament, color, conformation or other attributes of these species to an extent that makes them unique and distinguishable from wild individuals of their species.*~~]

§ 13. Endangered *and threatened* species. *Adoption of federal list; additional species enumerated.*

A. The board hereby adopts the Federal Endangered and Threatened Species List, Endangered Species Act of December 28, 1973 (16 U.S.C. 1531-1543), as amended, and declares all species listed thereon to be endangered or threatened species in the Commonwealth.

B. In addition to the provisions of subsection A, the following species are declared endangered *or threatened* in this Commonwealth, and are afforded the protection provided by Article 6, Chapter 5, Title 29.1 of the Code of Virginia:

1. Fish:

~~Blackbanded sunfish~~	~~Enneacanthus chaetodon~~
~~Sharphead darter~~	~~Etheostoma acuticeps~~
~~Carolina darter~~	~~Etheostoma collis~~
~~Blueside darter~~	~~Etheostoma jessiae~~
~~Tippecanoe darter~~	~~Etheostoma tippecanoe~~
Endangered:	
Dace, Tennessee	*Phoxinus Tennesseensis*
Darter, duskytail	*Etheostoma [percnurum sp]*
Darter, sharphead	*Etheostoma acuticeps*
Darter, variegate	*Etheostoma variatum*
Sunfish, blackbanded	*Enneacanthus chaetodon*
Threatened:	
Darter, Carolina	*Etheostoma collis*
Darter, Tippecanoe	*Etheostoma tippecanoe*
Darter, greenfin	*Etheostoma chlorobranchium*
Darter, longhead	*Percina macrocephala*
Darter, western sand	*Ammocrypta clara*
Madtom, orangefin	*Noturus gilberti*
Paddlefish	*Polyodon spathula*

Shiner, emerald	*Notropis atherinoides*
Shiner, steelcolor	*Cyprinella whipplei*
Shiner, whitemouth	*Notropis alborus*

2. Amphibians:

~~Eastern tiger salamander~~	~~Ambystoma tigrinum~~
~~Shenandoah salamander~~	~~Plethodon shenandoah~~
Endangered:	
Salamander, eastern tiger	*Ambystoma tigrinum*
Threatened:	
Salamander, Mabee's	*Ambystoma mabeei*
Treefrog, barking	*Hyla gratiosa*

3. Reptiles:

~~Bog turtle~~	~~Clemmys muhlenbergii~~
~~Chicken turtle~~	~~Deirochelys reticularia~~
Endangered:	
Rattlesnake, canebrake	*Crotalus horridus atricaudatus*
Turtle, bog	*Clemmys muhlenbergii*
Turtle, chicken	*Deirochelys reticularia*
Threatened:	
Lizard, eastern glass	*Ophisaurus ventralis*
Turtle, wood	*Clemmys insculpta*

4. Birds:

~~Wilson's plover~~	~~Charadrius wilsonia~~
~~Bewick's wren~~	~~Thryomanes bewickii~~
~~Loggerhead shrike~~	~~Lanius ludovicianus~~
Endangered:	
Plover, Wilson's	*Charadrius wilsonia*
Wren, Bewick's	*Thryomanes bewicki*
Threatened:	
Sandpiper, upland	*Bartramia longicauda*
Shrike, loggerhead	*Lanius ludovicianus*
Sparrow, Bachman's	*Ammophila aestivalis*
Sparrow, Henslow's	*Ammodrammus henslowii*
Tern, gull-billed	*Sterna nilotica*

5. Mammals:

~~Water shrew~~	~~Sorex palustris~~
~~Fisher~~	~~Martes pennanti~~
~~Rafinesque's big-eared bat~~	~~Plecotus rafinesquii~~
Endangered:	
Bat, eastern big-eared	*Plecotus rafinesquii macrotis*
Hare, snowshoe	*Lepus americanus*
Shrew, water	*Sorex palustris*
Vole, rock	*Microtus chrotorrhinus*

6. Molluscs:

~~James River spiny mussel~~	~~Canthyria collina~~
~~Cumberland combshell~~	~~Epioblasma brevidens~~
~~Oyster pearly mussel~~	~~Epioblasma capsaeformis~~
~~Snuffbox pearly mussel~~	~~Epioblasma triquetra~~
~~Little-wing pearly mussel~~	~~Pegias fabula~~
Endangered:	
Bean, purple	*Villosa perpurpurea*
Cavesnail, Unthanks	*Holsingeria unthanksensis*
Coil, rubble	*Helicodiscus lirellus*
Coil, shaggy	*Helicodiscus diadema*
Combshell, Cumberland	*Epioblasma brevidens*
Deertoe	*Truncilla truncata*
Elephant-ear	*Elliptio crassidens*
Floater, brook	*Alasmidonta varicosa*
Heelsplitter, Tennessee	*Lasmigona holstonia*
Lilliput, purple	*Toxolasma lividus*
Mussel, oyster	*Epioblasma capsaeformis*
Mussel, slippershell	*Alasmidonta viridis*
Pigtoe, Ohio	*Pleurobema cordatum*
Pigtoe, pink	*Pleurobema rubrum*
Snuffbox	*Epioblasma triquetra*
Spectaclecase	*Cumberlandia monodonta*
Supercoil, spirit	*Paravitrea hera*
Threatened:	
Papershell, fragile	*Leptodea fragilis*
Pearlymussel, slabside	*Lexingtonia dolabelloides*
Pigtoe, Atlantic	*Fusconaia masoni*
Pimpleback	*Quadrula pustulosa pustulosa*
Rabbitsfoot, rough	*Quadrula cylindrica strigillata*
Riversnail, spiny	*Io fluvialis*
Sandshell, black	*Ligumia recta*
Sheepnose	*Plethobasus cyphyus*
Supercoil, brown	*Paravitrea septadens*

7. *Arthropods:*

Threatened:	
Amphipod, Madison Cave	*Stygobromus stegerorum*
Pseudotremia, Ellett Valley	*Pseudotremia cavernarum*
Xystodesmid, Laurel Creek	*Sigmoria whiteheadi*

C. It shall be unlawful to take, transport, process, sell or offer for sale within the Commonwealth any threatened or endangered species of fish or wildlife.

§ 14. Endangered species–Definitions.

For the purposes of §§ 29.1-564 through 29.1-570 of the Code of Virginia, § 13 of this regulation and this section:

1. *"Endangered species"* means any species which is in danger of extinction throughout all or a significant portion of its range within the Commonwealth, other than a species of the class Insecta deemed to be a pest whose protection would present an overriding risk to the health or economic welfare of the Commonwealth.

2. *"Fish or wildlife"* means any member of the animal kingdom, vertebrate or invertebrate, without limitation, and includes any part, products, egg or the dead body or parts thereof.

3. *"Harass,"* in the definition of "take," means an intentional or negligent act or omission which creates

the likelihood of injury to wildlife by annoying it to such an extent as to significantly disrupt normal behavior patterns which include, but are not limited to, breeding, feeding or sheltering.

4. *"Harm,"* in the definition of "take," means an act which actually kills or injures wildlife. Such act may include significant habitat modifications or degradation where it actually kills or injures wildlife by significantly impairing essential behavioral patterns, including breeding, feeding or sheltering.

5. *"Person"* means any individual, firm, corporation, association or partnership.

6. *"Special concern"* means any species ~~being considered by the director for listing as an endangered or a threatened species, but not yet the subject of a proposed rule~~ [,] *on a list maintained by the director* [,] *which is restricted in distribution, uncommon, ecologically specialized or threatened by other imminent factors .*

7. *"Species"* includes any subspecies of fish or wildlife and any district population segment of any species or vertebrate fish or wildlife which interbreed when mature.

8. *"Take"* means to harass, harm, pursue, hunt, shoot, wound, kill, trap, capture, possess or collect, or to attempt to engage in any such conduct.

9. *"Threatened species"* means any species which is likely to become an endangered species within the foreseeable future throughout all or a significant portion of its range within the Commonwealth.

~~[§ 18. Taking of invertebrates.~~

~~A. Earthworms.~~

~~Earthworms may be taken at any time for private or commercial use.~~

~~B. Other invertebrates.~~

~~Except as otherwise provided for in §§ 3.1-1020 through 3.1-1030 and 29.1-418 of the Code of Virginia and in VR 325-01-1 § 14 ; § 13 , and VR 325-01-2, invertebrates, other than those listed as endangered , or threatened or of special concern , may be taken for private use.]~~

~~[VR 325-01-2. Importation, Possession, Sale, Etc., of Animals.~~

~~§ 1. Possession, importation, sale, etc., of wild animals.~~

~~Under authority of §§ 29.1-103 and 29.1-521 of the Code of Virginia, it shall be unlawful to take, possess, import, cause to be imported, export, cause to be exported, buy, sell, offer for sale or liberate within the Commonwealth any wild animal unless otherwise specifically permitted by law or regulation.]~~

~~[§ 2. Permit required to import, liberate or possess predatory or undesirable animals or birds.~~

~~Under the authority of § 29.1-542 of the Code of Virginia, live wolves or coyotes, or birds or animals otherwise classed as predatory or undesirable, may not be imported into the Commonwealth or liberated therein, or possessed therein, except under a special permit of the board. Before such permit is issued, the importer shall make application to the department, giving the place of origin, the name and address of the exporter and a certificate from a licensed practicing veterinarian certifying that the animal to be imported is disease free.]~~

~~[§ 3. Exclusions.~~

~~This regulation does not cover those domestic animals listed below:~~

~~Domestic dog (Canis familiaris), including hybrids with canids.~~

~~Domestic cat (Felis catus), including hybrids with wild felines.~~

~~Domestic horse (Equus caballus), including hybrids with Equus asinus).~~

~~Domestic ass, burro and donkey (Equus asinus).~~

~~Domestic cattle (Bos taurus and Bos indicus).~~

~~Domestic sheep (Ovis aries), including hybrids with wild sheep.~~

~~Domestic goat (Capra hircus).~~

~~Domestic swine (Sus scrofa domestica), including pot-bellied pig.~~

~~Llama (Lama glama).~~

~~Alpaca (Lama pacos).~~

~~Camels (Camelus bactrianus and Camelus dromedarius).~~

~~Domesticated races of hamsters (Mesocricetus spp.).~~

~~Domesticated races of mink (Mustela vison) where adults are heavier than 1.15 kg and/or their coat color can be distinguished from wild mink.~~

~~Domesticated races of red fox (Vulpes) where their coat color can be distinguished from wild red fox.~~

~~Domesticated races of guinea pigs (Cavia porcellus).~~

Domesticated races of gerbils (Meriones unguiculatus).

Domesticated races of chinchillas (Chinchilla laniger).

Domesticated races of rats (Rattus norvegicus and Rattus rattus).

Domesticated races of mice (Mus musculus).

Domesticated races of European rabbit (Oryctolagus cuniculus).

Domesticated races of chickens (Gallus).

Domesticated races of turkeys (Meleagris gallopavo).

Domesticated races of ducks and geese (Anatidae) distinguishable morphologically from wild birds.

Feral pigeons (Columba domestica and Columba livia) and domesticated races of pigeons.

Domesticated races of guinea fowl (Numida meleagris).

Domesticated races of peafowl (Pavo cristatus).]

[§ 4. Non-native (exotic) mammals and birds permitted for importation.

An importation permit is not required from the department for the following non-native (exotic) mammals and birds, excluding noted exceptions; provided, that such mammals and birds shall be subject to all applicable local, state and federal laws and regulations, including those that apply to threatened/endangered species; and further provided, that such animals shall not be liberated within the Commonwealth:

Mammals:

Order	Family	Genus/Species	Common Name
Carnivora	Mustelidae	Mustela putorius furo	Ferret
Insectivora	Erinaceidae	Erinaceus hindei	East African Hedgehog
Primates	Callithricidae	All Species EXCEPT	Marmosets and Tarmarins
		Callithrix flaviceps	
		Saguinus oedipus	
		S. oedipus	
		S. leucopus	
		Leontideus spp.	

Birds:

Order	Family	Genus/Species	Common Name
Columbiforms	Columbidae	All species	Pigeons and Doves
		EXCEPT:	
		Columba flavirostris	Red-billed pigeon
		Columba inca	Inca Dove
		Columbina passerina	Ground Dove
		Leptotila verreauxi	White-fronted Dove
		Zenaida asiatica	White-winged Dove
Coraciiformes	Bucerotidae	All species	Hornbills
	Coraciidae	All species	Rollers
	Motmotidae	All species	Motmots
Cuculiformes	Musophagidae	All species	Turacos
Galliformes	Megapodiidae	All species	Megapodes
Gruiformes	Turnicidae	All species	Buttonquails
Passeriformes	Cotingidae	All species	Cotingas
	Estrildidae	All species	Waxbills,
		EXCEPT:	Mannikins, Munias
		Lonchcura punctulata nisoria	Spotted Munia
	Eurylaimidae	All species	Broadbills
	Fringillidae	All species	Finches
	Icteridae	All species	Icterids
		EXCEPT:	
		Agelaius spp.	Blackbirds
		Molothrus spp.	Cowbirds
	Irenidae	All species	Leafbirds
	Meliphagidae	All species	Honeyeaters
	Nectariniidae	All species	Sunbirds
	Ploceidae	All species	Weavers, Whydahs
		EXCEPT:	
		Foudia madagascariensis	Madagascar Weaver
		Passer spp.	Weaver finches
		(except p. domesticus)	
		Ploceus baya	Baya Weaver
		Ploceus philippines	Cape Sparrow
		Quelia quelea	Dioch
	Sturnidae	Gracula religiosa	Hill Myna
		Sturnus vulgaris	European Starling
	Timaliidae	All species	Babblers
	Zosteropidae	All species	White Eyes
		EXCEPT:	
		Zosterops spp.	
Piciformes	Capitonidae	All Species	Barbets
	Ramphastidae	All species	Toucans
Psittaciformes	Psittacidae	All species	Parrots
		EXCEPT:	
		Myiopsitta monachus	Monk Parakeet
		Nandayus nenday	Nanday Conure

]

[§ 5. Importation requirements for non-native (exotic) amphibians, fish, reptiles and mollusks.

An importation permit is required and may be issued by the department, if consistent with the department's fish and wildlife management program, for only those non-native (exotic) amphibians, fish, reptiles and mollusks listed below that the board finds and declares to be predatory or undesirable within the meaning and intent of § 29.1-542 of the Code of Virginia, in that their introduction into the Commonwealth will be detrimental to the native fish and wildlife resources of Virginia;

~~*provided, that all other non-native (exotic) amphibians, fish, reptiles or mollusks, not listed below, shall be subject to all applicable local, state and federal laws and regulations, including those that apply to threatened/endangered species; and further provided, that such animals shall not be liberated within the Commonwealth.*~~

~~AMPHIBIANS:~~

~~Order~~	~~Family~~	~~Genus/Species~~	~~Common Name~~
~~Anura~~	~~Buforidae~~	~~Bufo marinus~~	~~Giant or marine toad~~
	~~Pipidae~~	~~Xenopus laevis~~	~~Tongueless or African clawed frog~~

~~FISH:~~

~~Order~~	~~Family~~	~~Genus/Species~~	~~Common Name~~
~~Cypriniformes~~	~~Catostomidae~~	~~Ictiobus bubalus~~	~~Smallmouth Buffalo~~
		~~I. cyprinellus~~	~~Bigmouth Buffalo~~
		~~I. niger~~	~~Black Buffalo~~
	~~Characidae~~	~~Pygopristis spp.~~	~~Piranhas~~
	~~Pygocentrus spp.~~		
	~~Rooseveltiella spp.~~		
	~~Serrasalmo spp.~~		
	~~Serrasalmus spp.~~		
	~~Taddyella spp.~~		
	~~Cyprinidae~~	~~Aristichyhys nobilis~~	~~Bighead carp~~
		~~Ctenopharyngodon idella~~	~~Grass carp or white amur~~
		~~Hypophthalmichthys molitrix~~	~~Silver carp~~
		~~Mylopharyngodom piceus~~	~~Black carp~~
		~~Scardinius erythrophthalmus~~	~~Rudd~~
		~~Tinca tinca~~	~~Tench~~
~~Perciformes~~	~~Cichlidae~~	~~Tilapia spp.~~	~~Tilapia~~
		~~Gymnocephalus cernua~~	~~Ruffe~~
~~Siluriformes~~	~~Clariidae~~	~~All species~~	~~Air-breathing catfish~~

~~REPTILES:~~

~~Order~~	~~Family~~	~~Genus/Species~~	~~Common Name~~
~~Squamata~~	~~Alligatoridae~~	~~All species~~	~~Alligators, caimans~~
	~~Colubridae~~	~~Boiga irregularis~~	~~Brown tree snake~~
	~~Crocodylidae~~	~~All species~~	~~Crocodiles~~
	~~Gavialidae~~	~~All species~~	~~Gavials~~
	~~Varanidae~~	~~Varanus Komodoensis~~	~~Komodo dragon~~

~~MOLLUSKS:~~

~~Order~~	~~Family~~	~~Genus/Species~~	~~Common Name~~
~~Veneroida~~	~~Dreissenidae~~	~~Dreissena polymorpha~~	~~Zebra Mussel~~

~~]~~

VR 325-02. GAME.

VR 325-02-27. Permits.

[§ 12. Importation of certain animals.

It shall be unlawful to import or cause to be imported or to liberate within the Commonwealth of Virginia any gray fox (Urocyon Cinereoargenteus), red fox (Vulpes fulva), raccoon (Procyon lotor) or any other wild animal or wild bird unless a permit therefor is first obtained from the department. Before such permit is issued, the importer shall make application to said department giving the place of origin, the name and address of the exporter and a certificate from a licensed practicing veterinarian setting forth that the animal, or animals, to be imported is free of rabies or any other infection or contagious disease.
]

[§ 13. Importation of European hare and European or San Juan rabbit.

In accordance with authority conferred by § 29.1-103 of the Code of Virginia, the department finds and declares the following species to be predatory or undesirable within the meaning and intent of those terms as used in § 29.1-542 of the Code, in that their introduction into the Commonwealth will be detrimental to the native wildlife resources of Virginia; European hare (lepus europeaeous) and European or San Juan rabbit (Oryctolagus cuniculus).

It shall be unlawful, pursuant to § 29.1-542 of the code, to import, cause to be imported, buy, sell or offer for sale or liberate within the Commonwealth any of the above named species unless a permit therefor is first obtained from the department. Before such permit is issued, the importer shall make application to said department giving the place of origin, the name and address of the exporter and a certificate from a licensed practicing veterinarian setting forth that the animal, or animals, to be imported is free of rabies or any other infection or contagious disease.
]

§ 15. Duty to comply with permit conditions.

A permit holder shall comply with all terms and conditions of any permit issued by the Department of Game and Inland Fisheries pursuant to Title 29.1 of the Code of Virginia and the regulations of the board pertaining to hunting, fishing, trapping, taking, attempting to take, possession, sale, offering for sale, transporting or causing to be transported, importing or exporting of any wild bird, wild animal or fish.

VR 325-03. FISH

VR 325-03-1. Fishing Generally.

§ 2. Creel limits.

The creel limits for the various species of fish shall be as follows:

1. Largemouth, smallmouth and spotted bass, five a day in the aggregate.

2. Landlocked striped bass and landlocked striped bass X white bass hybrids, in the aggregate, four a day; except, that in Smith Mountain Reservoir and its tributaries, including the Roanoke River upstream to Niagara Dam, the limit shall be two a day in the aggregate. For anadromous (coastal) striped bass above the fall line in all coastal rivers, the limit shall be zero (catch and release only).

3. White bass, 25 per day.

4. Walleye or yellow pike perch and chain pickerel or jackfish, eight a day of each; except, that in Gaston Reservoir and Buggs Island (Kerr) Reservoir there shall be no daily limit for chain pickerel or jackfish.

5. Northern pike and muskellunge, two a day.

6. Sauger, eight per day.

7. Bluegill (bream) and other sunfish, excluding crappie ~~or~~ *(* silver perch *)* ~~and~~ , rock bass ~~or~~ *(* redeye *) and Roanoke bass,* 50 a day in the aggregate; crappie ~~or~~ *(* silver perch *)* and rock bass ~~or~~ *(* redeye *)* , 25 a day of each species *; Roanoke bass, 5 a day on the Nottoway and Meherrin rivers and their tributaries* . There shall be no limit on any of the species included in this subdivision 7 in Gaston and Buggs Island (Kerr) Reservoirs and that portion of the New River from the Virginia - North Carolina state line downstream to the confluence of the New and Little Rivers in Grayson County.

8. American shad in the James River above the fall line (14th Street Bridge), in the Meherrin River above Emporia Dam and in the Chickahominy River above Walkers Dam, zero (catch and release only).

§ 3. Size limit.

Except as provided in this regulation and VR 325-03-2, §§ 5, 11, 12 and 13, there shall be no size limit on any species of fish.

1. There shall be a 30-inch minimum size limit on muskellunge, and a 20-inch minimum size limit on northern pike, landlocked striped bass (rockfish) and landlocked striped bass X white bass hybrids.

2. There shall be a 14-inch minimum size limit on largemouth, smallmouth and spotted bass in Occoquan Reservoir from the reservoir dam upstream to the Lake Jackson Dam on Occoquan Creek and upstream to the Yates Ford Bridge (Route 612) on Bull Run Creek. It shall be unlawful to have any such bass less than 14 inches in length in one's possession on the above described waters of this reservoir.

3. There shall be a 12-inch minimum size limit on largemouth, smallmouth and spotted bass in the Chickahominy, Claytor, Philpott and Flannagan Reservoirs, and in Lake Moomaw (Gathright Project). It shall be unlawful to have any largemouth, smallmouth or spotted bass less than 12 inches in length in one's possession while on any of the waters mentioned in the preceding sentence.

4. There shall be a 14-inch minimum size limit on largemouth, smallmouth and spotted bass on the Roanoke (Staunton) and Dan Rivers and their tributaries and impoundments (Gaston, John Kerr, Leesville and Smith Mountain Reservoirs) downstream from Niagara Dam on the Roanoke River and the Brantly Steam Plant Dam on the Dan River; except, that as many as two of such bass of a lesser size caught in such waters may be retained in the creel, but no more than two such bass may be in possession on such waters that are less than 14 inches in length.

5. It shall be unlawful to have any largemouth, smallmouth or spotted bass from 12 to 15 inches in length, both inclusive, in one's possession on North Anna Reservoir and its tributaries, on Briery Creek Lake (Prince Edward County), on Chesdin Reservoir or the Appomattox River from the Brasfield (Chesdin) Dam to Bevel's Bridge on Chesterfield County Route 602, on Beaverdam Reservoir (Loudoun County) and on the waters of Quantico Marine Reservation.

6. It shall be unlawful to have any smallmouth, largemouth or spotted bass from 11 to 14 inches in length, both inclusive, in one's possession on the Shenandoah River, including the North and South Forks downstream from the Route 42 bridge on the North Fork and from the confluence of the North and South Rivers on the South Fork below Port Republic; on the New River from Claytor Dam to the West Virginia boundary line; on the James River from the confluence of the Jackson and Cowpasture rivers downstream to the Interstate 95 bridge at Richmond; on North Fork Pound Reservoir; or on the Clinch River within the boundaries of Scott, Wise, Russell or Tazewell Counties.

7. It shall be unlawful to have any largemouth, smallmouth or spotted bass less than 15 inches in length from March 1 through June 15, both inclusive, in the Virginia tidal tributaries of the Potomac River upstream of the Route 301 Bridge. There shall be no size limit for largemouth, smallmouth or spotted bass from June 16 through the last day of February in those tributaries.

8. It shall be unlawful to have any Roanoke bass less than eight inches in length in one's possession on the Nottoway and Meherrin rivers and their tributaries.

[§ 5. Permit required for importation, etc., of certain species.

In accordance with authority conferred by § 29.1-103 of the Code of Virginia, the board finds and declares the

following species to be predatory or undesirable within the meaning and intent of those terms as used in § 29.1-542 of the Code, in that their introduction into the Commonwealth will be detrimental to the native fish resources of Virginia: Rudd (genus Scardinius), tilapia, (any of the genera Tilapia Serotherodon or Oreochromis), piranha (any of the genera 1 Serrasalmus, Rooseveltiella, or Pygocentrus), walking catfish (any of the genus Clarias), cichlid (Texas), perch (Chichlasoma cyanoguttattum), grass carp (any genus Ctenopharynogodon), African clawed frog (Xenopus laevis) or zebra mussel (Dreissena polymorpha).

It shall be unlawful, pursuant to § 29.1-542 of the Code, to import, cause to be imported, possess, buy, sell or offer for sale or liberate within the Commonwealth any live specimens, live hybrids or viable eggs of the above-named species unless a permit therefor is first obtained from the department, except that the African clawed frog may be imported or sold, but not liberated, without such permit, when such action can be shown to be an essential part of a specific research or educational project designed to advance scientific knowledge by achieving precisely formulated objectives.]

VR 325-03-2. Trout Fishing.

§ 2. Same. Continuous open season.

A. Certain lakes and reservoirs. It shall be lawful to fish for trout in ~~Claytor Lake, Fairystone Park Lake, Leesville Lake~~ Moomaw (Gathright Project), ~~Smith Mountain Lake, Irvin's Cove and~~ Flannagan, ~~North Fork of Pound,~~ South Holston and Philpott reservoirs at any time.

B. Commercially operated fishing ponds. There shall be a continuous open season for taking trout in any department authorized commercially operated fishing ponds without creel or hour restrictions.

C. Trout fishing preserves. There shall be a continuous open season for taking trout in any stream which the department has authorized to be operated as a trout fishing preserve without creel or hour restrictions. Such authorization will be given by the department only when such stream is stocked with trout at the owner's expense in an annual quantity approved by the department subsequent to the owner's application for tentative approval. Such preserves shall be deemed to be within the purview of § 29.1-612 of the Code of Virginia and shall not be exempt from license requirements.

§ 5. Size limit.

Except as otherwise specifically provided by the sections appearing in this regulation, there shall be a seven-inch minimum size limit on trout generally and a 10-inch minimum size limit on trout in *Flannagan, Moomaw and* Philpott ~~and Moomaw~~ Reservoirs.

§ 11. Special provisions applicable to certain portions of *Jackson River,* Smith Creek and Snake Creek.

It shall be lawful to fish using only artificial lures with single hooks *in that portion of the Jackson River in Bath County from the swinging bridge located just upstream from the mouth of Muddy Run, upstream 3.0 miles to the last ford on FS 481D,* in that portion of Smith Creek in Alleghany County from the Clifton Forge Reservoir Dam downstream to a sign at the Forest Service boundary above the C&O Dam, and on Snake Creek in Carroll County upstream from its mouth to Hall's Fork on Big Snake Fork and to the junction of Routes 922 and 674 on Little Snake Fork. All trout caught in these waters under 12 inches in length shall be immediately returned to the water unharmed. It shall be unlawful for any person to have in his possession any natural bait or any trout under 12 inches in length in these areas.

§ 12. Special provisions applicable to certain portions of Buffalo Creek, ~~Mossy Creek~~ *Dan River, Sinking Creek* , Smith Creek and Smith River.

A. It shall be lawful year around to fish using only artificial lures with single hooks in that portion of Buffalo Creek in Rockbridge County from the confluence of Colliers Creek upstream 2.9 miles to the confluence of North and South Buffalo Creeks, ~~in that portion of Mossy Creek in Augusta County upstream from the Augusta/Rockingham County line to a sign posted at the confluence of Joseph's Spring, in that portion of Smith Creek in Rockingham County from a sign posted 1.0 miles below the confluence of Lacy Spring to a sign posted 0.4 miles above Lacy Spring, and~~ in that portion of Smith River in Henry County from *signs below* the east bank of Towne Creek for a distance of approximately three miles downstream ~~to the State Route 666 bridge crossing; except, that in Mossy Creek and Smith Creek, only flyfishing is lawful~~ *and in that portion of the Dan River in Patrick County from Talbott Dam approximately six miles downstream to a sign posted just upstream from the confluence of Dan River and Townes Reservoir .*

B. It shall be lawful year around to fish using only artificial flies with single hooks in that portion of Sinking Creek in Giles County from a cable and department sign 0.4 miles below the State Route 703 low-water bridge upstream 1.8 miles to a cable and department sign 0.1 miles above the Reynolds Farm covered bridge, in that portion of Sinking Creek in Craig County from a cable and department sign 1.0 mile below the State Route 642 bridge upstream to a cable and department sign 0.5 miles above the State Route 642 Bridge, and in that portion of Smith Creek in Rockingham County from a sign posted 1.0 miles below the confluence of Lacy Spring to a sign posted 0.4 miles above Lacy Spring.

C. The daily creel limit in these waters shall be two trout a day year around and the size limit shall be 16 inches or more in length. All trout caught in these waters under 16 inches in length shall be immediately returned to the water unharmed. It shall be unlawful for any person to have in his possession any natural bait or any trout under 16 inches in length in these areas.

§ 12-1. Special provision applicable to certain portions of Mossy Creek.

It shall be lawful year around to fish using only artificial flies with single hooks in that portion of Mossy Creek in Augusta County upstream from the Augusta/Rockingham County line to a sign posted at the confluence of Joseph's Spring. The daily creel limit in these waters shall be one trout a day year around and the size limit shall be 20 inches in length. All trout caught in these waters under 20 inches in length shall be immediately returned to the water unharmed. It shall be unlawful for any person to have in his possession any natural bait or any trout under 20 inches in length in this area.

§ 14. Special provision applicable to Stewarts Creek Trout Management Area and certain portions of *Dan,* Rapidan and Staunton rivers and tributaries.

It shall be lawful year round to fish for trout using only artificial lures with single hooks within the Stewarts Creek Trout Management Area in Carroll County, ~~and~~ in the Rapidan and Staunton rivers and their tributaries upstream from a sign at the lower Shenandoah National Park boundary in Madison County *and in the Dan River and its tributaries between the Townes Dam and the Pinnacles Hydroelectric Project powerhouse in Patrick County* . All trout caught in these waters must be immediately returned to the water. No trout may be in possession at any time in these areas.

§ 14-1. Special provision applicable to certain portions of *North River and* South River.

It shall be lawful to fish from October 1 through May 15, both dates inclusive, using only artificial lures with single hooks ~~;~~ *in the North River (Augusta County) from the base of Elkhorn Dam downstream 1.5 miles to a sign posted at the head of Staunton City Reservoir and* in the South River from the ~~CSX Railroad bridge located 0.1 miles below Broad Street in the City of Waynesboro to a sign posted 2.5 miles upstream at the upstream boundary of Ridgeview Park.~~ *Second Street Bridge upstream 2.4 miles to the base of Rife Loth Dam in the city of Waynesboro.* From October 1 through May 15, all trout caught in these waters must be immediately returned to the water unharmed, and it shall be unlawful for any person to have in his possession any natural bait or trout. During the period of May 16 through September 30, these waters shall revert to general trout regulations and the above restrictions will not apply.

VR 325-03-3. Seines and Nets.

§ 2. Haul seines to take fish for personal use.

A. Authorization to take fish for personal use.

Pursuant to §§ 29.1-412 and 29.1-416 of the Code of Virginia, a permit to use a haul seine to take fish for personal use authorizes the holder of such permit to take nongame fish with a haul seine for private table use, but not for sale, *only* in ~~the~~ *those* waters ~~of~~ *as specified in § 29.1-531 of the Code of Virginia in* the county for which such permit is issued, except ~~in the waters where the use of such seines is~~ *as* otherwise prohibited *in VR 325-03-1, § 10, VR 325-03-2, § 6 and VR 325-03-3, § 6* .

B. Holder to be present when seine operated.

The holder of a permit to take fish with a haul seine for personal use must be present when the seine is being operated but may have other persons to assist him who are not required to have a permit.

~~C. Portion of Smith River.—It shall be lawful to fish for carp for personal use and not for sale with haul seines in that portion of the Smith River in Henry County from the Highway 220 bridge to the North Carolina line.~~

§ 6. Seines and nets prohibited in certain areas.

~~Except as specifically provided by § 7 of this regulation,~~ It shall be unlawful to use seines and nets of any kind for the taking of fish from the public waters of the Roanoke (Staunton) and Dan Rivers in Campbell, Charlotte, Halifax and Pittsylvania counties, *and in the City of* Danville; provided, however, this section shall not be construed to prohibit the use of hand-landing nets for the landing of fish legally hooked *or the taking of fish bait from these waters pursuant to the provisions of VR 325-03-5* .

~~§ 7. Taking bait fish with hand nets on Roanoke River in certain counties.~~

~~It shall be lawful on the Roanoke River in Halifax, Campbell and Pittsylvania counties to use a hand held landing net with a handle not to exceed eight feet, bow diameter not greater than 20 inches, to dip nongame fish from the bank only for bait, but not for sale. Such nets when so used shall not be deemed to be dip nets under provisions of the Code of Virginia § 29.1-416.~~

VR 325-03-4. Gigs, Grab Hooks, Trotlines, Snares, Etc.

§ 6. Trotlines , *juglines* or set poles.

A. Generally.

Except or otherwise provided by local legislation and by subsection B of this section, and except on waters stocked with trout and within 600 feet of any dam, it shall be lawful to use trotlines , *juglines* or set poles for the purpose of taking nongame fish and turtles , provided that no live bait is used. Notwithstanding the provisions of this section, live bait other than game fish may be used on trotlines to take catfish in the Clinch River in the Counties of Russell, Scott and Wise. *Any person setting or in possession of a trotline, jugline or set pole shall have it marked by means of a nonferrous metal tag bearing his name and address, and is required to check all lines at*

least once each day and remove all fish and animals caught. This requirement shall not apply to landowners on private ponds, nor to a bona fide tenant or lessee on private ponds within the bounds of land rented or leased by him, nor to anyone transporting any such device from its place of purchase.

B. Quantico Marine Reservation.

It shall be unlawful to fish with trotlines in any waters within the confines of Quantico Marine Reservation.

VR 325-03-5. Aquatic Invertebrates, Amphibians, Reptiles and Nongame Fish.

§ 1. Taking aquatic invertebrates, amphibians, reptiles and nongame fish for private use.

A. Generally.

Except as otherwise provided for in § 29.1-418 of the Code of Virginia, VR 325-01-1, § 13 ~~, VR 325-01-1, § 14, VR 325-03-1, VR 325-03-2, VR 325-03-3, VR 325-03-4~~ and the sections of this regulation, it shall be lawful to take and possess *for private use and not for sale* no more than ~~three~~ *five* individuals of any single species of amphibian and reptile ~~or~~ *and* 20 individuals of any single species of aquatic invertebrates and nongame fish ~~for private use~~ *not specifically listed in this subsection and 50 individuals, in aggregate, of any species of "fish bait" listed in subsection B of this section .*

The following species may be taken in unlimited numbers from inland waters statewide: carp, bowfin, longnose gar, mullet, bullhead catfish, suckers, gizzard shad, herring, white perch, yellow perch, alewife, [~~and~~] *stoneroller (hornyhead), fathead minnow, golden shiner and goldfish. The following species may be taken in unlimited numbers from inland waters below the fall line: channel catfish, white catfish and blue catfish. These possession limits apply to all methods of taking aquatic invertebrates, amphibians, reptiles and nongame fish species unless otherwise stated in the Code of Virginia or specific regulations.*

B. "Fish bait."

"Fish bait," as used in this section, shall be defined as minnows and chubs (Cyprinidae), ~~alewives, blueback herring, suckers, gizzard shad,~~ salamanders, crayfish, and hellgrammites. Except as provided for in VR 325-01-1, § 13 ~~, VR 325-03-1, VR 325-03-2, VR 325-03-3, VR 325-03-4~~ and VR 325-03-5, § 1, subsection A, and except in any waters where the use of nets is prohibited, it shall be lawful to take "fish bait" for private use, but not for ~~commercial purposes~~ *sale* . Possession limit shall be 50 individuals in aggregate, unless said person has purchased "fish bait" and has a receipt specifying the number of individuals by species purchased. *However, stonerollers (horneyheads), fathead minnows, golden shiners and goldfish may be possessed in unlimited numbers as provided for in subsection A of this section.* "Fish bait" may only be taken with a seine not exceeding four feet in depth by 10 feet in length, an umbrella type net not exceeding five by five feet in diameter, small minnow traps with throat openings no larger than one inch in diameter, cast nets not to exceed four feet in radius and hand-held bow nets with diameter not to exceed 20 inches and handle length not to exceed eight feet (such cast net and hand-held bow nets, when so used, shall not be deemed dip nets under the provisions of § 29.1-416 of the Code of Virginia).

C. Bullfrogs.

It shall be lawful to take bullfrogs for private use except from the banks or waters of designated trout waters. The daily limit for bullfrogs shall be 15.

D. Mollusks.

Except as provided for in §§ 29.1-418 and 29.1-568 of the Code of Virginia, the taking of mussels and the spinya riversnail (Io fluvialis) is prohibited in the Tennessee drainage in Virginia (Clinch, Powell and the North, South and Middle Forks of the Holston Rivers and tributaries) , and *the taking of* mussels *is prohibited* in the James River and tributaries west of U.S. Route 29 *and in the entire North Fork of the Shenandoah River* .

E. Salamanders.

Except as provided for in §§ 29.1-418 and 29.1-568 of the Code of Virginia, the taking of salamanders shall be prohibited in Grayson Highlands State Park and on National Forest lands in the Jefferson National Forest in those portions of Grayson, Smyth and Washington counties bounded on the east by State Route 16, on the north by State Route 603 and on the south and west by U.S. Route 58.

§ 2. Taking minnows and chubs for sale.

A. "Haul seine" defined.

"Haul seine," as used in this section, when used in the inland waters of the Commonwealth above where the tide ebbs and flows, shall mean a haul seine not exceeding four feet in depth by 15 feet in length, and when used in the public inland waters below where the tide ebbs and flows, shall mean a haul seine not exceeding four feet in depth by 100 feet in length. Such a term shall be construed also to include umbrella type nets without limit as to size and also small minnow traps with throat openings no larger than one ~~(1)~~ inch in diameter.

B. Permit required.

Except as provided for in VR 325-01-1, § 13, it shall be unlawful to take minnows and chubs (Cyprinidae) for sale from the inland waters of the Commonwealth without having a permit therefor as provided for in *§ 29.1-416 of the* Code of Virginia ~~§ 29.1-416~~ .

C. Permit holder to be present when seine operated; persons assisting.

The holder of a permit to seine for minnows and chubs (Cyprinidae) must be present at all times when the seine is being operated to catch minnows and chubs (Cyprinidae). Persons assisting in the operation of the haul seine need not obtain permits.

D. Records.

The holder of a permit to take minnows and chubs (Cyprinidae) for sale shall keep a record of the approximate number of minnows and chubs (Cyprinidae) taken by location (name and county of water body and sold, together with the amount received therefor.

E. Commercial bait operations.

Commercial bait operations may possess and sell unlimited quantities of minnows and chubs (Cyprinidae), when possession is accompanied by a valid invoice or bill of sale from an individual permitted under subsection B of this section or from a properly permitted aquaculture facility in Virginia or out-of-state.

MILK COMMISSION

NOTICE: The Milk Commission is exempted from the Administrative Process Act (§ 9-6.14:4 of the Code of Virginia); however, it is required by § 9-6.14:22 to publish its regulations.

Due to its length, the following regulation filed by the Milk Commission is not being published; however, in accordance with § 9-6.14:22 of the Code of Virginia, a summary is being published in lieu of full text. Also, the amended text is set out below. The full text of the regulation is available for public inspection at the office of the Registrar and at the Milk Commission.

Title of Regulation: **VR 475-02-02. Rules and Regulations for the Control, Regulation and Supervision of the Milk Industry in Virginia (§ 1 of Regulation No. 8).**

Statutory Authority: § 3.1-430 of the Code of Virginia.

Effective Date: December 1, 1990.

Summary:

This amendment to Regulation No. 8 adds subdivisions (i), (ii), and (iii) to § 1 A 4. The inclusion of these paragraphs was necessary to provide automatic market alignment between the State Milk Commission Class I prices and adjacent market prices.

VR 475-02-02. Rules and Regulations for the Control, Regulation and Supervision of the Milk Industry in Virginia (§ 1 of Regulation No. 8).

REGULATION NO. 8
CLASS PRICES FOR PRODUCER'S MILK
TIME AND METHOD OF PAYMENT
BUTTERFAT TESTING AND DIFFERENTIAL

§ 1. Class prices, delivery discounts, butterfat differential, time of payments.

A. Class I.

	July through February	March through June
1. Eastern Virginia Market	8.46/cwt.	$8.26/cwt.
2. Southwest Virginia Market	$7.96/cwt.	$7.76/cwt
3. Western Virginia Market	$8.16/cwt.	$7.96/cwt.

4. The above established Class I prices shall be adjusted automatically in accordance with the following procedure , *provided* :

(i) The Eastern Market Class I price shall not exceed the average prevailing Class I price of Federal Order No. 4 and Federal Order No. 5, base zone by more than $0.80 per hundredweight, nor be less than $0.3(per hundredweight above the average prevailing Clas: I price of Federal Order No. 4 and Federal Order No. 5 base zone;

(ii) The Southwest Market Class I price shall not exceed the prevailing Class I price of Federal Order No. 11 by more than $0.60 per hundredweight nor be less than $0.30 per hundredweight above the prevailing Class I price of Federal Order No. 11 and;

(iii) The Western Market Class I price shall not exceed the average prevailing Class I price of Federal Order No. 4 and Federal Order No. 5, Northwest Zone by more than $0.60 per hundredweight nor be less than $0.30 per hundredweight above the prevailing Class I price of Federal Order No. 4 and Federal Order No. 5, Northwest Zone:

a. Class I prices shall be increased by an amount determined by multiplying the number of two (2.0) point brackets that the average bi-monthly composite index exceeds 101.0 by twenty cents (20¢); and

b. Class I prices shall be decreased by an amount determined by multiplying the number of two (2.0) point brackets that the average bi-monthly composite index descends below 99.0 by twenty cents (20¢).

c. The average bi-monthly composite index brackets

shall be in accordance with the following schedule:

Average Bi-Monthly Composite Index Brackets Nos. through Nos. Continued			Amount of Adjustment Cents Continued
96.9	-	98.9	- 20
99.0	-	101.0	- 0
101.1	-	103.1	+ 20
103.2	-	105.2	+ 40
105.3	-	107.3	+ 60
107.4	-	109.4	+ 80
109.5	-	111.5	+ 100
111.6	-	113.6	+ 120
113.7	-	115.7	+ 140
115.8	-	117.8	+ 160
117.9	-	119.9	+ 180
120.0	-	122.0	+ 200
122.1	-	124.1	+ 220
124.2	-	126.2	+ 240
126.3	-	128.3	+ 260
128.4	-	130.4	+ 280
130.5	-	132.5	+ 300
132.6	-	134.6	+ 320
134.7	-	136.7	+ 340
136.8	-	138.8	+ 360
138.9	-	140.9	+ 380
141.0	-	143.0	+ 400
143.1	-	145.1	+ 420
145.2	-	147.2	+ 440
147.3	-	149.3	+ 460
149.4	-	151.4	+ 480
151.5	-	153.5	+ 500
153.6	-	155.6	+ 520
155.7	-	157.7	+ 540
157.8	-	159.8	+ 560
159.9	-	161.9	+ 580
162.0	-	164.0	+ 600
164.1	-	166.1	+ 620
166.2	-	168.2	+ 640
168.3	-	170.3	+ 660
170.4	-	172.4	+ 680
172.5	-	174.5	+ 700
174.6	-	176.6	+ 720
176.7	-	178.7	+ 740
178.8	-	180.8	+ 760
180.9	-	182.9	+ 780
183.0	-	185.0	+ 800
185.1	-	187.1	+ 820
187.2	-	189.2	+ 840
189.3	-	191.3	+ 860
191.4	-	193.4	+ 880
193.5	-	195.5	+ 900
195.6	-	197.6	+ 920
197.7	-	199.7	+ 940
199.8	-	201.8	+ 960
201.9	-	203.9	+ 980
204.0	-	206.0	+ 1000
206.1	-	208.1	+ 1020
208.2	-	210.2	+ 1040
210.3	-	212.3	+ 1060
212.4	-	214.4	+ 1080
214.5	-	216.5	+ 1100
216.6	-	218.6	+ 1120

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: **State Plan for Medical Assistance Relating to Coordination of Title XIX with Part A and Part B of Title XVIII.**
VR 460-01-29. Premiums.
VR 460-01-29.1. Deductibles/Coinsurance.
VR 460-01-31.1. Medicaid for Medicare Cost Sharing for Qualified Medicare Beneficiaries.
VR 460-02-3.2100. Coordination of Title XIX with Part A and Part B of Title XVIII.
VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates - Other Types of Care.
VR 460-03-4.1922. Methods and Standards for Establishing Payment Rates - Other Types of Care.

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

Effective Date: January 1, 1992.

Summary:

The purpose of this action is to promulgate permanent regulations that limit the payment of the Medicare coinsurance amount by Medicaid so that the combined payments of Medicare Part B and Medicaid would not exceed the Medicaid allowance for a particular procedure.

This regulation affects three preprinted pages in the State Plan for Medical Assistance, as well as Attachments 3.2 A (Coordination of Title XIX with Part A and Part B of Title XVIII; 4.19 B, Methods and Standards for Establishing Payment Rates - Other Than Types of Care); and 4.19 B, Supplement 2, Methods and Standards for Establishing Payment Rates - Other Types of Care.

For individuals who are eligible for both Medicare and Medicaid, Medicare pays for procedures up to 80% of the Medicare allowable maximum payment. The remainder of the Medicare maximum allowance is then paid by Medicaid even if the additional amount results in net payments which exceed the Medicaid maximum allowance for that procedure.

Federal statute and regulations allow DMAS to limit its coinsurance payments to the Medicaid maximum instead of the Medicare maximum allowable payment. The regulatory action promulgates the permanent rules needed to implement this policy.

NOTICE: As provided in § 9-6.14:22 of the Code of Virginia, this regulation is not being republished. The regulation was adopted as it was proposed in 7:21 VA.R. 3140-3148 July 15, 1991.

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NOTICE: The proposed amendments relating to home health services were published in 7:21 VA.R. 3148-3172 July 15, 1991, and the proposed amendments relating to outpatient rehabilitative services were published in 7:22 VA.R. 3408-3438 July 29, 1991. Both regulatory actions amend VR 460-03-3.1100 and VR 460-02-3.1300. These amendments have been combined and incorporated into the full text of the regulations and printed below.

Title of Regulation: **State Plan for Medical Assistance Relating to Home Health Services and Outpatient Rehabilitative Services.**
VR 460-03-3.1100. Amount, Duration and Scope of Services.
VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality of Care.
VR 460-04-3.1300. Regulations for Outpatient Physical Rehabilitative Services.

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

Effective Date: January 1, 1992.

Summary:

A. Home Health Services.

The purpose of this action is to promulgate permanent regulations providing for the authorization and utilization review (UR) of home health services to supersede the current emergency regulations which became effective January 1, 1991.

The sections of the State Plan for Medical Assistance modified by this action are "Amount, Duration, and Scope of Services" (Attachment 3.1 A & B) and "Standards Established and Methods Used to Assure High Quality Care" (Attachment 3.1-C). The Durable Medical Equipment (DME) and Supplies Listing that was placed in Supplement 4 of Attachment 3.1 A & B of the emergency regulation was removed from the proposed regulation at the request of the Health Care Financing Administration. The DME listing is found in the provider manuals for rehabilitative be periodically updated. In addition, the proposed regulations are more specific regarding noncovered items than the emergency regulations.

Home health services are provided by certified home health agencies on a part-time or intermittent basis to home-bound recipients in their residences other than hospitals or nursing facilities. The Department of Medical Assistance Services (DMAS) has provided reimbursement for home health services since 1969 without the specified requirements and limits contained in this regulatory action.

DMAS expects to prevent unnecessary expenditures by implementing an authorization and utilization review process for home health services. Authorization ensures the delivery of medically necessary services and allows DMAS to control inappropriate use. Utilization review shall be performed to ensure that home health services are provided only when medically necessary and that the rendered care meets established written criteria and quality standards.

Covered home health services include nursing services, home health aide services, physical therapy, occupational therapy, speech-language pathology services, and medical supplies and equipment suitable for use in the home. Any of these services can be offered individually and the services are not contingent upon the provision of another service. Home health services must be prescribed by a physician and be part of a written plan of care. The physician must certify that the service is medically necessary and that the treatment prescribed is in accordance with standards of medical practice.

All practitioners, providers of services, and agencies shall be required to meet state and federal licensing and/or certification standards as a condition of provider enrollment. All services furnished by a home health agency, whether provided directly by the agency or under arrangements with others, must be furnished by or under the supervision of qualified personnel. Services not specifically documented in patients' medical records as having been rendered shall be deemed not to have been rendered and no reimbursement shall be provided.

Home health services provide for authorization for a given number of services within a specific time period and allow for further authorization of extended services based on individual need. For home health aide services and rehabilitative therapy services (physical therapy, occupational therapy, and speech-language pathology services), 24 visits may be made by each discipline to home health recipients within a 60-day period or 48 visits annually without authorization from DMAS. For nursing services, 5 visits may be made within a 60-day period without authorization. A recipient may receive a maximum of 64 nursing visits annually without authorization. The provider's documentation must justify the need for the services which have been provided in the approved time period.

If extended services are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services using the "Request for Authorization for Extended Home Health Services" (DMAS-450) which must be accompanied by the Home Health Certification and Plan of Treatment forms (HCFA 485, 486 and 487). Payment shall not be made for additional service unless authorized by DMAS.

Predetermined limits, based upon the Health Care Financing Administration Common Procedure Coding System (HCPCS), have been determined for durable medical equipment and supplies. If extended use of the equipment and/or supplies is required, then the provider must request additional equipment or supplies from DMAS. Payment will not be made for additional equipment or supplies unless the extended provision of services has been authorized by DMAS.

The following criteria apply to the provision of home health services:

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

These services shall be furnished under a written plan of care and must be reviewed by a physician at least once every 62 days. The requested services or items must be necessary to carry out the plan of care and must be related to the patient's condition. A physician recertification is required at intervals of at least once every 62 days and must be signed and dated by the physician who reviews the plan of care. The written plan of care and recertifications must appear on the Home Health Certification and Plan of Treatment forms (HCFA 485, 486, and 487).

b. Nursing Services: Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing who is licensed as a registered nurse. Nursing visit categories are as follows:

(1) initial visit is a comprehensive assessment of patients' health care needs and development of nursing plans of care based on the physicians' plans of care

(2) routine follow-up visit is a visit to perform or teach a specific task and/or monitor compliance

(3) intensive/extended visit is a visit requiring complex high technology skills.

c. Home Health Aide Services: Home health aides must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aide services may include assisting with personal hygiene, meal preparation and feeding, walking, and taking and recording blood pressure, pulse, and respiration.

These services must be provided under the general supervision of a registered nurse. Such visits made for supervisory purposes only are not reimbursable. A recipient may not receive duplicative home health aide services and personal care aide services.

d. Rehabilitative Services: Rehabilitative services may include physical and occupational therapies and speech-language pathology services that are used for the purpose of symptom control or for the individual to improve performance of activities of daily living and basic functional skills. Physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services. There are two types of visits, as follows:

(1) initial visit is a visit to conduct a comprehensive assessment of patient's rehabilitative needs and to develop a rehabilitative plan of care

(2) routine follow-up visit is a visit to perform or to teach specific treatment and/or monitor compliance with established plan of care

e. Medical Supplies and Equipment: Durable medical equipment and supplies must be ordered by the physician, be related to the needs of the recipient, and listed in the plan of care. Physician orders for durable medical equipment and supplies shall include the specific item identification including all modifications, the number of supplies needed monthly, and an estimate of how long the recipient will require the use of the equipment or supplies. Treatment supplies used during the visit are included in the visit rate. Treatment supplies left in the home to maintain treatment after the visits should be charged separately.

B. Outpatient Rehabilitative Services.

The purpose of this action is to promulgate permanent regulations to supersede the current emergency regulations providing for the authorization and UR of intensive outpatient physical rehabilitation services and outpatient physical therapy and related services (physical and occupational therapies and speech-language pathology services).

The sections of the State Plan affected by this proposed regulation are Attachment 3.1 C (Standards Established and Methods Used to Assure High Quality Care) and Attachment 3.1 A & B (Amount, Duration, and Scope of Services), Supplement 1. The state regulations affected by this action are VR 460-04-3.1300. The Durable Medical Equipment (DME) and Supplies Listing that was placed in Supplement 4 of Attachment 3.1 A & B of the emergency regulation is not being promulgated at the specific request of the Health Care Financing Administration. The DME listing is found in the provider manuals for rehabilitative services, DME, home health, and local health departments and will be periodically updated.

DMAS has reimbursed physical therapy and related rehabilitative services for Medicaid recipients since 1978. These services are provided by acute care inpatient hospitals, rehabilitation hospitals, rehabilitation agencies, home health providers, and outpatient hospitals. This regulation provides for new limits and increased utilization review requirements on these services. DMAS' service limits policy will now require authorization for extensions of normal services for physical and occupational therapies and

speech-language pathology services based upon individual medical needs.

An intensive rehabilitation program was implemented in February 1986 to provide a package of comprehensive rehabilitation services to include rehabilitation nursing, speech-language pathology services, social services, psychology, therapeutic recreation, durable medical equipment (to assist individuals being discharged from rehabilitation facilities), and physical, occupational, or cognitive therapies. This comprehensive package of services must be provided by a freestanding rehabilitation hospital, a Comprehensive Outpatient Rehabilitation Facility (CORF), or by an acute care hospital that has a physical rehabilitation unit which has been exempted from the Medicare Prospective Payment System.

By implementing the authorization and UR process for all intensive rehabilitation services and for physical and occupational therapies and speech-language pathology services, DMAS expects to prevent unnecessary expenditures and ensure better quality of care.

Nothing in this regulation is intended to preclude DMAS from reimbursing for special intensive rehabilitative services on an exception basis and reimbursing for these services on an individually negotiated rate basis. DMAS places some individuals with complex intensive physical rehabilitative needs (such as high level spinal cord injury and ventilator dependency) in out-of-state rehabilitation facilities because in-state facilities cannot provide the necessary services within their existing reimbursement. This regulation will also allow Medicaid to negotiate individual contracts with in-state intensive physical rehabilitation facilities for those individuals with special needs. To ensure efficient use of available in-state services, negotiated rates for special intensive physical rehabilitative care will only be used when the patient meets the criteria for intensive physical rehabilitation.

Service limits have been determined for medically necessary medical supplies and equipment which will continue to be covered for Medicaid recipients who receive outpatient intensive physical rehabilitative services. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. Requests for items not identified on the DME listing must be submitted to DMAS for individual consideration. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.

The regulations are substantively the same as the emergency regulations that became operative on January 1, 1991. Differences in the final regulations from the emergency regulations include the removal of the DME Listing from the Plan, the addition of examples of noncovered items, and the expansion of rehabilitative therapists' qualifications to include certain therapists who are employed by school districts. Technical changes were also made for clarity.

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

General.

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

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

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

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

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

D. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional preoperative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

E. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified.

Hospital claims with admission dates on Friday or Saturday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

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

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

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

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

I. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

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

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

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

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

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

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

5. The department may, at its option, depending on the utilization review performance determined by an audit based on criteria set forth in the hospital provider manual, remove a hospital from delegated review status and reapply certain or all prepayment utilization review documentation requirements.

§ 2. Outpatient hospital and rural health clinic services.

2a. Outpatient hospital services.

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

a. Are furnished to outpatients;

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

c. Are furnished by an institution that:

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

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

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

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

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

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

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with § 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

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

§ 3. Other laboratory and x-ray services.

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

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

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

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

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

1. Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

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

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

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

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

§ 5. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are not covered except when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well-child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

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

E. Any procedure considered experimental is not covered.

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

G. Physician visits to inpatient hospital patients are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses and is further restricted to medically necessary inpatient hospital days as determined by the Program.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Payments for physician visits for inpatient days determined to be medically unjustified will be adjusted.

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

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

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

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

§ 6. Medical care by other licensed practitioners within the scope of their practice as defined by state law.

A. Podiatrists' services.

1. Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by state law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity or for utilization control, or both.

B. Optometric services.

1. Diagnostic examination and optometric treatment procedures and services by ophthamologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services.

Not provided.

D. Other practitioners' services.

1. Clinical psychologists' services.

a. These limitations apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first

year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

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

§ 7. Home health services.

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

B. *Nursing services provided by a home health agency.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

h. Home or vehicle modifications.

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

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

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

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

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

§ 8. Private duty nursing services.

Not provided.

§ 9. Clinic services.

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

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

1. Are provided to outpatients;

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

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

§ 10. Dental services.

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

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

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

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

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

§ 11. Physical therapy and related services.

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

11a. Physical Therapy.

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

B. Effective July 1, 1988, the Program will not provide direct reimbursement to enrolled providers for physical therapy service rendered to patients residing in long term care facilities. Reimbursement for these services is and

continues to be included as a component of the nursing homes' operating cost.

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

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

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

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

11b. Occupational therapy.

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

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

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

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

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

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

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

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

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

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

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

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who

meets the qualifications in number 1. The program shall meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

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

11d. Authorization for services.

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

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

11e. Documentation requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13a. Diagnostic services.

Not provided.

13b. Screening services.

Not provided.

13c. Preventive services.

Not provided.

13d. Rehabilitative services.

A. Intensive ~~medical~~ *physical* rehabilitation:

1. Medicaid covers intensive inpatient rehabilitation services as defined in § ~~2.1~~ *subdivision A 4* in facilities certified as rehabilitation hospitals or rehabilitation units in acute care hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient *physical* rehabilitation services as defined in § ~~2.1~~ *subdivision A 4* in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs) ~~; or when the outpatient program is administered by a rehabilitation hospital or an exempted rehabilitation unit of an acute care hospital certified and participating in Medicaid~~ .

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

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

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

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

14a. Inpatient hospital services.

Provided, no limitations.

14b. Skilled nursing facility services.

Provided, no limitations.

14c. Intermediate care facility.

Provided, no limitations.

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

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

Provided, no limitations.

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

Provided, no limitations.

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

Not provided.

§ 17. Nurse-midwife services.

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

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

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

B. Categories of care.

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

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

2. Continuous home care consists of at-home care that is predominantly nursing care and is provided a

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

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

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

C. Covered services.

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

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

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

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

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

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

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

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

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

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

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

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

h. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a

safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

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

D. Eligible groups.

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

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

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

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

Provided, with limitations. See Supplement 2 for detail.

§ 20. Extended services to pregnant women.

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

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

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

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

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

21a. Transportation.

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

21b. Services of Christian Science nurses.

Not provided.

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

Provided, no limitations.

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

Provided, no limitations.

21e. Emergency hospital services.

Provided, no limitations.

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

Not provided.

Emergency Services for Aliens (17.e)

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

Emergency services are defined as:

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

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

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part.

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

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

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

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

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

§ 2. Utilization control.

A. Hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

plan of care on a monthly basis; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Services required for terminal care.

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

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

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

C. Nursing facilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Home health services.

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

2. Home health services shall be provided by a [~~*certified*~~ *licensed*] *home health agency on a part-time or intermittent basis to a homebound recipient in his place of residence. The place of residence shall not include a hospital or nursing facility. Home health services must be prescribed by a physician and be part of a written plan of care utilizing the Home Health Certification and Plan of Treatment forms which the physician shall review at least every* [~~*60*~~ *62*] *days.*

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

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

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

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

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

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

a. When the combined cost of transportation and medical treatment exceeds the cost of a home

health services visit;

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

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

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

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

a. Nursing services,

b. Home health aide services,

c. Physical therapy services,

d. Occupational therapy services,

e. Speech-language pathology services, or

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

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

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

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

c. A physician recertification shall be required at intervals of at least once every [~~60~~ 62] days, must be signed and dated by the physician who reviews the plan of care, and should be obtained when the plan of care is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long home health services will be needed. Recertifications must appear on the Home Health Certification and Plan of Treatment forms.

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

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

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

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

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

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

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

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

(1) Diagnosis and prognosis,

(2) Functional limitations,

(3) Orders for nursing or other therapeutic services,

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

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

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

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

(8) Orders for medical tests, when applicable, including laboratory tests and x-rays

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

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

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

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

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

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

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

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

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

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

F. Optometrists' services are limited to examinations (refractions) after preauthorization by the state agency

except for eyeglasses as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

G. In the broad category of Special Services which includes ~~medical~~ ~~supplies~~ ~~and~~ ~~equipment~~ ~~and~~ nonemergency transportation, all such services for recipients will require preauthorization by a local health department. ~~Local~~ ~~Health~~ ~~Department~~ ~~staff~~ ~~will~~ ~~also~~ ~~assist~~ ~~the~~ ~~patients~~ ~~in~~ ~~obtaining~~ ~~the~~ ~~necessary~~ ~~supplies~~ ~~and~~ ~~equipment~~ ~~of~~ ~~good~~ ~~quality.~~ ~~Medicare~~ ~~guidelines~~ ~~will~~ ~~be~~ ~~closely~~ ~~followed.~~

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

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

* * *

PART I.
~~ADMISSION~~ ~~CRITERIA~~ ~~FOR~~ *INTENSIVE PHYSICAL* REHABILITATIVE SERVICES.

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

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

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

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

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

1. Occupational Therapy

2. Physical Therapy

3. Cognitive Rehabilitation

4. Speech-Language Therapy

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

PART II.
INPATIENT ADMISSION AUTHORIZATION.

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

PART III.
DOCUMENTATION REQUIREMENTS.

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

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

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

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

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

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

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

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

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

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

PART IV.
INPATIENT REHABILITATION EVALUATION.

§ 4.1. For a patient with a potential for [*physical*] rehabilitation for which an outpatient assessment cannot be adequately performed, an ~~inpatient~~ *intensive* evaluation of no more than seven calendar days will be allowed. A comprehensive assessment will be made of the patient's medical condition, functional limitations, prognosis, possible need for corrective surgery, attitude toward rehabilitation, and the existence of any social problems affecting rehabilitation. After these assessments have been made, the physician, in consultation with the rehabilitation team, shall determine and justify the level of care required to achieve the stated goals.

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

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

PART V.
CONTINUING EVALUATION.

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

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

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

PART VI.
THERAPEUTIC FURLOUGH DAYS.

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

PART VII.
DISCHARGE PLANNING.

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

PART VIII.
REHABILITATION SERVICES TO PATIENTS.

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

A. Rehabilitative nursing.

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

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

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

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

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

4. The service shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative nursing services

which can only be provided in an intensive rehabilitation setting.

B. Physical therapy.

~~1.~~ Physical therapy services are those services furnished a patient which meet all of the following conditions:

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

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

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

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

C. Occupational therapy.

~~1.~~ Occupational therapy services are those services furnished a patient which meet all of the following conditions:

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

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

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

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

D. Speech-Language therapy.

~~1.~~ Speech-Language therapy services are those services furnished a patient which meet all of the following conditions:

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

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

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

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

E. Cognitive rehabilitation.

~~1.~~ Cognitive rehabilitation services are those services furnished a patient which meet all of the following conditions:

~~a.~~ *1.* The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a clinical psychologist experienced in working with the neurologically impaired and licensed by the Board of

Medicine;

~~b.~~ *2.* The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be rendered after a neuropsychological evaluation administered by a clinical psychologist or physician experienced in the administration of neuropsychological assessments and licensed by the Board of Medicine and in accordance with a plan of care based on the findings of the neuropsychological evaluation;

~~c.~~ *3.* Cognitive rehabilitation therapy services may be provided by occupational therapists, speech-language pathologists, and psychologists who have experience in working with the neurologically impaired when provided under a plan recommended and coordinated by a physician or clinical psychologist licensed by the Board of Medicine;

~~d.~~ *4.* The cognitive rehabilitation services shall be an integrated part of the total patient care plan and shall relate to information processing deficits which are a consequence of and related to a neurologic event;

~~e.~~ *5.* The services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning, memory, discrimination and behavior; and

~~f.~~ *6.* The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis.

F. Psychology.

~~1.~~ Psychology services are those services furnished a patient which meet all of the following conditions:

~~a.~~ *1.* The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

~~b.~~ *2.* The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified psychologist as required by state law;

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

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

G. Social work.

~~1.~~ Social work services are those services furnished a patient which meet all of the following conditions:

~~a.~~ *1.* The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

~~b.~~ *2.* The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified social worker as required by state law;

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

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

H. Recreational therapy.

~~1.~~ Recreational therapy are those services furnished a patient which meet all of the following conditions:

~~a.~~ *1.* The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

~~b.~~ *2.* The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services are performed as an integrated part of a comprehensive rehabilitation plan of care by a recreation therapist certified with the National Council for Therapeutic Recreation at the professional level;

~~c.~~ *3.* The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of

time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

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

I. Prosthetic/orthotic services.

1. Prosthetic services furnished to a patient include prosthetic devices that replace all or part of an external body member, and services necessary to design the device, including measuring, fitting, and instructing the patient in its use;

2. Orthotic device services furnished to a patient include orthotic devices that support or align extremities to prevent or correct deformities, or to improve functioning, and services necessary to design the device, including measuring, fitting and instructing the patient in its use; and

3. Maxillofacial prosthetic and related dental services are those services that are specifically related to the improvement of oral function not to include routine oral and dental care.

4. The services shall be directly and specifically related to an active written treatment plan approved by a physician after consultation with a prosthetist, orthotist, or a licensed, board eligible prosthodontist, certified in Maxillofacial prosthetics.

5. The services shall be provided with the expectation, based on the assessment made by physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance.

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

J. Durable medical equipment.

1. Durable medical equipment furnished the patient receiving approved covered rehabilitation services is covered when the equipment is necessary to carry out an approved plan of rehabilitation. A rehabilitation hospital or a rehabilitation unit of a hospital enrolled with Medicaid under a separate provider agreement for rehabilitative services may supply the durable medical equipment. The provision of the equipment is to be billed as an outpatient service. ~~All durable medical equipment over $1,000 shall be preauthorized by the Department; however,~~ ~~all~~ *Medically necessary medical supplies, equipment and appliances shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase. Payment shall not be made for additional equipment or supplies unless the extended provision of services has been authorized by DMAS. All* durable medical equipment is subject to justification of need. Durable medical equipment normally supplied by the hospital for inpatient care is not covered by this provision.

2. Supplies, equipment, or appliances that are not covered for recipients of intensive physical rehabilitative services include, but are not limited to, the following:

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

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

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

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

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

f. Home or vehicle modifications;

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

h. Equipment that the primary function is vocationally or educationally related (i.e., but not limited to, computers, environmental control devices, speech devices) environmental control devices, speech devices).

PART IX.
HOSPICE SERVICES.

[§ ~~9.0. Hospice services.~~]

§ 9.1. Admission criteria.

To be eligible for hospice coverage under Medicare or Medicaid, the and elect to receive hospice services rather than active treatment for the illness. Both the attending physician (if the individual has an attending physician) and the hospice medical director must certify the life expectancy.

§ 9.2. Utilization review.

Authorization for hospice services requires an initial preauthorization by DMAS and physician certification of life expectancy. Utilization review will be conducted to determine if services were provided by the appropriate provider and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patients' medical records as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

§ 9.3. Hospice services are a medically directed, interdisciplinary program of palliative services for terminally ill people and their families, emphasizing pain and symptom control. The rules pertaining to them are:

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

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

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

4. Counseling services. Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him to adjust to the individual's approaching death. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

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

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

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

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

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

§ 10. [RESERVED for Community Mental Health Services.]

[PART XI.]
GENERAL OUTPATIENT PHYSICAL REHABILITATION SERVICES.

§ 11.1. Scope.

A. Medicaid covers general outpatient physical rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals and by rehabilitation agencies which have a provider agreement with the Department of Medical Assistance Services (DMAS).

B. Outpatient rehabilitative services shall be prescribed by a physician and be part of a written plan of care.

§ 11.2. Covered outpatient rehabilitative services.

Covered outpatient rehabilitative services shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service.

§ 11.3. Eligibility criteria for outpatient rehabilitative services.

To be eligible for general outpatient rehabilitative services, the patient must require at least one of the following services: physical therapy, occupational therapy, speech-language pathology services, and respiratory therapy. All rehabilitative services must be prescribed by a physician.

§ 11.4. Criteria for the provision of outpatient rehabilitative services.

All practitioners and providers of services shall be required to meet state and federal licensing and/or certification requirements.

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

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

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

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

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

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

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

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

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

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

Audiology and Speech Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440 110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who meets the qualifications in Subdivision B1 above. The program must meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

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

§ 11.5. Authorization for services.

A. General physical rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals and by rehabilitation agencies shall include authorization for up to 24 visits by each ordered rehabilitative service within a 60-day period. A recipient may receive a maximum of 48 visits annually without authorization. The provider shall maintain documentation to justify the need for services. [A visit shall be defined as the duration of time that a rehabilitative therapist is with a client to provide services prescribed by the physician. Visits shall not be defined in measurements or increments of time.]

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized by using the Rehabilitation Treatment Authorization form (DMAS-125). This request must be signed and dated by a physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS. Periods of care beyond those allowed which have not been authorized by DMAS shall not be approved for payment.

§ 11.6. Documentation requirements.

A. Documentation of general outpatient rehabilitative services provided by a hospital-based outpatient setting or a rehabilitation agency shall, at a minimum:

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

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

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

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

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

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

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

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

§ 11.7. Service limitations.

The following general conditions shall apply to reimbursable physical rehabilitative services:

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

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

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

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

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

F. Rehabilitation care is to be terminated regardless of the approved length of stay when further progress toward

the established rehabilitation goal is unlikely or when the services can be provided

VR 460-04-3.1300. Regulations for Outpatient Physical Rehabilitative Services.

§ 1. Scope

A. Physical therapy and related services shall be defined as physical therapy, occupational therapy, and speech-language pathology services.

B. Physical therapy and related services shall be prescribed by a physician and be part of a written plan of care.

C. Any one of these services may be offered as the sole rehabilitative service and is not contingent upon the provision of another service.

D. All practitioners and providers of services shall be required to meet State and Federal licensing or certification requirements.

§ 2. Physical therapy.

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

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

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

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

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

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

§ 3. Occupational therapy.

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

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

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

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

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

3. The services shall be specific and provide effective

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

§ 4. Services for individuals with speech, hearing, and language disorders.

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

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

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

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

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

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

§ 5. Authorization for services.

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, or home health agencies shall include authorization for up to 24 visits by each ordered rehabilitative service within a 60-day period. A recipient may receive a maximum of 48 visits annually without authorization. The provider shall maintain documentation to justify the need for services. [A visit shall be defined as the duration of time that a rehabilitative therapist is with a client to provide services prescribed by the physician. Visits shall not be defined in measurements or increments of time.]

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized by using the Rehabilitation Treatment Authorization form (DMAS-125). This request must be signed and dated by a physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS. Periods of care beyond those allowed which have not been authorized by DMAS shall not be approved for payment.

§ 6. Documentation requirements.

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

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

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

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

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

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

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

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

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

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

§ 7. Service limitations.

The following general conditions shall apply to reimbursable physical therapy, occupational therapy, and speech-language pathology services:

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

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

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

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

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

6. Rehabilitation care is to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

* * * * * * * * *

Title of Regulation: **VR 460-04-8.3. Client Medical Management Program.**

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

Effective Date: January 1, 1992.

Summary:

This regulatory package replaces the current emergency regulation entitled Expansion of the Client Medical Management Program (VR 460-04-8.3).

Under the revised Virginia Client Medical Management Program, DMAS will assign clients who abuse the program or overuse services to primary care physicians and designated pharmacies for case management. The program also prohibits providers who abuse or provide unnecessary services from being designated as primary care providers for recipients in the program.

Revisions to the Client Medical Management regulations are necessary to expedite the utilization review process in order to increase the caseload to the targeted levels. New criteria that specify abusive activities and utilization levels which are considered excessive will allow DMAS' staff to determine more efficiently the clients' needs for coordination of medical care. More recipients of medical assistance will be evaluated for care coordination. Appropriateness of placement in care coordination will be ensured by the combined use of numeric thresholds and DMAS medical staff's reviews.

These regulatory revisions are also necessary to support the department in its administrative appeals process by defining the amount, duration and scope of certain medically unnecessary services.

There are no substantive changes to the proposed regulations in this final adopted package. There have been some grammatical and technical changes made for the final regulations as a result of public comments. Clarifying language has been added regarding the distinction between abusive practices and inappropriate utilization patterns.

VR 460-04-8.3. Client Medical Management Program.

§ 1. Definitions.

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

"APA" means the Administrative Process Act established by Chapter 1.1:1 (§ 9-6.14:1 et seq.) of Title 9 of the Code of Virginia.

"Abuse by recipients" means ~~a pattern of practice by a provider or a pattern of~~ [~~health care utilization~~ *practices*] by ~~a recipient~~ *recipients* which [~~is~~ *are*] inconsistent with sound fiscal ~~,~~ ~~business,~~ or medical practices and [~~results~~ *result*] in unnecessary costs to the Virginia Medicaid [~~program , or in reimbursement for a level of utilization or pattern of services that are not medically necessary~~ *Program*] ~~or that fail to meet professionally recognized standards for health care~~ .

"Abuse by providers" means practices which are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Virginia Medicaid Program or in reimbursement for a level of utilization or pattern of services that is not medically

necessary.

"Card-sharing" means the intentional sharing of a recipient eligibility card for use by someone other than the recipient for whom it was issued, or a pattern of repeated unauthorized use of a recipient eligibility card by one or more persons other than the recipient for whom it was issued due to the failure of the recipient to safeguard the card.

"Client Medical Management Program for recipients" means the recipients' utilization control program designed to [prevent abuse and] promote improved and cost efficient medical management of essential health care for noninstitutionalized recipients through restriction to one primary care provider and one pharmacy. Referrals may not be made to providers restricted through the Client Medical Management Program, nor may restricted providers serve as covering providers.

"Client Medical Management Program for providers" means the providers' utilization control program designed to complement the recipient [abuse and] utilization control program in promoting improved and cost efficient medical management of essential health care. Restricted providers may not serve as designated providers for restricted recipients. Restricted providers may not serve as referral or covering providers for restricted recipients.

~~"Code of Federal Regulations" or "CFR" means that codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.~~

"Contraindicated medical care" means treatment which is medically improper or undesirable and which results in duplicative or excessive utilization of services.

"Contraindicated use of drugs" means the concomitant use of two or more drugs whose combined pharmacologic action produces an undesirable therapeutic effect or induces an adverse effect by the extended use of a drug with a known potential to produce this effect.

"Covering provider" means a provider designated by the primary provider to render health care services in the temporary absence of the primary provider.

"DMAS" means the Department of Medical Assistance Services.

"Designated provider" means the provider who agrees to be the primary health care provider or designated pharmacy from whom the restricted recipient must first attempt to seek health care services.

"Diagnostic category" means the broad classification of diseases and injuries found in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) which is commonly used by providers in billing for medical services.

"Drug " means a substance or medication intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease as defined by the Virginia Drug Control Act (§ 54.1-524.2 et seq. of the Code of Virginia).

"Duplicative medical care" means two or more practitioners concurrently treat the same or similar medical problems or conditions falling into the same diagnostic category, excluding confirmation for diagnosis, evaluation, or assessment.

"Duplicative medications" means more than one prescription of the same drug or more than one drug in the same therapeutic class [~~or with similar pharmacologic actions~~] .

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

"Excessive medical care" means obtaining greater than necessary services such that health risks to the recipient or unnecessary costs to the Virginia Medicaid Program may ensue from the accumulation of services or obtaining duplicative services.

"Excessive medications" means obtaining medication in excess of generally acceptable maximum therapeutic dosage regimens or obtaining duplicative medication from more than one practitioner.

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

"Health care" means any covered services, including equipment or supplies, provided by any individual, organization, or entity that participates in the Virginia Medical Assistance Program.

~~"Health Care Financing Administration (HCFA)" means that unit of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.~~

~~"Client Medical Management Program" for recipients means the recipients' utilization control program designed to promote improved and cost-efficient medical management of essential health care for noninstitutionalized recipients through restriction to one primary care provider and one pharmacy.~~

~~"Client Medical Management Program" for providers means the providers' utilization control program designed to complement the recipient utilization control program in promoting improved and cost-efficient medical~~

~~management of essential health care. Restricted providers may not serve as designated providers for restricted recipients.~~

"Medical emergency" means a situation in which a delay in obtaining treatment may cause death or ~~lasting injury or harm to~~ *serious impairment of the health of* the recipient.

"Medical management of essential health care" means a case management approach to health care in which the designated primary physician has responsibility for assessing the needs of the patient and making referrals to other physicians and clinics as needed. The designated pharmacy has responsibility for monitoring the drug regimen of the patient. [~~*Coordination of medical services promotes continuity of care and cost efficiency.*~~]

~~"Medically necessary" means necessary for the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.~~

~~"Medicare" means the Health Insurance for the Aged and Disabled enacted by Congress in 1965 as Title XVIII of the Social Security Act.~~

"Noncompliance" means failing to follow Client Medical Management Program procedures, or a pattern of utilization which is inconsistent with sound fiscal or medical practices. Noncompliance includes, but is not limited to, failure to follow a recommended treatment plan or drug regimen; failure to disclose to a provider any treatment or services provided by another provider; or requests for medical services or medications which are not medically necessary.

"Not medically necessary" means an item or service which is not consistent with the diagnosis or treatment of the patient's condition or an item or service which is duplicative, contraindicated, or excessive [*;* ~~*or results in a pattern of abuse*~~] .

"Pattern" means [~~an identifiable series of events or activities resulting in abuse~~ *duplication or occurring more than once.*]

"Practitioner" means a health care provider licensed, registered, or otherwise permitted by law to distribute, dispense, prescribe and administer drugs or otherwise treat medical conditions.

"Provider" means the individual or facility registered, licensed, or certified, as appropriate, and enrolled by DMAS to render services to Medicaid recipients eligible for services.

"Psychotropic drugs" means drugs which alter the mental state. Such drugs include, but are not limited to, morphine, barbiturates, hypnotics, antianxiety agents, antidepressants, and antipsychotics.

"Recipient" means the individual who is eligible, under Title XIX of the Social Security Act, to receive Medicaid covered services.

"Recipient eligibility card" means the document issued to each Medicaid family unit, listing names and Medicaid numbers of all eligible individuals within the family unit.

"Restriction" means an administrative action imposed on a recipient which limits access to specific types of ~~medical care and~~ *health care* services through a designated primary ~~provider(s)~~ *provider* or an administrative action imposed on a provider to prohibit participation as a designated *primary* provider *, referral, or covering provider* for restricted recipients.

"Social Security Act" means the the Act, enacted by the 74th Congress on August 14, 1935, which provides for the general welfare by establishing a system of federal old age benefits, and by enabling the several states to make more adequate provisions for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws.

"State Plan for Medical Assistance" or *"the Plan"* means the document listing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Surveillance and Utilization Review Subsystem (SURS)" means a computer subsystem of the Medicaid Management Information System (MMIS) which collects claims data and computes statistical profiles of recipient and provider activity and compares them with that of their particular peer group.

"Therapeutic class" means a group of drugs with similar pharmacologic actions and uses.

"Utilization control" means the control of covered *health care* services to assure the use of *cost efficient,* medically necessary ~~and~~ *or* appropriate services.

§ 2. ~~Authority~~ *Client Medical Management Program for recipients* .

A. ~~Federal regulations at 42 CFR 456.3 require the Medicaid agency to implement a statewide surveillance and utilization control program.~~ *Purpose.*

The Client Medical Management Program is a utilization control program designed to [*prevent abuse and*] *promote improved and cost efficient medical management of essential health care.*

B. Authority.

1. Federal regulations at 42 CFR § 456.3 require the Medicaid agency to implement a statewide

surveillance and utilization control program [*and 42 CFR § 455.1 through 16 require the Medicaid agency to conduct investigations of abuse by recipients*].

~~B.~~ *2.* Federal regulations at 42 CFR § 431.54 (e) allow states to restrict recipients to designated providers when the recipients have utilized services at a frequency or amount that is not medically necessary in accordance with utilization guidelines established by the state. [*42 CFR § 455.16(c)(4) provides for imposition of sanctions for instances of abuse identified by the agency.*]

~~C. Federal regulations at 42 CFR 431.54 (f) allow states to restrict providers from participating in the Medicaid program if the agency finds that the provider of items or services under the State Plan has provided items or services at a frequency or amount not medically necessary in accordance with utilization guidelines established by the state, or has provided items or services of a quality that do not meet professionally recognized standards of health care.~~

~~D. DMAS shall not impose restrictions which would result in denying recipients reasonable access to Medicaid services of adequate quality, including emergency services (42 CFR 431.54 (f)(4)).~~

[~~*3. Federal regulations at 42 CFR §§ 455.15 through 455.16 require the Medicaid agency to conduct investigations of abuse by recipients and allow sanctions to be applied.*~~]

§ ~~3.~~ *C.* Identification of Client Medical Management Program participants.

~~A.~~ DMAS ~~identifies~~ *shall identify* recipients for review from computerized ~~exception~~ reports *such as but not limited to* ~~(~~ Recipient SURS ~~)~~ or by referrals from agencies, health care professionals, or other individuals ~~for suspected utilization of unnecessary or inappropriate medical services~~ .

~~B. DMAS identifies providers for review through computerized exception reports (Provider SURS) or by referrals from agencies, health care professionals, or other individuals for suspected provision of unnecessary or inappropriate medical services.~~

§ ~~4.~~ *D.* ~~Participant~~ *Recipient* evaluation for restriction.

~~A.~~ *1.* DMAS shall review recipients ~~and providers~~ to determine if services are being utilized ~~or provided~~ at a frequency or amount that ~~is~~ *results in a level of utilization or a pattern of services which is* not medically necessary [*or which exceeds the thresholds established in these regulations*]. Evaluation of utilization patterns ~~for both recipients and providers~~ can include but is not limited to review *by the department staff* of ~~diagnoses,~~ *medical records or computerized reports generated by the department reflecting claims submitted for* physician visits, drugs/prescriptions, outpatient and emergency room visits, lab and diagnostic procedures, hospital admissions, *and* referrals ~~; and procedures not usually performed by primary health care providers~~ .

2. [*Abusive activities shall be investigated and, if appropriate, the recipient shall be reviewed for restriction.*] *Recipients demonstrating* [*unreasonable questionable*] *patterns of utilization or exceeding reasonable levels of utilization shall be reviewed for restriction.*

~~B.~~ *3.* DMAS ~~shall recommend~~ *may restrict* recipients ~~for restriction~~ if ~~a pattern of~~ [~~one or more~~ *any*] of the ~~following conditions~~ [*following activities or*] *patterns or levels of utilization* [~~; *including but not limited to the following,* is identified~~ *are identified. These activities or patterns or levels of utilization include but shall not be limited to*]:

a. Exceeding 200% of the maximum therapeutic dosage of the same drug or multiple drugs in the same therapeutic class for a period exceeding four weeks.

b. Two occurrences of having prescriptions for the same drugs filled two or more times on the same or the subsequent day.

c. Utilizing services from three or more prescribers and three or more dispensing pharmacies in a three-month period.

d. Receiving more than 24 prescriptions in a three-month period.

e. Receiving more than 12 psychotropic prescriptions or more than 12 analgesic prescriptions or more than 12 prescriptions for controlled drugs with potential for abuse in a three-month period.

f. Exceeding the maximum therapeutic dosage of the same drug or multiple drugs in the same therapeutic class for a period exceeding four weeks [~~*and being*~~ *. In addition, such drugs must be*] *prescribed by two or more practitioners.*

g. Receiving two or more drugs, duplicative in nature or potentially addictive (even within acceptable therapeutic levels), dispensed by more than one pharmacy or prescribed by more than one practitioner for a period exceed four weeks.

h. Utilizing three or more different physicians of the same type or specialty in a three-month period for treatment of the same or similar conditions.

i. Two or more occurrences of seeing two or more physicians of the same type or specialty on the

same or subsequent day for the same or similar diagnosis.

~~1.~~ *j.* Duplicative ~~or~~ , excessive , *or contraindicated* utilization of medications, medical supplies, or appliances *dispensed by more than one pharmacy or prescribed by more than one practitioner* for the time period specified[*by DMAS*].

~~2.~~ *k.* Duplicative ~~or~~ , excessive , *or contraindicated* utilization of medical visits, procedures, or diagnostic tests *from more than one practitioner* for the time period specified[*by DMAS*].

~~3.~~ *l.* ~~Emergency room use for nonemergency care.~~ *Use of emergency hospital services for three or more emergency room visits for nonemergency care during a three-month period.*

m. One or more providers recommends restriction for medical management because the recipient has demonstrated [~~*abusive*~~ *inappropriate*] *utilization practices.*

n. A pattern of noncompliance which is inconsistent with sound fiscal or medical practices [~~*and results in abuse*~~] . *Noncompliance is characterized by, but not limited to:*

(1) Failure to disclose to a provider any treatment or services provided by another provider; or

(2) Failure to follow a drug regimen or other recommended treatment; or

(3) Requests for medical services or medications which are not medically necessary.

~~4.~~ *o.* Use of preauthorized transportation services with no corresponding medical services.

~~5.~~ *p.* One or more documented occurrences of ~~recipient~~ *a recipient's* use of ~~recipient~~ *the* eligibility card to *obtain drugs under false pretenses, which includes, but is not limited to the* purchase or attempt to purchase drugs ~~on~~ *via* a forged or altered prescription.

~~6.~~ *q.* One or more documented occurrences of card-sharing.

~~7.~~ *r.* One or more documented occurrences of alteration of the recipient eligibility card.

~~C. DMAS shall recommend providers for restriction if a pattern for one or more of the following conditions is identified:~~

~~1. Visits billed at a frequency or level exceeding that which is medically necessary;~~

~~2. Diagnostic tests billed in excess of what is medically necessary;~~

~~3. Billed diagnostic tests which are unrelated to the diagnosis;~~

~~4. Medications and prescriptions in excess of recommended dosages;~~

~~5. Medications and prescriptions unrelated to the diagnosis;~~

~~D. DMAS shall recommend providers for restriction if the provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.~~

~~E. The Director of the Medical Support Section or his designee shall review and approve or disapprove the recommendations for recipient or provider restriction.~~

~~F. DMAS shall implement restriction without medical review when:~~

~~1. Recipients have misused their recipient eligibility cards by alteration or card sharing, or both, or~~

~~2. Recipients have obtained drugs under false pretenses.~~

§ ~~5.~~ *E.* Recipient restriction procedures.

~~A.~~ *1.* DMAS shall advise affected recipients by written notice of the proposed restriction under the Client Medical Management Program. Written notice shall include an explanation of restriction procedures and the recipient's right to appeal the proposed action.

~~B.~~ *2.* The recipient shall have ~~30 calendar days~~ *the opportunity* to select designated providers . If a recipient fails to respond by the date specified in the restriction notice, DMAS shall select designated providers.

~~C.~~ *3.* ~~The recipient shall have 30 calendar days from the date of the notification to appeal the proposed restriction.~~ DMAS shall not implement restriction if a ~~timely~~ *valid* appeal is noted. (See § ~~13~~ *§ 2 K* .)

~~D.~~ *4.* DMAS shall restrict recipients to their designated providers for 18 months .

5. A recipient who has completed a period of enrollment in the Client Medical Management Program and who is subsequently found, through the procedures specified in § 2 D of this regulation, to have resumed abusive practices during the unrestricted period, shall again be restricted for 24 months.

§ ~~6.~~ *F.* Eligible providers.

~~A.~~ *1.* A designated health care provider must be a physician enrolled as an individual practitioner unrestricted by ~~the Department of Medical Assistance Services~~ *DMAS* .

~~B.~~ *2.* A designated pharmacy provider must be a pharmacy enrolled as a community pharmacy unrestricted by ~~the Department of Medical Assistance Services~~ *DMAS* .

~~C.~~ *3.* ~~Restricted recipients shall have reasonable access to all essential medical services. Other provider types such as clinics or ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.~~ *Providers restricted through the Client Medical Management Program may not serve as designated providers, may not provide services through referral, and may not serve as covering providers for restricted recipients.*

4. Physicians with practices limited to the delivery of emergency room services may not serve as designated primary providers.

5. Restricted recipients shall have reasonable access to all essential medical services. Other provider types such as clinics or ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.

§ ~~7.~~ *G.* Provider reimbursement for covered services.

~~A.~~ *1.* DMAS shall reimburse for covered outpatient medical, pharmaceutical, and physician services only when they are provided by the designated providers, or by physicians seen on referral from the primary health care provider, or in a medical emergency. Prescriptions may be filled by a nondesignated pharmacy only in emergency situations when the designated pharmacy is closed, or when the designated pharmacy does not stock [,] or is unable to obtain the drug *in a timely manner* .

~~B.~~ *2.* DMAS shall require a written referral from the primary health care provider for payment of covered outpatient services by nondesignated practitioners unless there is a medical emergency requiring immediate treatment.

§ ~~8.~~ *H.* Recipient eligibility cards.

DMAS shall provide an individual recipient eligibility card listing the recipient's designated primary care providers for each restricted recipient .

§ ~~9.~~ *I.* Changes in designated providers.

~~A.~~ *1.* DMAS must give prior authorization to all changes of designated providers.

~~B.~~ *2.* The recipient or the designated provider may initiate requests for change for the following reasons:

~~1.~~ *a.* Relocation of the recipient or provider.

~~2.~~ *b.* Inability of the provider to meet the routine health needs of the recipient.

~~3.~~ *c.* Breakdown of the recipient/provider relationship.

~~C.~~ *3.* If the designated provider initiates the request and the recipient does not select a new provider by established deadlines, DMAS shall select a provider, subject to concurrence from the provider.

~~D.~~ *4.* If DMAS denies the recipient's request, the recipient ~~is~~ *shall be* notified in writing and given the right to appeal the decision. (See § ~~13~~ *§ 2 K* .)

§ ~~10.~~ *J.* Review of recipient restriction status.

~~A.~~ *1.* DMAS shall review a recipient's utilization prior to the end of the restriction period to determine restriction termination or continuation. (See § 4 *§ 2 D* .) DMAS shall extend utilization control restrictions for 18 months if ~~a pattern for one or more~~ *any* of the following conditions is identified:

~~1.~~ *a.* The recipient's utilization patterns include one or more conditions listed in § 4 ~~B~~ *§ 2 D 3* .

~~2.~~ *b.* The recipient has not complied with Client Medical Management Program procedures resulting in services or medications received from one or more nondesignated providers without a written referral or in the absence of a medical emergency.

~~3.~~ *c.* One or more of the designated providers recommends continued restriction status because the recipient has demonstrated noncompliant behavior which is being controlled by Client Medical Management Program restrictions.

d. Any changes of designated provider [*have been made*] *due to the breakdown of the recipient/provider relationship as a result of the recipient's noncompliance.*

~~B.~~ *2.* DMAS shall notify the recipient and designated ~~provider(s)~~ *provider* in writing of the review decision. If restrictions are continued, written notice shall include the recipient's right to appeal the proposed action. (See § ~~13~~ *§ 2 K* .)

~~C.~~ *3.* DMAS shall not implement the continued recipient restriction if a ~~timely~~ *valid* appeal is noted.

§ ~~11. Provider restriction procedures.~~

~~A. DMAS shall advise affected providers by written notice of the proposed restriction under the Client Medical~~

~~Management Program. Written notice shall include an explanation of the basis for the decision, request for additional documentation, if any, and notification of the provider's right to appeal the proposed action.~~

~~B. The provider shall have 30 calendar days from the date of notification to appeal the proposed restriction . Appeals shall be held in accordance with § 9-6.14:11 et seq. of the Code of Virginia (Virginia Administrative Process Act).~~

~~C. DMAS shall restrict providers from being the designated provider for recipients in the Client Medical Management Program for 18 months.~~

~~D. DMAS shall not implement provider restriction if a timely appeal is noted.~~

~~§ 12. Review of Provider Restriction status.~~

~~A. DMAS shall review a restricted provider's claims history record prior to the end of the restriction period to determine restriction termination or continuation (see § 4). DMAS shall extend provider restriction for 18 months in one or more of the following situations:~~

~~1. Where new abusive practices are identified.~~

~~2. Where the practices which led to restriction continue.~~

~~B. In cases where the provider has submitted an insufficient number of claims during the restriction period to enable DMAS to conduct a claims history review, DMAS shall continue restriction until a reviewable six-months claims history is available for evaluation.~~

~~C. If DMAS renews restriction following the review, the provider shall be notified of the agency's proposed action, the basis for the action, and appeal rights. (See § 13.)~~

~~D. If the provider continues a pattern of medically unnecessary services, DMAS may make a referral to the appropriate peer review group or regulatory agency for recommendation or action, or both.~~

~~§ 13.~~ *K. Recipient* appeals.

~~A.~~ *1.* ~~Restricted providers and~~ Recipients shall have the right to appeal ~~the application of the utilization control criteria used to determine their restriction~~ *any adverse action taken by DMAS under these regulations* .

~~B. Provider appeals shall be held pursuant to the provisions of § 9-6.14:11 et seq. of the Code of Virginia (Administrative Process Act).~~

~~C.~~ *2.* Recipient appeals shall be held pursuant to the provisions of ~~42 CFR 431.200ff and the State Plan for Medical Assistance~~ *VR 460-04-8.7, Client Appeals* .

§ 3. Client Medical Management Program for providers.

A. Purpose.

The Client Medical Management Program is a utilization control program designed to promote improved and cost efficient medical management of essential health care.

B. Authority.

1. Federal regulations at 42 CFR § 456.3 require the Medicaid agency to implement a statewide surveillance and utilization control program.

2. Federal regulations at 42 CFR § 431.54 (f) allow states to restrict providers' participation in the Medicaid program if the agency finds that the provider of items or services under the State Plan has provided items or services at a frequency or amount not medically necessary in accordance with utilization guidelines established by the state, or has provided items or services of a quality that do not meet professionally recognized standards of health care.

C. Identification of Client Medical Management Program participants.

DMAS shall identify providers for review through computerized reports such as but not limited to Provider SURS or by referrals from agencies, health care professionals, or other individuals.

D. Provider evaluation for restriction.

1. DMAS shall review providers to determine if health care services are being provided at a frequency or amount that is not medically necessary or that are not of a quality to meet professionally recognized standards of health care. Evaluation of utilization patterns can include but is not limited to review by the department staff of medical records or computerized reports generated by the department reflecting claims submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab or diagnostic procedures, hospital admissions, and referrals.

2. DMAS may restrict providers if any [*one or more*] *of the following conditions is identified* [*. These conditions include but shall not be limited to the following*] *:*

a. Visits billed at a frequency or level exceeding that which is medically necessary;

b. Diagnostic tests billed in excess of what is medically necessary;

c. Diagnostic tests billed which are unrelated to the diagnosis;

d. Medications prescribed or prescriptions dispensed in excess of recommended dosages;

e. Medications prescribed or prescriptions dispensed unrelated to the diagnosis.

f. If the provider's license to practice in any state has been revoked or suspended.

E. Provider restriction procedures.

1. DMAS shall advise affected providers by written notice of the proposed restriction under the Client Medical Management Program. Written notice shall include an explanation of the basis for the decision, request for additional documentation, if any, and notification of the provider's right to appeal the proposed action.

2. DMAS shall restrict providers from being the designated provider, a referral provider, or a covering provider, for recipients in the Client Medical Management Program for 18 months.

3. DMAS shall not implement provider restriction if a valid appeal is noted.

F. Review of provider restriction status.

1. DMAS shall review a restricted provider's claims history record prior to the end of the restriction period to determine restriction termination or continuation (See § 3 D). DMAS shall extend provider restriction for 18 months in one or more of the following situations:

a. Where abuse by the provider is identified.

b. Where the practices which led to restriction continue.

2. In cases where the provider has submitted an insufficient number of claims during the restriction period to enable DMAS to conduct a claims history review, DMAS shall continue restriction until a reviewable six-months claims history is available for evaluation.

3. If DMAS renews restriction following the review, the provider shall be notified of the agency's proposed action, the basis for the action, and appeal rights. (See § 3 E).

4. If the provider continues a pattern of inappropriate health care services, DMAS may make a referral to the appropriate peer review group or regulatory agency for recommendation [~~*or*~~ *and*] *action* [*as appropriate*] .

G. Provider appeals.

1. Providers shall have the right to appeal any adverse action taken by the department under these regulations.

2. Provider appeals shall be held pursuant to the provisions of § 9-6.14:11 et seq. of the Code of Virginia (Administrative Process Act).

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RECIPIENT/PRIMARY PROVIDER AGREEMENT

PHARMACY

DATE: _____

RECIPIENT NAME: _____ IMAS#: _____

I. My choice for designated pharmacy is given below. I understand that Medicaid will pay for covered outpatient pharmacy services from my designated pharmacy. Other pharmacies will be paid only when my designated pharmacy does not stock or cannot supply medications in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: ( ) _____

II. PRINT NAME AND ADDRESS OF PHARMACY: _____

_____

I agree to monitor the drug utilization and provide all outpatient pharmaceutical needs for the recipient named above.

PHARMACY REPRESENTATIVE'S SIGNATURE: _____ DATE: _____

PHARMACY'S MEDICAID ID#: _____ TELEPHONE NUMBER: ( ) _____
(Use number preprinted on the invoice)

MAIL TO:

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VIRGINIA 23219

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.
2. The pharmacy you select must be a Medicaid provider that bills on the Daily Drug Claim Ledger. The pharmacist can tell you if the pharmacy meets these requirements. Any questions can be directed to the Recipient Monitoring Unit in Richmond, (804) 786-6548.
3. If the pharmacist agrees to be your designated provider, ask him/her to **sign and date the form and write in the pharmacy's Medicaid provider number.**
4. Be sure the name and address of the pharmacy is PRINTED clearly in Section II.
5. When Sections I and II are completed, return the form to our office in the enclosed postage paid envelope.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RECIPIENT/PRIMARY PROVIDER AGREEMENT

PHARMACY CHANGE

DATE: _____

RECIPIENT NAME: _____ IMAS#: _____

I. My choice for designated pharmacy is given below. I understand that Medicaid will pay for covered outpatient pharmacy services from my designated pharmacy. Other pharmacies will be paid only when my designated pharmacy does not stock or cannot supply medications in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: ( ) _____

II. PRINT NAME AND ADDRESS OF PHARMACY: _____

_____

I agree to monitor the drug utilization and provide all outpatient pharmaceutical needs for the recipient named above.

PHARMACY REPRESENTATIVE'S SIGNATURE: _____ DATE: _____

PHARMACY'S MEDICAID ID#: _____ TELEPHONE NUMBER: ( ) _____
(Use number preprinted on the invoice)

MAIL TO:

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VIRGINIA 23219

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.
2. The pharmacy you select must be a Medicaid provider that bills on the Daily Drug Claim Ledger. The pharmacist can tell you if the pharmacy meets these requirements. Any questions can be directed to the Recipient Monitoring Unit in Richmond, (804) 786-6548.
3. If the pharmacist agrees to be your designated provider, ask him/her to **sign and date the form and write in the pharmacy's Medicaid provider number.** The change will be effective on the date the form is signed.
4. Be sure the name and address of the pharmacy is PRINTED clearly in Section II.
5. When Sections I and II are completed, return the form to our office in the enclosed postage paid envelope.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RECIPIENT/PRIMARY PROVIDER AGREEMENT

PHYSICIAN

DATE: _____

RECIPIENT NAME: _____ IMAS#: _____

I. My choice for primary physician is given below. I understand that Medicaid will pay for covered outpatient physician services provided by my primary physician. Other physicians will be paid only when my primary physician makes a medical referral or is unable to provide services in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: (____) _____

II. PRINT NAME AND ADDRESS OF PHYSICIAN: _____

_____

I agree to undertake primary health care and make appropriate referrals to specialists for the recipient named above.

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S MEDICAID ID#: _____ TELEPHONE NUMBER: (____) _____
(Use number preprinted on the invoice)

MAIL TO:

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VIRGINIA 23219

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.

2. The physician you select must be a enrolled as an individual physician with Medicaid and bill on a Practitioner Invoice using his/her own Medicaid provider number. The physician can tell you if these requirements are met. Any questions can be directed to the Recipient Monitoring Unit in Richmond, (804) 786-6548.

3. If the physician agrees to be your primary physician, ask him/her to **sign and date the form and write in the Medicaid provider number.**

4. Be sure the physician's name and the office address are PRINTED clearly in Section II.

5. When Sections I and II are completed, return the form to our office in the enclosed postage paid envelope.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RECIPIENT/PRIMARY PROVIDER AGREEMENT

PHYSICIAN CHANGE

DATE: _____

RECIPIENT NAME: _____ IMAS#: _____

I. My choice for primary physician is given below. I understand that Medicaid will pay for covered outpatient physician services provided by my primary physician. Other physicians will be paid only when my primary physician makes a medical referral or is unable to provide services in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: (____) _____

II. PRINT NAME AND ADDRESS OF PHYSICIAN: _____

_____

I agree to undertake primary health care and make appropriate referrals to specialists for the recipient named above.

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S MEDICAID ID#: _____ TELEPHONE NUMBER: (____) _____
(Use number preprinted on the invoice)

MAIL TO:

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VIRGINIA 23219

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.

2. The physician you select must be a enrolled as an individual physician with Medicaid and bill on a Practitioner Invoice using his/her own Medicaid provider number. The physician can tell you if these requirements are met. Any questions can be directed to the Recipient Monitoring Unit in Richmond, (804) 786-6548.

3. If the physician agrees to be your primary physician, ask him/her to **sign and date the form and write in the Medicaid provider number.** The change will be effective on the date the form is signed.

4. Be sure the physician's name and the office address are PRINTED clearly in Section II.

5. When Sections I and II are completed, return the form to our office in the enclosed postage paid envelope.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RECIPIENT/PRIMARY PROVIDER AGREEMENT

DATE: _____

RECIPIENT NAME: _____ DMAS#: _____

I. My choices for primary physician and pharmacy are given below. I understand that Medicaid will pay for covered outpatient physician and pharmacy services provided by the providers listed below. Other physicians will be paid only when my primary physician makes a medical referral or is unable to provide services in a medical emergency requiring immediate treatment. Other pharmacies will be paid only when my designated pharmacy does not stock or cannot supply medications in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: (_____) _____

II. PRINT NAME AND ADDRESS OF PRIMARY PHYSICIAN: _____

_____

I agree to undertake primary health care and make appropriate referrals to specialists for the recipient named above.

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S MEDICAID ID#: _____ TELEPHONE NUMBER: (___) _____
(Use number preprinted on the invoice)

III. PRINT NAME AND ADDRESS OF PHARMACY: _____

_____

I agree to monitor the drug utilization and provide all outpatient pharmaceutical needs for the recipient named above.

PHARMACY REPRESENTATIVE'S SIGNATURE: _____ DATE: _____

PHARMACY'S MEDICAID ID#: _____ TELEPHONE NUMBER: (___) _____
(Use number preprinted on the invoice)

MAIL TO:

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VIRGINIA 23219

INSTRUCTIONS ON REVERSE SIDE

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RECIPIENT/PRIMARY PROVIDER AGREEMENT

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.
2. The physician you select must be enrolled as an individual physician with Medicaid and bill on a Practitioner Invoice using his/her own Medicaid provider number. The pharmacy you select must be a Medicaid provider that bills on the Daily Drug Claim Ledger. The physician and pharmacist can tell you if these requirements are met. Any questions can be directed to the Recipient Monitoring Unit in Richmond, (804) 786-6548.
3. If they agree to be your primary care providers, ask them to **sign and date the form and write in their Medicaid provider numbers in the appropriate Sections (II and III).**
4. Be sure their names and addresses are PRINTED clearly in the appropriate section.
5. When Sections I, II, and III are complete, return the form to our office in the enclosed postage paid envelope.

PLEASE RETURN THE FORM TO:

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VIRGINIA 23219

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RECIPIENT/PRIMARY PROVIDER AGREEMENT

PROVIDER CHANGES

DATE: _____

RECIPIENT NAME: _____ DMAS#: _____

I. My choices for primary physician and pharmacy are given below. I understand that Medicaid will pay for covered outpatient physician and pharmacy services provided by the providers listed below. Other physicians will be paid only when my primary physician makes a medical referral or is unable to provide services in a medical emergency requiring immediate treatment. Other pharmacies will be paid only when my designated pharmacy does not stock or cannot supply medications in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: (____) _____

II. PRINT NAME AND ADDRESS OF PRIMARY PHYSICIAN: _____

_____

I agree to undertake primary health care and make appropriate referrals to specialists for the recipient named above.

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S MEDICAID ID#: _____ TELEPHONE NUMBER: (__) _____
(Use number preprinted on the invoice)

III. PRINT NAME AND ADDRESS OF PHARMACY: _____

_____

I agree to monitor the drug utilization and provide all outpatient pharmaceutical needs for the recipient named above.

PHARMACY REPRESENTATIVE'S SIGNATURE: _____ DATE: _____

PHARMACY'S MEDICAID ID#: _____ TELEPHONE NUMBER: (__) _____
(Use number preprinted on the invoice)

MAIL TO:

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VIRGINIA 23219

INSTRUCTIONS ON REVERSE SIDE

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

RECIPIENT/PRIMARY PROVIDER AGREEMENT

PROVIDER CHANGES

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.

2. The physician you select must be enrolled as an individual physician with Medicaid and bill on a Practitioner Invoice using his/her own Medicaid provider number. The pharmacy you select must be a Medicaid provider that bills on the Daily Drug Claim Ledger. The physician and pharmacist can tell you if these requirements are met. Any questions can be directed to the Recipient Monitoring Unit in Richmond, (804) 786-6548.

3. If they agree to be your primary care providers, ask them to **sign and date the form and write in their Medicaid provider numbers in the appropriate Sections (II and III).** The changes will be effective on the date(s) the form was signed.

4. Be sure their names and addresses are PRINTED clearly in the appropriate section.

5. When Sections I, II, and III are complete, return the form to our office in the enclosed postage paid envelope.

PLEASE RETURN THE FORM TO:

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VIRGINIA 23219

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

_____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

_____

_____ See one time only for _____

_____ See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____

Signature of Primary Health Care Provider

_____

Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone #: ( ) _____

(Instructions on Back)

INSTRUCTIONS

The primary health care provider whose name and Medicaid identification number appear on the restricted recipient's eligibility card completes the form.

NOTE: If the recipient is restricted to a clinic, the clinic physician serving as the primary physician completes and signs the form. The clinic name and number are listed under the physician's signature.

The Referral Physician's Copy is mailed to the referral physician or given to the recipient to take to the appointment with the referral physician.

The Recipient's Copy is given to the recipient. The recipient should show the copy to the designated pharmacist when filling a prescription from the referral physician.

The Primary Health Care Provider's Copy is retained in the recipient's record in the office of the primary health care provider.

DRUG UTILIZATION REVIEW REPLY

REVIEW PERIOD: _____

RECIPIENT: _____ DMAS#: _____

I. Are you aware of the total medication utilization by this patient as indicated on the enclosed drug chart? _____ yes _____ no

II. Please list the medications prescribed by you, giving the prescription order and related diagnosis, OR submit copies of your medical records for the review period.

MEDICATION (including dose and frequency)	and	RELATED DIAGNOSIS
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

III. Are you aware of this patient being treated by any other physician?
yes _____ no _____
If yes, please list: _____

_____

_____

IV. In your opinion, does this patient need to be restricted to one primary physician and pharmacy? yes _____ no _____

V. Additional Comments:

PLEASE RETURN THE FORM TO:

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VIRGINIA 23219

_____
PRESCRIBER'S SIGNATURE

_____
DATE

_____
PRESCRIBER'S NAME

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

QUESTIONNAIRE

NAME: _____ DMAS#: _____

TELEPHONE # WHERE RECIPIENT CAN BE REACHED: (____)_____

1. What does the recipient indicate are specific medical problems?

2. What drugs is the recipient currently taking, and why?

3. Explain why the recipient is using more than one physician.

4. Explain why the recipient is using more than one pharmacy.

5. Explain why the recipient is using the emergency room.

(SEE REVERSE SIDE)

6. Does the recipient appear to understand the Client Medical Management Program?

7. Which pharmacy and physician does the recipient plan to designate? (The primary physician is usually a General Practitioner or Internist who provides routine medical care and refers to specialists as needed. **Instruct the recipient to return the Recipient/Primary Provider Agreement with the required signatures).**

8. What is your general impression of the home situation?

9. Is there someone in or outside the home who assists the recipient with daily living skills?

10. Can the recipient read and write?

11. Is this an active service case?

12. Please list names and Medicaid numbers for other recipients residing at the same address.

_____
Interviewer's Name

(____) _____
Telephone

_____
Agency

_____
Date

Please return form to:

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VIRGINIA 23219

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

PROFILE OF RECIPIENT'S UTILIZATION

RECIPIENT NAME: _____ DMAS#: _____

During the review period of _____, we found that the recipient:

(SEE ITEMS THAT ARE CHECKED)

_____ 1. Used _____ physicians/groups of physicians.

_____ Used _____ physicians/physician groups for routine care.

_____ Used more than one physician of the same provider type: _____.

_____ 2. Used _____ pharmacies.

_____ Used multiple pharmacies consistently.

_____ Used one pharmacy primarily (_____) and other pharmacies occasionally.

_____ 3. Received services of the same type from two or more physicians and/or pharmacies.

_____ Treatment by _____ physicians for same diagnosis.

_____ Duplicative medical visits, lab/diagnostic procedures.

_____ Used more than one pharmacy or more than one prescriber to receive drugs duplicative in nature or potentially addictive.

_____ 4. Excessively used medications.

_____ Received large quantities of specific drugs from one or more prescribers. Drug Classifications: _____

_____ Different prescribers writing for same types of drugs are unaware of total drug utilization. Drug classifications: _____

_____ Obtained prescriptions at a frequency or amount that does not comply with prescribers's directions. (ex: refilling prescriptions early). Drug classifications: _____

_____ Physician reports that strict controls for prescribing medications are necessary due to recipient requesting specific medications.

(SEE REVERSE SIDE)

____ **PLEASE EXPLAIN TO THE RECIPIENT why using multiple physicians and pharmacies is not in the recipient's best interest. Mixing prescriptions from a a number of prescribers can be detrimental to the recipient's health and serves no therapeutic purpose. Using one primary physician allows the physician to follow the recipient's medical progress and provides continuity of care. Using one pharmacy allows the pharmacist to monitor the recipient's drug regimen and work with the physician if complications should develop.

_____ 5. Made _____ visits to _____ hospital(s). Based on Medicaid criteria for treatment in the emergency room, _____ visits were considered non-emergency.

____ **PLEASE EXPLAIN TO THE RECIPIENT that a hospital emergency room is to be used only when the threat to the life or health of the recipient necessitates the use of the most accessible hospital facility available that is equipped to furnish the services. Once restricted to a primary physician, reimbursement for emergency room services is conditional upon the review of the necessary documentation supporting the need for emergency services. If Medicaid determines that the recipient used the emergency room for treatment which could have been provided in a physician's office, Medicaid will not pay for the visits and the hospital can bill the recipient.

The recipient is expected to make an appointment with the primary physician for routine, non-emergency care. If the primary physician is not available, the recipient is expected to see the physician who is covering, usually an associate sharing the office.

_____ 6. Use of pre-authorized transportation services on dates for which no corresponding medical services can be verified.

____ **PLEASE EXPLAIN TO THE RECIPIENT that Medicaid transportation can be used only for services covered by Medicaid.

ADDITIONAL COMMENTS:

If you have any questions regarding this information, please call _____, Recipient Monitoring Unit, Department of Medical Assistance Services, at (804) 786-6548.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

PRIMARY HEALTH CARE PROVIDER'S REVIEW FORM

REVIEW PERIOD: _____

RECIPIENT: _____ IMAS#: _____

I. Please list the maintenance drugs and any controlled substances, giving the prescription order and related diagnosis, OR submit copies of your medical records for the review period.

MEDICATION (including prescription order)	and	RELATED DIAGNOSIS
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

II. If a drug chart giving weekly quantities for each medication covered by the Department is enclosed for your review, are you aware of the total drug utilization? _____ yes _____ no

Have you had to implement strict controls of medications due to drug seeking behaviors during the last 10 months? (ex: requesting early refills) _____ yes _____ no

Has the recipient demonstrated non-compliance in taking maintenance drugs during the last 10 months? (ex: asthmatic patient not using prescribed bronchial dilators) _____ yes _____ no

Comments:

III. Have you referred this patient to any other physician(s)? (NOTE: other physicians treating this recipient for non-emergency medical problems will only be paid with a referral from the primary health care provider.)
_____ yes _____ no

If yes, please list physician(s) name, date(s) of referral and related diagnosis.

_____

_____

_____

Has the recipient requested unnecessary medical services (referrals or procedures) during the last 12 months? _____ yes _____ no

IV. A Medicaid recipient's use of an emergency room for routine medical care is considered abuse of the Department of Medical Assistance Services. We have requested copies of this recipient's visits on _____ to determine the basis for the utilization.

Are you aware of these visits? _____ yes _____ no

If you referred the recipient to the Emergency Room, please specify dates:

_____

_____

V. Do you recommend renewing this recipient's restriction status?
_____ yes _____ no

Comments:

PLEASE RETURN TO:

Recipient Monitoring Unit
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia 23219

_____
PHYSICIAN'S SIGNATURE

_____
PHYSICIAN'S NAME

_____
DATE

* * * * * * * * *

Title of Regulation: **VR 460-04-8.12. Home and Community Based Services for Individuals with Mental Retardation.**

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

Effective Date: January 1, 1992.

Summary:

The purpose of this final regulation is to promulgate permanent regulations for the provision of home and community-based services for persons with mental retardation to supersede the temporary emergency regulation which became effective on January 1, 1992.

Virginia has received approval from the Health Care Financing Administration (HCFA) for two waivers under § 1915(c) of the *** ERROR *** INVALID COMMAND *Social Security Act. These waivers allow Virginia to provide home and community-based services to mentally retarded and developmentally disabled individuals who require the level of care provided in nursing facilities (NF) for mentally retarded individuals, the cost of which would be reimbursed under the State Plan for Medical Assistance.*

DMHMRSAS has identified 1,770 persons who either currently reside in intermediate care facilities for mentally retarded persons or in the community receiving state-funded community services, or are expected to require such services over the three-year period of the requested waiver. In addition, a waiver has been requested to provide community-based services to approximately 200 persons currently residing in NFs who have been identified through an annual resident review process, mandated by the Omnibus Reconciliation Act of 1987, as requiring care in intermediate care facilities for the mentally retarded (ICF/MR). These individuals, in the absence of a community-based care waiver alternative, would be transferred to an ICF/MR facility.

The services to be provided by these waivers are residential support, day support, habilitation, and therapeutic consultation services. All individuals served through these waivers must also receive case management services as a supportive service which enables the efficient and effective delivery of waiver services. Case management services are not included in the waiver but will be reimbursed as State Plan optional targeted case management services.

All Medicaid eligible individuals must be assessed according to a standardized assessment instrument and determined to meet the criteria for nursing facilities for mentally retarded persons (ICF/MR level of care criteria, VR 460-04-8.2) prior to development of a plan of care for waiver services.

Case managers employed by the community services boards are responsible for completing assessments and developing plans of care for those individuals found to meet ICF/MR criteria. The case manager may then recommend approval of the plan of care for waiver services to a care coordinator employed by DMHMRSAS. The care coordinator must give authorization for waiver services prior to implementation of waiver services and DMAS reimbursement.

DMAS is the single state authority responsible for supervision of the administration of the waiver services. DMAS will contract with those providers of services which meet all licensing and certification criteria required in these regulations and which are willing to adhere to DMAS' policies and procedures. Both DMHMRSAS and DMAS are responsible for periodically reevaluating all individuals authorized for waiver services to assure they continue to meet the ICF/MR criteria and that the community services are sufficient to promote their continued health and well-being.

The service definitions, provider requirements and qualifications, and utilization review requirements included in this emergency regulation were developed by a task force of DMAS, DMHMRSAS, and local community services board representatives.

These final regulations contain several nonsubstantive corrections made as a result of public comment. Otherwise, they are identical to the emergency regulations which they are intended to replace.

VR 460-04-8.12. Home and Community Based Services for Individuals with Mental Retardation.

§ 1. Definitions.

"Care coordinators" means persons employed by the Department of Mental Health, Mental Retardation and Substance Abuse Services to perform utilization review, recommendation of preauthorization for service type and intensity, and review of individual level of care criteria.

"Case management" means the assessment, planning, linking and monitoring for individuals referred for mental retardation community-based care waiver services [~~*which*~~ *. Case management (i)*] *ensures the development, coordination, implementation, monitoring, and modification of the individual service plan* [~~*and linkage of*~~ *; (ii) links*] *the individual with appropriate community resources and supports* [*;* ~~*coordination of*~~ *; (iii) coordinates*] *service providers* [*; ;*] *and* [~~*monitoring of*~~ *(iii) monitors*] *quality of care.*

"Case managers" means individuals possessing a combination of mental retardation work experience and relevant education which indicates that the individual possesses the knowledge, skills and abilities, as established

by DMHMRSAS, necessary to perform case management services.

"Community based care waiver services" or "waiver services" means the range of community support services approved by the Health Care Financing Administration pursuant to § 1915(c) of the Social Security Act to be offered to mentally retarded and developmentally disabled individuals who would otherwise require the level of care provided in a nursing facility for the mentally retarded.

"Community services board" or "CSB" means the public organization authorized by the Code of Virginia to provide services to individuals with mental illness or retardation, operating autonomously but in partnership with the DMHMRSAS.

"Consumer Service Plan" or "CSP" means that document addressing the needs of the recipient of home and community-based care mental retardation services, in all life areas. The Individual Service Plans developed by service providers are to be incorporated in the CSP by the case manager. Factors to be considered when this plan is developed may include, but are not limited to, the recipient's age, primary disability, and level of functioning.

"DMAS" means the Department of Medical Assistance Services.

"DMHMRSAS" means 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 in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self-care, physical development, and transportation to and from training sites, services and support activities.

"Developmental disability" means a severe, chronic disability that (i) is attributable to a mental or physical impairment (attributable to mental retardation, cerebral palsy, epilepsy, autism, or neurological impairment or related conditions) or combination of mental and physical impairments; (ii) is manifested before that individual attains the age of 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major areas: self-care, language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and (v) results in the individual's need for special care, treatment or services that are individually planned and coordinated, and that are of lifelong or extended duration.

"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 diagnostic and evaluative criteria.

"Habilitation" means prevocational and supported employment for mentally retarded individuals who have been discharged from a Medicaid certified nursing facility or nursing facility for the mentally retarded, aimed at preparing an individual for paid or unpaid employment.

"HCFA" means the Health Care Financing Administration as that unit of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.

"Individual Service Plan" or "ISP" means the service plan developed by the individual service provider related solely to the specific tasks required of that service provider. ISPs help to comprise the overall Consumer Service Plan of care for the individual. The ISP is defined in DMHMRSAS licensing regulations VR 470-02-09.

"Inventory for client and agency planning" or "ICAP" means the assesment instrument used by case managers and care coordinators to record the mentally retarded individual's needs and document that the individual meets the ICF/MR level of care.

"Mental retardation" means the diagnostic classification of substantial subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behavior.

"Prevocational services" means services aimed at preparing an individual for paid or unpaid employment. The services do not include activities that are specifically job or task oriented but focus on goals such as attention span and motor skills. Compensation, if provided, would be for persons whose productivity is less than 50% of the minimum wage.

"Related conditions" means those conditions defined in 42 CFR 435.1009 as severe, chronic disabilities attributable to cerebral palsy or epilepsy or other conditions found to be closely related to mental retardation due to the impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, which requires treatment or services similar to those required for these persons. A related condition must manifest itself before the person reaches age 22, be likely to continue indefinitely and result in substantial functional limitations in three or more areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

"Residential support services" means support provided in the mentally retarded individual's home or in a licensed residence which includes training, assistance, and supervision in enabling the individual to maintain or

improve his health, assistance in performing individual care tasks, training in activities of daily living, training and use of community resources, and adapting behavior to community and home-like environments. Reimbursement for residential support shall not include the cost of room and board.

"Therapeutic consultation" means consultation provided by members of psychology, social work, behavioral analysis, speech therapy, occupational therapy or physical therapy disciplines to assist the individual, parents/family members, residential support and day support providers in implementing an individual service plan.

"State Plan for Medical Assistance" or "Plan" means the regulations identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

§ 2. General coverage and requirements for home and community-based care services.

A. Waiver service populations.

Home and community-based services shall be available through two waiver services programs. The services, eligibility determination, authorization process and provider requirements set forth in these regulations apply equally to both waiver programs. DMAS shall assign individuals to a waiver program based on the individual's diagnosis or condition.

1. Coverage shall be provided under a waiver program specifically for the following individuals currently residing in nursing facilities who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded:

a. Individuals with mental retardation.

b. Individuals with related conditions.

2. Coverage shall be provided under a separate waiver program for the following individuals who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded:

a. Individuals with mental retardation.

b. Individuals under the age of six at developmental risk who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded. At age six, these individuals must be determined to be mentally retarded to continue to receive home and community-based care services.

B. Covered services.

1. Covered services shall include: residential support, habilitation, day support and therapeutic consultation.

2. These services shall be clinically appropriate and necessary to maintain these individuals in the community. Federal waiver requirements provide that the average per capita fiscal year expenditure under the waiver must not exceed the average per capita expenditures for the level of care provided in an intermediate care facility for the mentally retarded under the State Plan that would have been made had the waiver not been granted.

C. Patient eligibility requirements.

1. Virginia shall apply the financial eligibility criteria contained in the State Plan for the categorically needy and the medically needy. Virginia has elected to cover the optional categorically needy group under 42 CFR 435.211, 435.231 and 435.217. The income level used for 435.211, 435.231 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person.

2. 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 be Medicaid eligible in an institution. 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.

3. Virginia shall reduce its payment for home and community-based 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 deducting the following amounts in the following order from the individual's income:

a. For individuals to whom § 1924(d) applies, Virginia intends to waive the requirement for comparability pursuant to § 1902(a)(10)(B) to allow for the following:

(1) An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a noninstitutionalized individual unless the individual is a working patient. Those individuals involved in a planned

habilitation program carried out as a supported employment or prevocational or vocational training shall be allowed to retain an additional amount not to exceed the first $75 of gross earnings each month and up to 50% of any additional gross earnings up to a maximum personal needs allowance of $575 per month (149% of the SSI payment level for a family of one with no 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, the same as that applied for the institutionalized patient.

(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, the same as that applied for the institutionalized patient.

(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 covered under the Plan.

b. For all other individuals:

(1) An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a noninstitutionalized individual unless the individual is a working patient. Those individuals involved in a planned habilitation program carried out as a supported employment or prevocational or vocational training will be allowed to retain an additional amount not to exceed the first $75 of gross earnings each month and up to 50% of any additional gross earnings up to a maximum personal needs allowance of $575 per month (149% of the SSI payment level for a family of one with no income).

(2) For an individual with a family at home, an additional amount for the maintenance needs of the family which shall be equal to the medically needy income standard for a family of the same size.

(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 covered under the state Medical Assistance Plan.

D. Assessment and authorization of home and community-based care services.

1. The individual's need for home and community-based care services shall be determined by the CSB case manager after completion of a comprehensive assessment of the individual's needs and available support. The case manager shall complete the Inventory for Client and Agency Planning (ICAP), determine whether the individual meets the intermediate care facility for the mentally retarded (ICF/MR) criteria and develop the Consumer Service Plan (CSP) with input from the recipient, family members, service providers and any other individuals involved in the individual's maintenance in the community.

2. 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 (VR 460-04-8.2).

3. The case manager shall gather relevant medical, social, and psychological data and identify all services received by the individual. Medical examinations shall be completed no earlier than 60 days prior to beginning waiver services. Social assessments must have been completed within one year of beginning waiver services. Psychological evaluations or reviews must be completed within a year prior to the start of waiver services. In no case shall a psychological review be based on a full psychological evaluation that precedes admission to waiver services by more than three years.

4. The case manager shall explore alternative settings to provide the care needed by the individual. Based on the individual's preference, [~~or~~] preference of parents [or guardian] for minors [,] or [preference of] guardian or authorized representative for adults, and the assessment of needs, a plan of care shall be developed for the individual. For the case manager to make a recommendation for waiver services, community-based care services must be determined to be an appropriate service alternative to delay, avoid, or exit from nursing facility placement.

5. Community-based care 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 is either mentally retarded as defined in § 37.1-1 of the Code of Virginia, has a related condition 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 individual requesting waiver services shall not receive such services while an inpatient of a

nursing facility or hospital.

6. The case manager must submit the results of the comprehensive assessment and a recommendation to the care coordinator for final determination of ICF/MR level of care and authorization for community-based care services. DMHMRSAS authorization must be obtained prior to referral for service initiation and Medicaid reimbursement for waiver services. DMHMRSAS will communicate in writing to the case manager whether the recommended service plan has been approved or denied and, if approved, the amounts and type of services authorized.

7. All Consumer Service Plans are subject to approval by DMAS. DMAS is the single state authority responsible for the supervision of the administration of the community-based care waiver. DMAS has contracted with DMHMRSAS for recommendation of preauthorization of waiver services and utilization review of those services.

§ 3. General conditions and requirements for all home and community-based care participating providers.

A. General requirements.

Providers approved for participation shall, at a minimum, perform the following:

1. Immediately notify DMAS in writing of any change in the information which the provider previously submitted to DMAS.

2. Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the services required and participating in the Medicaid Program at the time the service was performed.

3. Assure the recipient's freedom to refuse medical care and treatment.

4. Accept referrals for services only when staff is available to initiate services.

5. Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin and of Section 504 of the Rehabilitation Act of 1973 which prohibits discrimination on the basis of a handicap [and both the Virginians with Disabilities Act and the Americans with Disabilities Act] .

6. Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.

7. Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

8. Accept Medicaid payment from the first day of the recipient's eligibility.

9. Accept as payment in full the amount established by DMAS.

10. Use program-designated billing forms for submission of charges.

11. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

a. Such records shall be retained for at least five years from the last date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years.

b. Policies regarding retention of records shall apply even if the agency discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia.

12. Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

13. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid.

14. Hold confidential and use for authorized DMAS or DMHMRSAS purposes only all medical assistance information regarding recipients.

15. When ownership of the provider agency changes, DMAS shall be notified within 15 calendar days of such change.

B. Requests for participation.

DMAS will screen requests to determine whether the provider applicant meets the following basic requirements for participation.

C. Provider participation standards.

For DMAS to approve contracts with home and community-based care providers the following standards shall be met:

1. The provider must have the ability to serve all individuals in need of waiver services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement.

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

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

4. The provider of residential and day support services must meet the licensing requirements of DMHMRSAS that address standards for personnel, residential and day program environments, and program and service content. Residential support services may also be provided in programs licensed by DSS (homes for adults) or in adult foster care homes approved by local DSS offices pursuant to state DSS regulations. In addition to licensing requirements, persons providing residential support services are required to pass an objective, standardized test of skills, knowledge and abilities developed by DMHMRSAS and administered by employees of the CSB according to DMHMRSAS policies.

5. Habilitation services shall be provided by agencies that are either licensed by DMHMRSAS or are vendors of prevocational, vocational or supported employment services for DRS.

6. Services provided by members of professional disciplines shall meet all applicable state licensure requirements. Persons providing consultation in behavioral analysis shall be certified by DMHMRSAS based on the individual's work experience, education and demonstrated knowledge, skills, and abilities.

7. All facilities covered by § 1616(e) of the Social Security Act in which home and community-based care services will be provided shall be in compliance with applicable standards that meet the requirements of 45 CFR Part 1397 for board and care facilities. Health and safety standards shall be monitored through the DMHMRSAS's licensure standards, VR 470-02-08, VR 470-02-10 and VR 470-02-11 or through DSS licensure standards VR 615-22-05 and VR 615-50-1.

D. Adherence to provider contract and DMAS provider service manual.

In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider contracts and in the DMAS provider service manual.

E. Recipient choice of provider agencies.

If there is more than one approved provider agency in the community, the waiver recipient shall have the option of selecting the provider agency of his choice.

F. Termination of provider participation.

DMAS may administratively terminate a provider from participation upon 60 days' written notification. DMAS may also cancel a contract immediately or may give such notification in the event of a breach of the contract by the provider as specified in the DMAS contract. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

G. Reconsideration of adverse actions.

Adverse actions may include, but are not limited to, disallowed payment of claims for services rendered which are not in accordance with DMAS policies and procedures, contract limitation or termination. The following procedures shall be available to all providers when DMAS takes adverse action which includes termination or suspension of the provider agreement.

1. The reconsideration process shall consist of three phases:

a. A written response and reconsideration of the preliminary findings.

b. The informal conference.

c. The formal evidentiary hearing.

2. The provider shall have 30 days to submit information for written reconsideration, 15 days from the date of the notice to request the informal conference, and 15 days from the date of the notice to request the formal evidentiary hearing.

3. An appeal of adverse actions shall be heard in accordance with the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of the final agency determination shall be made in accordance with the Administrative Process Act.

H. Responsibility for sharing recipient information.

It shall be the responsibility of the case management provider to notify DMAS and DSS, in writing, when any

of the following circumstances occur:

1. Home and community-based care services are implemented.

2. A recipient dies.

3. A recipient is discharged or terminated from services.

4. Any other circumstances (including hospitalization) which cause home and community-based care services to cease or be interrupted for more than 30 days.

I. Changes or termination of care.

It is the care coordinator's responsibility to authorize any changes to a recipient's CSP based on the recommendation of the case management provider.

1. Agencies providing direct service are responsible for modifying their individual service plan and submitting it to the case manager any time there is a change in the recipient's condition or circumstances which may warrant a change in the amount or type of service rendered.

2. The case manager will review the need for a change and may recommend a change to the plan of care to the care coordinator.

3. The care coordinator will approve or deny the requested change to the recipient's plan of care and communicate this authorization to the case manager within 72 hours of receipt of the request for change.

4. The case manager will communicate in writing the authorized change in the recipient's plan of care to the individual service provider and the recipient, in writing, providing the recipient with the right to appeal the decision pursuant to DMAS Client Appeals Regulations (VR 460-04-8.7).

5. Nonemergency termination of home and community-based care services by the individual service provider. The individual service provider shall give the recipient or family and case manager 10 days' written notification of the intent to terminate services. The letter shall provide the reasons for and effective date of the termination. The effective date of services termination shall be at least 10 days from the date of the termination notification letter.

6. Emergency termination of home and community-based care services by the individual services provider. In an emergency situation when the health and safety of the recipient or provider agency personnel is endangered, the case manager and care coordinator must be notified prior to termination. The 10-day written notification period shall not be required.

7. Termination of home and community-based care services for a recipient by the care coordinator. The effective date of termination shall be at least 10 days from the date of the termination notification letter. The case manager has the responsibility to identify those recipients who no longer meet the criteria for care or for whom home and community-based services are no longer an appropriate alternative. The care coordinator has the authority to terminate home and community-based care services.

J. Suspected abuse or neglect.

Pursuant to § 63.1-55.3 of the Code of Virginia, if a participating provider agency knows or suspects that a home and community-based care recipient is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse/neglect/exploitation shall report this to the local DSS.

K. DMAS monitoring.

DMAS is 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 contract renewal with DMAS to provide home and community-based services. A provider's noncompliance with DMAS policies and procedures, as required in the provider's contract, may result in a written request from DMAS for a corrective action plan which details the steps the provider will take and the length of time required to achieve full compliance with deficiencies which have been cited.

§ 4. Covered services and limitations.

A. Residential support services shall be provided in the recipient's home or in a licensed residence in the amount and type dictated by the training, supervision, and personal care available from the recipient's place of residence. Service providers are reimbursed only for the amount and type of residential support services included in the individual's approved plan of care based on an hourly fee for service. Residential support services shall not be authorized in the plan of care unless the individual requires these services and they exceed the care included in the individual's room and board arrangement.

B. Day support services include a variety of training, support, and supervision offered in a setting which allows peer interactions and community integration. Service providers are reimbursed only for the amount and type of day support services included in the individual's approved plan of care based on a daily fee for service established according to the intensity and duration of the service to be delivered.

C. Habilitation services shall include prevocational and supported employment services for former institutional residents. Each plan of care must contain documentation

regarding whether prevocational or supported employment services are available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or in special education services through § 602(16) and (17) of the [Individuals with Disabilities] Education [~~of the Handicapped~~] Act. When services are provided through these sources, the plan of care shall not authorize them as a waiver funded expenditure. Service providers are reimbursed only for the amount and type of habilitation services included in the individual's approved plan of care based on a daily fee for service established according to the intensity and duration of the service delivered.

D. Therapeutic consultation is available under the waiver for Virginia licensed or certified practitioners in psychology, social work, occupational therapy, physical therapy and speech therapy. Behavioral analysis performed by persons certified by DMHMRSAS based on the individual's work experience, education and demonstrated knowledge, skills, and abilities may also be a covered waiver service. These services may be provided, based on the individual plan of care, for those individuals for whom specialized consultation is clinically necessary to enable their utilization of waiver services. Therapeutic consultation services may be provided in residential or day support settings or in office settings. Service providers are reimbursed according to the amount and type of service authorized in the plan of care based on an hourly fee for service.

§ 5. Reevaluation of service need and utilization review.

A. The Consumer Service Plan.

1. The Consumer Service Plan shall be developed by the case manager mutually with other service providers, the recipient, consultants, and other interested parties based on relevant, current assessment data. The plan of care process determines the services to be rendered to recipients, the frequency of services, the type of service provider, and a description of the services to be offered. Only services authorized on the CSP by DMHMRSAS according to DMAS policies will be reimbursed by DMAS.

The case manager is responsible for continuous monitoring of the appropriateness of the recipient's plan of care and revisions to the CSP as indicated by the changing needs of the recipient. At a minimum, the case manager shall review the plan of care every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

3. The care coordinator shall review the plan of care every six months or more frequently as required to assure proper utilization of services. Any modification to the amount or type of services in the CSP must be authorized by the care coordinator, another employee of DMHMRSAS or DMAS.

B. Review of level of care.

1. The care coordinator shall review the recipient's level of care and continued need for waiver services every six months or more frequently as required to assure proper utilization of services.

2. The case manager shall coordinate a comprehensive reassessment, including a medical examination and a psychological evaluation or review, for every waiver recipient at least once a year. This reassessment shall include an update of the ICAP instrument, or other appropriate instrument for children under six years of age, and any other appropriate assessment data based on the recipient's characteristics.

C. Documentation required.

1. The case management agency must maintain the following documentation for review by the DMHMRSAS care coordinator and DMAS utilization review staff for each waiver recipient:

a. All ICAP and other assessment summaries and CSP's completed for the recipient maintained for a period not less than five years from the recipient's start of care.

b. All ISP's from any provider rendering waiver services to the recipient.

c. All supporting documentation related to any change in the plan of care.

d. All related communication with the providers, recipient, consultants, DMHMRSAS, DMAS, DSS, DRS or other related parties.

e. An ongoing log which documents all contacts made by the case manager related to the waiver recipient.

2. The individual service providers must maintain the following documentation for review by the DMHMRSAS care coordinator and DMAS utilization review staff for each waiver recipient:

a. All ISP's developed for that recipient maintained for a period not less than five years from the date of the recipient's entry to waiver services.

b. An attendance log which documents the date services were rendered and the amount and type of service rendered.

c. Appropriate progress notes reflecting recipient's progress toward the goals on the ISP.

BUREAU OF FINANCIAL INSTITUTIONS

Title of Regulation: **VR 225-01-0001. Administrative Order Delegating Certain Authority to the Commissioner of Financial Institutions.**

Statutory Authority: § 12.1-16 of the Code of Virginia.

Effective Date: October 18, 1991.

Virginia Code § 12.1-16 provides (in part):

> In the exercise of the powers and in the performance of the duties imposed by law upon the Commission with respect to insurance and banking, the Commission may delegate to such employees and agents as it may deem proper such powers and require of them, or any of them, the performance of such duties as it may deem proper.

That statute provides further that the head of the Bureau through which the Commission administers the banking laws shall be designated "Commissioner of Financial Institutions."

The Commission has previously delegated various powers and duties to the Commissioner of Financial Institutions pursuant to this statute, and finds now that certain additional authority conferred upon the Commission under Title 6.1 of the Virginia Code should be delegated to the Commissioner of Financial Institutions in order to promote the efficient administration of said Title.

NOW THEREFORE, finding it lawful and proper to do so, the Commission hereby delegates to the Commissioner of Financial Institutions the authority to exercise its powers and to act for it in the following matters:

(1) To grant or deny petitions relating to service by an individual as a director of more than one financial institutions. (§ 6.1-2.7)

(2) To grant a certificate of authority to a bank formed for the purpose of its being acquired under the provisions of Chapter 14 of Title 6.1, or for the purpose of facilitating the consolidation of banks or the acquisition by merger of a bank pursuant to any provision of Title 6.1. (§§ 6.1-13, 6.1-43)

(3) To grant or deny authority to a bank, or to a trust subsidiary, to engage in the trust business or exercise trust powers. (§§ 6.1-16, 6.1-32.5)

(4) To grant or deny authority to a bank to establish a branch office, or to relocate its main office or any of its branch offices. (§ 6.1-39.3)

(5) To grant approval for directors' meetings of a bank to be held less frequently than monthly. (§ 6.1-52)

(6) To grant approval for the investing of more than fifty (50) percent of the aggregate amount of a bank's capital stock, surplus, and undivided profits in its bank building and premises; and to permit the payment of dividends while such investment exceeds 50 percent of capital, surplus, and undivided profits. (§ 6.1-57)

(7) To consent to a bank's investment in more than one service corporation. (§ 6.1-58)

(8) To give permission for the aggregate investment of more than fifty (50) percent of a bank's capital stock and permanent surplus in the stock, securities, or obligations of controlled-subsidiary and bank service corporations. (§ 6.1-58.1)

(9) To give written consent and approval for a bank to hold the possession of certain real estate for a longer period than ten (10) years. (§ 6.1-59(4))

(10) To approve the issuance by a bank of capital notes and debentures, so that such notes and debentures may qualify as surplus for the purpose of calculating the legal lending limit of a bank. (§ 6.1-61)

(11) To give written approval in advance for a bank or trust company to pledge its assets as security for certain temporary purposes. (§ 6.1-80)

(12) To require any bank to prepare and submit such reports and material as he may deem necessary to protect and promote the public interest. (§ 6.1-93)

(13) To approve the issuance of stock in a savings institution in exchange for property or services valued at an amount not less than the aggregate par value of the shares issued. (§ 6.1-194.11, §6.1-194.113)

(14) To reduce temporarily the reserve requirements for a savings institution upon a finding that such reduction is in the best interest of the association and its members. (§ 6.1-194.23)

(15) To grant a certificate of authority to a savings institution formed solely for the purpose of facilitating the merger or acquisition of savings institutions pursuant to any provision of Title 6.1.

(16) To grant or deny authority to a state association, a state savings bank or a foreign savings institution to establish a branch office, or other office or facility where deposits are accepted (§ 6.1-194.26, § 6.1-194.119), or to change the location of a main or branch office. (§ 6.1-194.28, § 6.1-194.121)

(17) To cause a special examination of a savings institution to be made. (§ 6.1-194.84:1)

(18) To grant or deny authority to a savings institution to exercise fiduciary powers. (§§ 6.1-195.77, et seq.; § 6.1-194.138)

(19) To grant or deny approval to a credit union to maintain a service facility or office (other than a main office). (§ 6.1-225.20)

(20) To approve the investment of credit union funds in certain stock, securities and other obligations. (§ 6.1-225.57(8))

(21) To grant or deny authority to an industrial loan association to relocate its office. (§ 6.1-233)

(22) To grant or deny licenses pursuant to Chapter 6 of Title 6.1. (§ 6.1-256.1)

(23) To grant or deny permission to a consumer finance licensee to change the location of an office. (§ 6.1-269.1)

(24) To grant or deny licenses to engage in the business of selling money orders for a fee or other consideration. (§ 6.1-371)

(25) To grant or deny licenses to operate non-profit debt counseling agencies. (§ 6.1-363.1)

(26) To grant or deny licenses to engage in business as a mortgage lender and/or mortgage broker. (§ 6.1-415)

(27) To grant or deny permission to a mortgage lender or mortgage broker licensee to relocate an office or open an additional office. (§ 6.1-416)

(28) To enter into cooperative agreements with appropriate regulatory authorities for the examination of regional bank holding companies and their subsidiaries and regional savings institution holding companies and their subsidiaries and for the accomplishment of other duties imposed on the Commission by Chapter 3.01, Article 11, and by Chapter 15 of Title 6.1.

(29) To prescribe the form and content of all applications, documents, undertakings, papers and information required to be submitted to the Commission under Title 6.1.

(30) To make all investigations and examinations, give all notices, and shorten, waive or extend any time period within which any action of the Commission must or may be taken or performed under Title 6.1.

In the performance of the duties hereby delegated to him, the Commissioner shall have the power and authority to make all findings and determinations permitted or required by law.

The foregoing delegations of authority shall be effective until revoked by order of the Commission. All actions taken by the Commissioner of Financial Institutions pursuant to the authority granted herein are subject to review by the Commission in accordance with the Rules of Practice and Procedure of the State Corporation Commission. Each delegation set forth in a numbered paragraph herein shall be severable from all others.

This order supersedes and revokes a certain order entitled "Administrative Order Delegating Certain Authority to the Commissioner of Financial Institutions" dated January 8, 1991.

AN ATTESTED COPY hereof shall be sent to the Commissioner of Financial Institutions.

EXECUTIVE ORDER NUMBER FORTY-ONE (91)

PROVIDING FOR THE COORDINATION OF EXECUTIVE BRANCH AGENCIES IN SERVICES PROVIDED TO VETERANS AND THEIR FAMILIES IN THE COMMONWEALTH

By virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and Title 2.1, Chapter 5 and Sections 2.1-41.1, 2.1-51.14, 2.1-51.20, 2.1-51.26, and 2.1-51.39 of the Code of Virginia, and subject to my continuing authority and responsibility to act in such matters, I hereby direct the Secretaries of Administration, Economic Development, Education, and Health and Human Resources, and their respective agencies, to cooperate in promoting a coordinated program of available services and benefits for veterans and their families.

Valiant contributions to the Commonwealth's well being have been made, and continue to be made, by veterans and their families. In response to these contributions, the Commonwealth must coordinate other efforts in providing advocacy, employment, income maintenance, educational, and health care services to the veterans and their families. The Commonwealth's programs should foster permanent relationships among the various state agencies administering such programs and should encourage participation by all eligible citizens. Operating with limited means, government must deliver services to veterans and their families more efficiently and more effectively.

Cooperatively, the Secretaries shall be responsible for advising the Governor on ways to enhance the delivery of services to the veterans and their families more efficiently and effectively. They shall review and recommend methods for developing a coordinated state effort to enhance opportunities for Virginia's veterans and their families.

To foster this cooperative program, I hereby direct the Secretary of Administration and the Director of the Department of Veterans' Affairs to initiate and direct the effort. The Secretaries mentioned herein, and other executive branch agencies, including but not limited to the Virginia Employment Commission, Department of Education, Department for the Aging, Department of Social Services, and the Department of Rehabilitative Services shall cooperate fully in this endeavor.

This Executive Order will become effective November 11, 1991, and will remain in full force and effect until January 14, 1994, unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this 31st day of October, 1991.

/s/ Lawrence Douglas Wilder
Governor

EXECUTIVE ORDER NUMBER FORTY-TWO (91)

CREATING THE GOVERNOR'S ADVISORY COMMISSION ON THE DILLON RULE AND LOCAL GOVERNMENT

By virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and, including, but not limited to, Section 2.1-51.36 of the Code of Virginia, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby create the Governor's Advisory Commission on the Dillon Rule and Local Government.

The Advisory Commission is classified as a gubernatorial advisory commission in accordance with Sections 2.1-51.35 and 9-6.25 of the Code of Virginia.

The Commission shall have the specific duty of advising the Governor relative to the following issues:

1. The Commission will review current local government powers in the Commonwealth.

2. The Commission shall assess the ability of the Commonwealth's local governments to deal with local and regional issues within the existing framework of the Code of Virginia.

3. The Commission will evaluate the need for changes to the Code of Virginia and make any recommendations deemed necessary to provide local governments with the ability to address local and regional issues.

The Chairman, Vice-Chairman, and members of the Commission shall be appointed by the Governor and shall serve at his pleasure. The Commission shall consist of no more than twenty members, including locally elected officials, county and city administrators, business and civic leaders, and a representative of the Office of the Secretary of Finance.

Such funding as is necessary for the fulfillment of the Commission's business during the term of its existence will be provided by such executive branch agencies as the Governor may from time to time designate. Total expenditures for the Commission's work are estimated to be $17,000.

Such staff support as is necessary for the conduct of the Commission's business during the term of its existence will be provided by the Department of Housing and Community Development or such other executive branch agencies as the Governor may from time to time designate. An estimated 5,200 hours of staff support will be required to assist the Commission.

Members of the Commission shall serve without compensation and shall not receive any expenses incurred in the discharge of their official duties.

The Commission shall complete its examinations of these matters and report to the Governor no later than November 1, 1992. It may issue interim reports and make recommendations at any time it deems necessary.

This Executive Order shall become effective November 2, 1991, and shall remain in full force and effect until November 1, 1992, unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this 31st day of October, 1991.

/s/ Lawrence Douglas Wilder
Governor

GOVERNOR'S COMMENTS ON PROPOSED REGULATIONS

(Required by § 9-6.12:9.1 of the Code of Virginia)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: **VR 460-04-8.3. Client Medical Management Program.**

Governor's Comment:

I approve of the form and the content of this proposal.

/s/ Lawrence Douglas Wilder
Governor
Date: November 19, 1991

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

Title of Regulation: **VR 615-45-02. Child Protective Services Client Appeals.**

Governor's Comment:

I concur with the form and the content of this proposal. My final approval will be contingent upon a review of the public's comments.

/s/ Lawrence Douglas Wilder
Governor
Date: November 19, 1991

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THIS ISSUE . . .

DIVISION OF LEGISLATIVE SERVICES

HJR 300: Southside Economic Development Commission

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October 29, 1991, Halifax

Having received public comment on proposed recommendations at hearings held throughout the region in August, the Southside Economic Development Commission reviewed and adopted 59 recommendations for submission to the Governor and the 1992 Session of the General Assembly. The commission's report will be dedicated to the study's chairman, the late A.L. Philpott, Speaker of the House of Delegates. Members also agreed that the commission should be continued for an additional year to monitor the implementation of its recommendations.

Education and Workforce Training

Delegate Ted Bennett presented recommendations addressing education and workforce training. Following a brief discussion, the commission adopted these 16 recommendations, which included the establishment of regional, multisite schools focusing on applied learning; funding for computer-enhanced instructional programs; and annual appropriations for the Southside Virginia Business and Education Commission. Central to the commission's education recommendations is the reduction of educational disparities in Southside Virginia. The Governor and the General Assembly will be requested to consider the special needs of school divisions beyond basic requirements and the adjustment of current funding formulas to reflect more accurately local capacity and willingness to pay for public education. Incentives to improve stu-

dent achievement levels, increased support for adult basic education and teacher and workforce recruitment, and enhanced partnerships between business and education were recommended by the commission as well.

Finance, Marketing, and Incentives

Recommendations addressing finance, marketing, and incentives were presented by Seward Anderson. The commission adopted all eight recommendations, which propose the enactment of a double-weighted sales factor apportionment formula for the Virginia Corporate Income Tax and the creation of an industrial manufacturing-modernization outreach program by the Center for Innovative Technology. The establishment of a 13-member Southside Virginia Marketing Council was recommended to help attract development prospects to Southside and to encourage localities to work cooperatively to promote the region. The Council's marketing efforts would be supported by local voluntary per-capita assessments, not to exceed $1 per resident annually, matched by state appropriations allocated from three percent of the state's cigarette tax. To provide the financial assistance for the infrastructure, relocation expenses, and venture capital necessary for industrial recruitment and expansion, a 12-member Southside Virginia Development Authority was proposed to administer a variety of loan programs.

Agriculture, Forestry, and Natural Resources

A total of 22 recommendations were adopted to address agriculture, forestry, and natural resources in Southside Virginia. Delegate Paul Councill, task force chairman, presented these recommendations, which focused on diversification, value-added processing, and marketing of agricultural products; promotion of the forestry industry; tourism; and balance in the regulatory environment. The Secretary of Economic Development will be requested to develop a strategic plan to guide the evolution of agriculture in the Commonwealth. The creation of a nonreverting conservation trust fund, supported by an increased tax on distilled spirits, was also recommended to facilitate land acquisitions and the expansion of existing parks. Other recommendations included the creation of regional forest products and agribusiness industrial parks and research targeting the use of wood wastes for fuels and other products. The commission also recommended funding for planning for the Southeast Virginia Regional Farmers' Market and the establishment of a loan program for agricultural diversification.

Infrastructure

Infrastructure recommendations, presented by Senator Virgil Goode, were then reviewed and adopted. These 13 recommendations included the development of a two-tiered advertising program, which would promote industrial site locations in rural areas and throughout the state, and funding for the Virginia Housing Partnership Fund. Also endorsed was the creation of a public marketing program to promote commercial air services and to encourage Southside residents, businesses, and industries to utilize existing air transportation services in the region. The continuation of the Department of Economic Development's Industrial Shell Building Program and the restoration of the Commonwealth's funding and construction schedule for U.S. 58 to their status prior to Virginia's funding shortfall were also recommended. Finally, the commission supported the inclusion of U.S. Routes 15, 29, 58, and 460; U.S. Route 220 from Roanoke to the North Carolina border; U.S. Route 360 from Danville to Richmond; Route 49 from Crewe to the North Carolina border; Route 501 from Lynchburg to South Boston; and all of Virginia Route 40 in the federal Highways of National Significance plan to enhance Southside's highway infrastructure and to promote rapid access to commercial markets.

Having adopted recommendations and approved its report, the commission members then agreed that the executive committee, comprised of Delegates Bennett, Clement, and Councill, and Senators Anderson, Goode, and Holland, would guide the development of any proposed legislation supporting the commission's recommendations. In addition, the executive committee will coordinate the publication and circulation of a regional newspaper supplement describing the commission's work and findings.

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The Honorable Howard P. Anderson, *Vice Chairman*

The Honorable Whittington W. Clement, *Vice Chairman*

Legislative Services contact: Kathleen G. Harris

HJR 293: Game Protection Fund

◆

September 10, 1991, Newport News

The joint subcommittee assessing the long-range financial status of the Game Protection Fund held a public hearing at Christopher Newport College in Newport News on September 10, 1991. The public, two members of the Board of Game and Inland Fisheries, several interest group representatives, and personnel from the Department of Game and Inland Fisheries (DGIF) and the Animal Damage Control Unit (ADC) of the United States Department of Agriculture offered comments on the following issues:

- The need to improve the financial status of the Game Protection Fund;
- Whether hunting should be permitted on Sundays; and
- How best to improve the Damage Stamp Program.

DGIF's Deteriorating Financial Condition

The Board of Game and Inland Fisheries is extremely concerned about the current financial condition of DGIF, which customarily carried over six-months' worth of operating cash from one fiscal year to the next, but now carries over only six weeks of operating capital. Cash carried over from one fiscal year to the next provides DGIF with the reserve it needs to continue operating during the lean revenue months of July, August, and September. Not until October of each year, when hunting license revenues pick up, does the department receive a new infusion of operating funds, and this year it was forced to borrow money from the treasury in order to survive during that three-month period.

In addition to eroding year-end balances, the steady annual decline in license fee revenues has also hurt the department, which relies on these revenues for nearly 70% of its funding. With hunting license sales declining each year, the board believes DGIF must receive new and broader financial support from less traditional sources if it is to continue providing its current level of services. Plagued by early retirement and insufficient revenues to hire personnel to fill 65 vacant positions, DGIF's situation has become critical, particularly in the law-enforcement division. The department recently lost most of its senior law-enforcement personnel to early retirement and must now replace its colonel, four of five captains, a lieutenant, and four sergeants. Despite this serious personnel shortage, the subcommittee was assured that each county would have game warden coverage during the 1991 fall hunting season.

With costs continuing to rise, DGIF's current level of funding will necessitate a perpetual downsizing. As its personnel level declines, the department will be forced to redefine its mission. Less essential activities have already been curtailed. Lack of funding for capital improvement projects may force DGIF to abandon a majority of its fish hatcheries in favor of making necessary improvements to only a few. During the upcoming biennium, the board estimates DGIF will have an operational funds shortfall of $10 million and a capital outlay shortfall of $3.1 million. Projected operational and capital outlay fund shortfalls for the 1994-96 biennium are $12.2 million and $3.4 million, respectively.

Revenue Enhancement Proposals

Subcommittee members agreed that additional financial support for DGIF is badly needed. Based upon recent discussions with the Secretary of Finance and the Secretary of Natural Resources, Chairman Thomas indicated he was optimistic that at least $750,000 of the moneys transferred from the Game Protection Fund during the current biennium would be paid back to DGIF during fiscal year 1993. The subcommittee also learned that the Southside Economic Development Commission was recommending the enactment of a $1.50 per gallon tax on distilled spirits, with revenues being earmarked for capital outlay projects initiated by the Department of Conservation and Recreation, the Department of Forestry, and DGIF. In addition to these funding enhancement possibilities, Chairman Thomas again urged support for the conservation permit proposal, estimated to provide in excess of $3.1 million in new annual revenues for DGIF.

Sunday Hunting

According to DGIF personnel, results of a random telephone survey of Virginia residents show that a substantial majority of the Commonwealth's citizens are opposed to hunting on Sundays. Of the 1,674 individuals surveyed by DGIF during the fall of 1990, 65% were opposed to Sunday hunting. A breakdown of those responding to the survey indicates that nearly 57% of all hunters and more than 76% of all rural landowners are opposed to Sunday hunting. The subcommittee was informed that other polls conducted on the issue of Sunday hunting have generated similar results.

The Damage Stamp Program

With the recent explosion of the deer population in Virginia, landowners are experiencing an increase in damage caused by wildlife. A recent survey of the Virginia Farm Bureau's membership shows that 25% of those responding experience at least $1,000 in wildlife dam-

ages per year, while over one-half of the respondents claim annual wildlife damages of $100-$1000. Assuming each of Virginia's 20,000 largest farms incurs annual wildlife damages of $500, this damage is costing Virginia agriculture $10 million per year.

According to a representative of the Virginia Farm Bureau, the Damage Stamp Program, originally enacted a decade ago to compensate farmers for damage caused by bear, deer, and big game hunters, has never really worked. Only nine counties currently participate in the local option program, and most of the program's revenue is now used for services unrelated to wildlife damage control. The bureau believes the program should be replaced with a $1 surcharge on all hunting licenses, with revenues directed exclusively to a joint program established by DGIF and the ADC unit of the United States Department of Agriculture. The bureau advocates using 25% of the revenues for program administration costs and the remaining balance for damage abatement measures and compensation. A spokesman for the ADC unit explained that such a program would provide the public with redress of wildlife problems, allow DGIF to continue its evolution into a wildlife conservation agency, and enable Virginia to receive federal matching funds.

Subcommittee members agreed that the current Damage Stamp Program has been unsuccessful. However, several members encouraged the subcommittee to await the results of the fall hunting season before recommending that the program be abolished. Remaining optimistic that the bonus deer permit legislation enacted during the 1991 Session will result in a thinning of the deer herd and a corresponding reduction in damage caused by wildlife, they urged the subcommittee to adopt a wait-and-see approach.

Future Meetings

The subcommittee plans to hold a public hearing in Loudon County and a working session in Richmond prior to the 1992 Session of the General Assembly.

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The Honorable A. Victor Thomas, *Chairman*

Legislative Services contact: Bethany P. Freeman

SJR 213/HJR 314: Joint Subcommittee Studying the Need for Restructuring the Commonwealth's Local Social Services Delivery Systems

◆

October 17, 1991, Richmond

The subcommittee's second meeting focused on the need for automation in determining eligibility for benefit programs administered by local departments of social services. The meeting started with a tour of the Richmond City Department of Social Services, led by Michael Evans, director of the department and one of two local directors on the subcommittee. Members viewed intake and eligibility determination areas and received an overview of the intake process. A departmental presentation on the eligibility determination process illustrated how repetitive and time-consuming the current process is (Table 1).

Automation: Local Government

George T. Drumwright, Jr., deputy county manager of Henrico and the chairman of the Virginia Association of Counties' Committee on Health and Human Services, addressed the subcommittee and emphasized the urgent need for automating the eligibility process. Because of the recent dramatic increase in applications for benefit services and frustration with the State Department of Social Services' pace in developing an automated eligibility/intake process for local departments, the Virginia Association of Counties and the Virginia Municipal League are considering forming a consortium to explore automation alternatives. Mr. Drumwright said that because of today's technology, existing data processing systems in localities can be modified and expanded to communicate with other systems rather than having to replace current systems. Mr. Drumwright advocated the establishment of a pilot program, since some federal funding is available and localities are very anxious to improve technology.

Automation: State Department of Social Services

Commissioner Larry D. Jackson of the State Department of Social Services said that the department is committed to automation and has worked with localities in developing its proposal to automate the applica-

	Aid to Dependent Children	General Relief	Food Stamps
Number of times the client must:			
✏ write his name	4	2	4
✏ write his address	1	1	2
✏ sign his name	9	4	7
✏ enter the date	8	4	6
Number of times the worker must:			
✏ write client's name	16	15	14
✏ write client's address	5	5	6
✏ write client's case number	15	14	13
✏ list program category	9	8	7
✏ identify locality as Richmond	11	9	9
✏ write his name	4	4	5
✏ write his worker code	6	7	7
✏ sign his name	11	10	9
✏ enter the date	17	17	16
Number of forms to be completed by client and worker:	22	17	19

Table 1. **The eligibility determination process.** Source: Richmond City Department of Social Services

tion and benefits system in Virginia. He explained that such a system is very complex and should be implemented on a pilot basis, because systems that have been tried on a statewide basis have been fraught with problems. Florida recently undertook a $100 million integrated human services automation project and has encountered numerous problems.

Mr. Jackson introduced Mary Ellen Roberts, chief of the Bureau of Applications Development, Division of Information Systems within the department, who explained Project ADAPT (Application Benefit Delivery Automation Project) to the subcommittee. After explaining how ADAPT was developed, Ms. Roberts stated that it will significantly streamline the application and benefit delivery process and put Virginia in the forefront of using new technology to enhance existing systems. One of the major objectives of ADAPT is to provide local agencies with a single point of contact for interfacing with multiple systems. Ms. Roberts presented a schedule for the various phases of the project and said that tangible benefits to local staff should begin with the fourth quarter of this calender year, and major portions of the project will be completed within 24 months. The success of ADAPT is dependent on financial support to procure equipment for local agencies and the availability of staff and other resources required for development, implementation, and maintenance. Estimated project cost is $16,204,183, and preliminary cost-benefit analysis indicates that the pay-back period will be less than four years.

Funding

The subcommittee expressed concern after learning that the entire amount of money needed to complete the work scheduled for FY 1992 is not currently available and that the budget addendum for 1993 does not contain the full amount needed. Federal funds will become available only if there are matching state and local funds. Senator Gartlan said that the subcommittee recognizes the importance of adequate funding and supports giving the social services delivery system the best management tools that the state can afford in accordance with needs. Although the subcommittee does not want to involve itself in management functions, it will be looking closely at how the state department and localities work together to improve automation. Millions of dollars and vast amounts of time will be spent developing and implementing this computer system, and it is essential that the product be workable at both the state and local level. Subcommittee members strongly encouraged the department and localities to work together so that the best system can be developed, rather than working on parallel tracks.

Subcommittee Actions

A unanimous vote expressed the sense of the subcommittee that consolidation proposals

imposing financial penalties on local social service agencies that fail to consolidate will not be considered and that the subcommittee would prefer to examine incentives for consolidation.

The subcommittee decided to introduce a resolution requesting that its study be continued for another year and to form a working group consisting of several subcommittee members and representatives of state government and interested groups, such as the Virginia League of Social Services Executives, the Virginia Municipal League, and the Virginia Association of Counties.

The subcommittee will meet again this year to follow up on progress with automation, learn about administrative and service delivery structure in other states, receive information on Virginia's ADC administrative costs, review previous related studies, and develop a work plan for 1992.

◆

The Honorable Joseph V. Gartlan, Jr., *Chairman*

Legislative Services contact: Jessica F. Bolecek

HJR 361: Joint Subcommittee Studying the Imposition of Local Business License Taxes on Nonprofit Hospitals, Colleges, and Universities

◆

September 18, 1991, Richmond

The Joint Subcommittee Studying the Imposition of Local Business License Tax on Nonprofit Hospitals, Colleges, and Universities, created in 1991 by HJR 361, held its organizational meeting on September 18.

The joint subcommittee will examine the issues related to the imposition of a business, professional, and occupational license tax (BPOL) on certain nonprofit organizations to determine the impact of payment of such taxes on the availability and affordability of health care and higher education.

Taxation of Nonprofits

According to the testimony of Susan Ward, of the Virginia Hospital Association, and Robert Lambeth, Jr., of the Council of Independent Colleges in Virginia, nonprofits have traditionally been exempt from taxation. Currently, they do not pay any tax on their real and personal property. Nonprofit hospitals, colleges, and universities contribute to their communities culturally, financially, and through certain free services — services which might otherwise be the government's responsibilities. Some even voluntarily pay a fee to their locality or municipality to help defray the costs of police and fire protection and water and sewer services. Some nonprofits do pay BPOL taxes on income-producing activities, such as giftshops and cafeterias, which are unrelated to the nonprofits' main purpose.

For nonprofit colleges and universities, a BPOL tax would result in a tax on tuition, which would have to be increased in order to raise the revenue needed. It was suggested that it is unfair to tax private colleges and universities and not tax public universities.

Localities'/Municipalities' Right to Tax Nonprofits

According to the testimony of Betty Long, of the Virginia Municipal League, nonprofits should be treated like for-profits because there are no exceptions in the statute that allows localities to levy the BPOL tax. To take this option from localities and municipalities would further erode local revenue opportunities at a time when localities are struggling economically. It was also suggested that any restriction on the revenue base for the BPOL tax requires fewer entities to bear the growing tax burden, thereby causing fewer taxpayers to pay more tax.

The option to levy the tax is important to localities, although only the City of Lynchburg actually collects a BPOL tax from a nonprofit hospital holding company. Although the City of Richmond has the authority through an ordinance, it has not collected any revenue from nonprofit hospitals or colleges. Both cities have a rate of $0.36 per $100 of gross receipts.

When asked why most localities have not yet imposed the tax , Ms. Long and Councilman Adams from Lynchburg both indicated that the local government did not want to, realizing the valuable services nonprofit hospitals and colleges offer. However, now that revenues are difficult to find, localities and municipalities are looking at all options.

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The Honorable Jay W. DeBoer, *Chairman*

Legislative Services contact: Joan E. Putney

Special Senate Commerce and Labor Subcommittee Studying SB 893

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October 3, 1991, Richmond

Members of a special subcommittee of the Senate Committee on Commerce and Labor met on October 3 to discuss issues presented by Senate Bill 893, introduced in the 1991 Session of the General Assembly. SB 893 would have amended Virginia's labor laws to permit public employers to meet and confer with public employee representatives for the purpose of labor contract negotiations. The Virginia Supreme Court has declared that public employers lack authority to do so under current law.

Session History

SB 893 was introduced in the 1991 Session and referred to the Senate Committee on Commerce and Labor, where it was discussed by the full committee on February 2, 1991. At the patron's request, an amendment in the nature of a substitute was adopted.

A motion to report the bill failed. A subsequent motion to pass by indefinitely (PBI) was made. However, a substitute motion to study the bill during the interim between the 1991 and 1992 sessions carried, and the committee chairman then appointed a six-member subcommittee to study the measure.

Substantive Background

Federal courts have held that Virginia's local governments have no *duty* to engage in collective bargaining with their employees unless explicit authority to do so is given by the Virginia General Assembly. *Teamsters Local 822 v. City of Portsmouth*, 423, F. Supp 954 (E.D. Va. 1975), aff'd 534 F. 2d 328 (4th Cir. 1976); *Fire Fighters Local 794 v. City of Newport News*, 339 F. Supp. 13 (E.D. Va. 1972). However, these federal cases left unanswered a critical question: whether public employers may, *if they choose*, bargain collectively with their employees.

The Virginia Supreme Court addressed the legality of voluntary collective bargaining in a 1977 case, *Commonwealth v. Board of Supervisors of Arlington County*, 217, Va. 558, 232 S.E.2d 30 (1977). It ruled unanimously that the Arlington County Board of Supervisors and School Board lacked authority to voluntarily engage in collective bargaining with their employees. The Court said: "...the General Assembly, the source of legislative intent, has never conferred upon local boards, by implication or otherwise, the power to bargain collectively and that express statutory authority, so far withheld, is necessary to confer the power" (Id., 558 Va. at 578-579, 232 S.E. 2d at 32). Thus, collective bargaining between public employers and their employees may not, in the opinion of the court, be undertaken without the express authorization of the General Assembly. To date, the General Assembly has not granted that authority.

SB 893 Purpose and Provisions

SB 893 would amend the Commonwealth's labor laws (Title 40.1) to allow cities, counties, towns, and other political subdivisions, *at their election*, to "meet and confer" with employee representatives about terms and conditions of employment. The bill further declares the rights of political subdivision employees to form, join, or assist employee associations or labor organizations. It provides, however, that its provisions do not give these employees the right to strike, thereby eliminating potential conflict with the provisions of § 40.1-55 forbidding strikes by public employees.

AFL-CIO spokesman Dan LeBlanc told the subcommittee that this year's 200th anniversary of the U.S. Constitution's Bill of Rights provides a fitting time to examine the fundamental issue in SB 893: whether public employees should be permitted a voice in determining the terms and conditions of their employment. He distinguished SB 893 from a true collective bargaining bill by emphasizing the measure's "local option" component: those localities that do not want to meet and confer with public employee representatives may decline to do so. Thus, collective bargaining is not mandated by this bill. A Communications Workers of America representative concurred with Mr. LeBlanc's position on the bill.

Bases of Opposition

Representatives of organizations opposed to key provisions in SB 893, including the Virginia Municipal League, the Virginia Association of Counties, the Virginia School Board Association, and the Virginia Chapter of the International Personnel Managers Association, emphasized their inability to separate "meeting and conferring" from "collective bargaining," since mandatory conferences with employee representatives would create expec-

tations of collective bargaining outcomes. Moreover, they maintained, SB 893 is intended to serve as a "foot in the door," a groundwork for comprehensive public employee collective bargaining.

Some suggested the bill is unnecessary because many local governments presently confer informally with public employees — particularly school teachers — about the terms and conditions of employment. These informal discussions are probably not prohibited under current law, they said, because local governments do so voluntarily and surrender no decision-making authority. However, mandating these consultations by statute would diminish local governments' authority over personnel matters at a time when an ever-changing economy often requires prompt, effective exercise of fiscal authority.

Private sector groups opposed to the bill added that the agreements contemplated by the proposed statute might, in some cases, be coerced by employee groups threatening to strike, despite the bill's anti-strike provision. They noted that other states with laws similar to that proposed in SB 893 have experienced public employee strike actions. These employees know, they stressed, that local governments, as a practical matter, cannot fire all members of an employee group embroiled in a contract dispute.

Key Areas of Contention

Opponents and proponents are divided principally by the bill's language permitting public employers and their employees to "agree." Opponents contend that such language empowers labor unions and associations to negotiate mutually binding accords with public employers, who would be stripped of their ultimate authority over personnel matters. Proponents, however, contend that anything less emasculates bona fide employee representation. The subcommittee learned that the Newport News Fire Fighters Association's representative is not permitted to address the Newport News city council in his capacity as that association's spokesman; he must re-identify himself as a private citizen to be recognized by the council chairman. Thus, SB 893's advocates maintain, without bargaining authority to accompany it, the right of public employees under current law to belong to an employee association or organization is a hollow privilege.

One line of compromise was suggested: substitute "meet and discuss" or "meet and communicate" for the phrase "meet and confer"; add language clarifying public employers' prerogative to meet with individuals or groups not affiliated with any employee union or association; and make any and all "agreements" subject to final ratification by the applicable political subdivision. Senator Miller expressed hope that such suggestions would provide a gateway to a final compromise between all parties on both sides of the issue.

The subcommittee will convene a public hearing on SB 893 during November.

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The Honorable Frank W. Nolen, *Chairman*

Legislative Services contact: Arlen K. Bolstad

HJR 310: Regulation of Underground Injection Wells

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September 5, 1991, Clintwood

As required under HJR 310, a subcommittee composed of members of the House Committee on Mining and Mineral Resources and the Senate Committee on Agriculture, Conservation and Natural Resources held a public hearing on the evening of September 5, 1991, at the Dickenson County Circuit Courthouse. Many of the more than 300 individuals who packed the courtroom voiced their opinion on the following issues:

- Are current laws and regulations governing the construction and use of underground injection wells in Virginia adequate to protect water quality?
- Should Virginia seek delegation of the Underground Injection Control (UIC) program from the United States Environmental Protection Agency (EPA)?

The Controversy in Dickenson County

The debate over underground injection in Dickenson County began when Equitable Resources Exploration (EREX) applied to EPA for a permit to operate a Class II injection well. EREX plans to use the well for the disposal of salty brines generated during the company's production of coalbed methane gas. In October of 1990, despite the protests of county residents concerned about contamination of their private water wells, EPA issued the permit. The Dickenson County Board of Supervisors then filed suit in the Dickenson County Circuit Court seeking a declaratory judgment

that the well violates a 1988 county ordinance prohibiting the establishment, maintenance, or operation of private landfills or dumps. Pending a decision in the case, EREX has voluntarily delayed operation of the injection well. (On October 7, 1991, the Dickenson County Circuit Court entered an order finding that EREX's injection well does not violate the county's ordinance.)

Public Comment

Numerous county residents, local elected officials, business owners, gas company officials and employees, and state and federal regulatory personnel testified before the subcommittee. Most of the individuals who spoke in opposition to the construction of Class II injection wells in Dickenson County were residents or local elected officials concerned about contamination of their groundwater resources. Several speakers asked who would pay for the replacement of their water resources should contamination occur. In addition, the testimony of many residents reflected a mistrust of industry, based upon their perception of how they and others had been treated in years past. Believing that the directive of EPA and Virginia's Department of Mines, Minerals and Energy is to foster, encourage, and promote the development of energy resources, some residents suggested that only the Board of Supervisors and local government would protect their county and its citizens. Consequently, they recommended that state law be amended to require local government approval before a Class II injection well permit could be issued. While some of those who opposed underground injection requested that Virginia seek primacy of the UIC program, others wanted EPA to continue administering the program.

Of particular interest was the testimony of a consultant geologist hired by the Dickenson County Citizens Committee, a group opposed to EREX's Class II injection well. After conducting a review of the injection well, the geology of the area, and the permit documents, the geologist informed the subcommittee that he believed the fears of residents were basically unfounded and that the injection well as proposed was feasible, with little potential of damaging the surface waters or well supplies of nearby residents. Industry officials and state and federal regulatory personnel expressed similar views, claiming that underground injection, when conducted under appropriate geologic conditions and in accordance with current regulatory requirements, is an environmentally safe method of brine disposal. Because EREX's injection well will inject the brine into a sealed and fracture-free formation nearly one mile beneath the residents' underground source of well water, they indicated there was virtually no chance of contamination.

Supporters of underground injection emphasized the importance of these wells to the region's economy. The production of coalbed methane gas should provide substantial severance tax revenues for local governments in Southwest Virginia and additional employment opportunities for the area's residents. Local businessmen and gas industry employees warned that without the availability of underground injection, the production of coalbed methane gas will be hampered by significantly higher brine disposal costs. The subcommittee was presented with a petition, signed by 251 individuals, which stated their belief "that the current programs for the regulation of UIC wells protect Virginia interests and should be maintained if the gas industry is to continue to operate and grow."

Future Meetings

Although not yet scheduled, the two standing committees plan to hold another meeting to review the results of the subcommittee's public hearing and to develop any recommendations they wish to make to the Governor and the 1992 Session of the General Assembly.

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The Honorable Alson H. Smith, Jr.,
Co-Chairman
The Honorable Howard P. Anderson,
Co-Chairman

Legislative Services contact:
Martin G. Farber

HJR 387: Joint Subcommittee Studying Maternal and Perinatal Drug Exposure and Abuse and Its Impact on Subsidized Adoption and Foster Care

◆

September 27, 1991, Richmond

In her introductory remarks, Chairman Van Landingham stated that the focus of the subcommittee's first meeting for 1991 would be the status report of Secretary Cullum's task force on perinatal drug exposure, which was requested to develop and recommend an effective interagency and interdisciplinary approach for the delivery of services to perinatally drug-exposed children and their families.

Task Force Status Report

Debbie Oswalt, deputy secretary of Health and Human Resources, presented the status report of the perinatal drug exposure task force. Noting that substance abuse during pregnancy occurs among women of all racial and socioeconomic levels and that recent studies indicate the success of early and regular prenatal care in reducing the adverse effects of perinatal drug exposure on the infant and associated costs of neonatal intensive care due to maternal drug use, the following *tentative* recommendations of the task force were summarized:

- Current state child abuse and neglect laws are sufficient, and amendment is not necessary.
- Criminal prosecution or coercive actions should not occur solely on the basis of drug use during pregnancy.
- Screening for substance abuse should be a standard and integral part of prenatal care for *all* women. Early identification of prenatal drug abuse should include the use of random toxicology testing, together with appropriate screening of women to determine the need for a substance-abuse evaluation and treatment plan. If the need for treatment or other appropriate interventive medical care is indicated, such women should have the choice to accept or refuse treatment without the fear that sanctions may be imposed.
- Hospitals should be required to develop and implement a protocol for dispensing a written discharge plan for postpartum substance-abusing women and drug-exposed infants. The plan would be discussed with the patient prior to discharge.
- Substance-abusing pregnant women should be given high priority status by local service agencies, and if the agency to which she has been referred upon discharge determines that the infant's health and well-being are endangered, the local child protective services unit should be contacted. Such patients should be monitored, evaluated, and given follow-up care. Monitoring should cease when the child is two years of age unless assessments indicate the need for further treatment.
- Interagency collaboration among public and private providers is necessary for coordination and effective delivery of services.

Problems of Substance Abusing Women

Sherry Galambos, a former patient at the MCV Center for Perinatal Addiction, alerted the joint subcommittee to certain problems faced by substance-abusing women after delivery and discharge from treatment programs, particularly child custody problems. She summarized a paper written by an area juvenile and domestic relations district court judge on the law and practice in contested child custody cases. There are generally five basic concepts employed by courts in custody litigation: (i) best interest of the child, (ii) *res judicata*, (i.e., final order of custody may be reviewed by an appropriate court under the doctrine of "changed circumstances"), (iii) preference for the natural parent, (iv) preference for stability and a conventional lifestyle, and (v) absence of presumption or inference of preference for either parent.

In custody disputes between natural parents, under current state law, the custody contestant must prove the unfitness of the other parent or that the contestant is a better parent. In this instance, the criteria by which unfitness may be weighed include issues of morality, poor judgment, child neglect and abuse, employment and economic resources, and stability in maintaining a home. In addition to these factors, some states have mandated that courts consider the primary caregiver of a child as a significant factor in determining custody; other states require that the existence of domestic violence be considered a disqualifying factor for custody; and some other states reward custody to the "friendly parent," who will foster an amicable relationship with the noncustodial parent. These criteria are absent in Virginia law, but may be critical in custody disputes between former substance-abusing women and the natural fathers of their children who may petition the court for custody. Relating her personal experiences in this area, Ms. Galambos noted that although she was

rehabilitated and has continually been the sole caregiver and custodial parent of her child, she believes that she is vulnerable to losing custody because courts in Virginia do not take into consideration the special circumstances of such women.

Meconium Analysis

Jacquelyn Peterson, director of Perinatal Addiction Program, Cion Inc., explained the use and benefits of meconium analysis as a means of screening for prenatal drug use. Meconium analysis involves the testing of the meconium of newborn infants for the presence of drugs. Although it is not possible to determine the quantity of the drugs used or when use occurred during the gestational period, meconium analysis is more accurate than other forms of drug testing because it can facilitate the identification of drugs used by providing a window of 16-20 weeks gestational age up to delivery for detecting their presence. The denial syndrome of substance-abusing women is effectively negated. The costs of such tests may range between $68 and $80 per patient.

Foster Care System

Nancy Abell, a foster home finder for Loudoun County, commented that perinatal drug exposure significantly affects the foster care system. In fiscal year 1991, infants under one year old constituted the single largest age group coming into foster care in the Commonwealth. There are few foster care parents who are at home full time and willing to take special needs babies. Often, working foster parents cannot take a baby unless they can afford child day care. Foster parents of drug-exposed infants need to be trained to recognize the unique needs of such children, provide necessary and individualized care, and use specialized medical equipment (e.g., Apnea monitor and CPR).

Although only a few localities participate in a pilot project to recruit and train respite providers for special needs children due to limited resources, training for foster care parents is not required in Virginia at this time, nor is there a coherent policy on respite care for such parents. At present, the state's foster care policy is based on the fundamental premise that the first goal of foster care should be to reunite the family. A stable and caring family relationship, however, may be nonexistent. It may be necessary, therefore, to reevaluate the objectives of the state's current foster care policy.

Related Issues

Staff presented a summary of related perinatal drug exposure issues that may have significant social and medical policy implications. Some such concerns involve the need for the development of a comprehensive educational plan to meet the unique instructional needs of drug-exposed children. Other issues include the problems of pregnant, substance-abusing, incarcerated women, as well as the need for support services for foster care parents and custodial relatives who also provide care.

Proposed Study Design

Staff reviewed the proposed study plan for the 1991 interim, which included a summary of the joint subcommittee's work to date, a review of its 1990 recommendations and legislative proposals, an action plan for addressing the 1991 study objectives, and a suggested meeting schedule.

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The Honorable Marian Van Landingham,
Chairman

Legislative Services contact:
Brenda H. Edwards

The Legislative Record summarizes the activities of all Virginia legislative study commissions and joint subcommittees. Published monthly in Richmond, Virginia, by the Division of Legislative Services, an agency of the General Assembly of Virginia.

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The Legislative Record is also published monthly in *The Virginia Register of Regulations*, available from the Virginia Code Commission, 910 Capitol Street, 2nd Floor, Richmond, Virginia 23219.
Notices of upcoming meetings of all legislative study commissions and joint subcommittees appear in the Calendar of Events in *The Virginia Register of Regulations*.

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

GENERAL NOTICES

NOTICE

Notices of Intended Regulatory Action are being published as a separate section of the Register beginning with the October 7, 1991, issue. The new section appears at the beginning of each issue.

DEPARTMENT FOR THE AGING

Notice of Public Comment Period for 1991-95 Intrastate Title III Funding Formula

Notice is hereby given that the Department for the Aging will accept comments on the formula for the distribution within Virginia of funds received under Title III of the Older Americans Act of 1965, as amended. Interested persons may submit data, views, and arguments orally or in writing to the department.

The Older Americans Act of 1965, as amended, requires that the Department for the Aging develop and publish for review and comment an intrastate formula for the distribution of Title III funds to the Area Agencies on Aging. Public comment on the formula was solicited and received during June and July, 1989. The department does not intend to change the formula which has been in effect since October 1, 1989. 1990 Census data have been used to update the population-based factors in the formula.

The updated Title III intrastate funding formula is computed on the basis of (1) the number of persons 60 years of age and over, from the 1990 Census, (2) the number of persons 60 years of age and over at or below the poverty level, from the 1980 US Census, (3) the number of minority persons 60 years of age and over at or below the poverty level, from the 1980 Census, and (4) the number of persons 60 years of age and over who reside in rural areas of the state.

The formula factors and their weights are as follows:

Population 60+.....30%

Rural residents 60+..10%

Poverty 60+.....50%

Minority Poverty 60+.10%

Population 60+. This factor distributes Title III funds on the basis of the geographical location of older Virginians. It reflects the distribution of persons age 60 and over throughout the state.

Rural Residents 60+. The rural 60+ factor is utilized to denote the geographical isolation faced by older Virginians who live in the rural areas of the state. "Rural area" means a city or county which is not within a Metropolitan Statistical Area (MSA) according to the Bureau of the Census or a city or county which is within an MSA but which has a population density of less than 50 persons per square mile.

Poverty 60+. This factor distributes Title III funds to those areas of the state with the greatest number of older persons in economic need. The financial condition of the older person is a major determinant of his ability to meet basic life needs, such as food, shelter, clothing, health care, and mobility. This factor is an application of the definition of greatest economic need.

Minority Poverty 60+. The low income minority elderly factor addresses the racial barrier as well as the economic needs of this group of older persons.

Hold Harmless Provision. In Fiscal Year (FY) 1992, each Area Agency on Aging will be held harmless at its FY 1989 funding level. This means that an Area Agency's total funding will not be reduced below its FY 1989 funding level. An agency will no longer be held harmless when its formula share and sufficient funds allow it to exceed the FY 1989 funding level. The hold-harmless provision will allow implementation of the formula without significant shifts in funding and major disruption of services. Implementation of this allocation plan is contingent upon no decrease in federal and state funding below the FY 1989 level.

No Area Agency on Aging will receive less than $100,000 in total funds distributed under this allocation plan.

What follows is a numerical statement of the funding formula to be used and a demonstration of the allocation of funds based on the formula:

PSA	FORMULA X	TITLE III-B	TITLE III-C(1)	TITLE III-C(2)	TITLE III-D	TITLE III-G
1	3.07823	202,744	135,592	87,173	4,620	1,782
2	3.11866	203,307	137,373	88,318	4,680	1,805
3	5.38562	362,401	237,230	152,517	8,083	3,118
4	2.95448	192,604	130,141	83,669	4,434	1,710
5	4.97958	324,622	219,345	141,018	7,473	2,883
6	5.06386	330,116	223,057	143,405	7,600	2,932
7	3.74690	244,262	165,047	106,109	5,623	2,169
8A	1.08721	122,053	47,890	30,780	1,632	629
8B	1.50457	169,927	66,275	42,608	2,258	871
8C	3.85722	357,125	169,906	109,234	5,789	2,233
8D	0.54403	35,466	23,964	15,407	817	315
8E	0.78308	51,441	34,758	22,346	1,184	457
9	2.77937	181,228	122,454	78,727	4,172	1,609
10	3.04363	198,807	134,333	86,363	4,577	1,765
11	4.17437	272,130	183,876	118,215	6,265	2,417
12	6.26872	408,661	276,130	177,525	9,408	3,629
13	3.56433	282,998	157,005	100,939	5,349	2,063
14	3.44828	224,795	151,833	97,653	5,175	1,996
15	10.22151	666,346	450,245	289,466	15,340	5,917
16	2.14530	139,853	94,498	60,753	3,220	1,242
17/18	4.01520	261,753	176,865	113,707	6,026	2,324
19	3.87857	252,846	170,846	109,838	5,821	2,245
20	13.57517	884,973	597,970	384,433	20,373	7,859
21	4.48129	292,138	197,396	126,907	6,725	2,594
22	2.28821	149,170	100,793	64,800	3,434	1,325

The department will hold at least one public hearing on the formula. Refer to the Calendar of Events Section for the dates, times, and locations of the public hearings. Persons who testify at the hearing(s) are urged to provide a written copy of their comments to the hearing officer. An interpreter for the deaf and hard-of-hearing will be provided upon request.

Written comments on the formula may be submitted until 5 p.m. on December 6, 1991. Comments should be sent to Mr. J. James Cotter, Director, Divisions of Program Development and Management, 700 East Franklin Street, 10th Floor, Richmond, Virginia 23219-2327. To obtain further information, write to the department at the above address or call 1-800-225-2271 or toll-free in Virginia 1-800-552-4464.

VIRGINIA COASTAL RESOURCES MANAGEMENT PROGRAM

Request for Review of Draft Document

The 1990 reauthorization of the Coastal Zone Management Act (CZMA), as amended, established under § 309 a new Coastal Zone Enhancement Grants Program which sets aside from 10% to 20% of the states' federally-approved Coastal Zone Management funds to encourage the states to seek to achieve one or more of eight legislatively defined coastal management objectives. The states are to achieve these objectives by implementing changes to their coastal management programs; for instance, by amending their laws, regulations, or boundaries or by other means that improve management of their coastal resources.

As part of this process, the Council on the Environment is completing an assessment of the eight management objectives identified in the legislation, specifically:

- The protection, enhancement, or creation of coastal wetlands;
- The prevention or significant reduction of threats to life and property through the control of coastal development and redevelopment in hazardous areas, and the anticipation and management of sea level rise;
- The development of increased opportunities for public access;
- The reduction of marine debris by managing uses and activities contributing to marine debris;
- The development and adoption of procedures to address the cumulative and secondary impacts of coastal growth and development;
- The preparation and implementation of special area management plans;
- The development of plans for the use of ocean resources; and
- The adoption of procedures and policies to facilitate the siting of energy facilitates and government facilities as well energy-related facilities and government activities which may be of greater than local significance.

The Council is requesting public comment on a draft of the assessment which will be made available for public review in mid-November, 1991. The public comment period will extend for 30 days. Written comments may be sent to the Council at the address shown below. In addition, the Council will accept oral comments at its upcoming quarterly meeting.

Copies of the assessment may be obtained at the Council on the Environment offices, located at 202 N. 9th Street, Suite 900, Richmond, Virginia. Copies may also be obtained by contacting, Lee Tetrault, Chesapeake Bay and Coastal Programs, Council on the Environment, 202 N. 9th Street, Suite 900, Richmond, Virginia 23219, telephone (804) 786-4500.

Following consideration of public comments, a final

assessment will be produced by January 10, 1992. A multi-year strategy, addressing priority state concerns identified in the assessment, will be developed by the end of February 1992. The assessment and strategy will provide the basis by which the Council will apply for § 309 grant funds from the National Oceanic and Atmospheric Administration for use under Virginia's Coastal Resources Management Program.

COUNCIL ON THE ENVIRONMENT

† Public Notice

Notice of Availability for Public Review

An Environmental Impact Assessment for an Exploratory Oil or Gas Well to be Drilled in Essex County, Virginia

Purpose of Notice: This notice informs the public of the availability of an environmental impact assessment for an oil or gas well drilling operation as required by Virginia Code § 62.1-195.1(D). The public is invited to review and comment on the environmental impact assessment. A general description of the proposed activity, its location, and the content of the environmental impact assessment follow.

Location: Texaco, Inc. has proposed locating an exploratory oil or gas well in Essex County. The site for the exploratory well is to be located about two miles from the town of Supply, Virginia, on a tract of land bordered by state route 639 on the west and state route 675 on the north. The proposed project can be located on the Supply Quadrangle, USGS topographic map, 7.5 minute series. The proposed well site and associated lease boundaries are generally described in the accompanying map.

Project Description: The proposed exploratory well drilling operation will be conducted to evaluate the potential for marketable quantities of oil or gas resources to exist in the Taylorsville Basin located in Tidewater, Virginia. The proposed drilling operation would require 3 to 4 weeks for site preparation, 12 to 14 weeks for drilling, 4 to 6 weeks for completion and testing as warranted, and 3 to 4 weeks for site restoration. The area to be directly affected by exploratory drilling operations is approximately 3.5 acres. The site will be located in an agricultural field currently planted in soybeans. Employees will live on-site during operations, water will be provided by a groundwater well, and there will be on-site sewage treatment facilities. The well site will be designed to contain the discharge of all fluids generated within the drill site. The drilling operations will be conducted 24 hours per day.

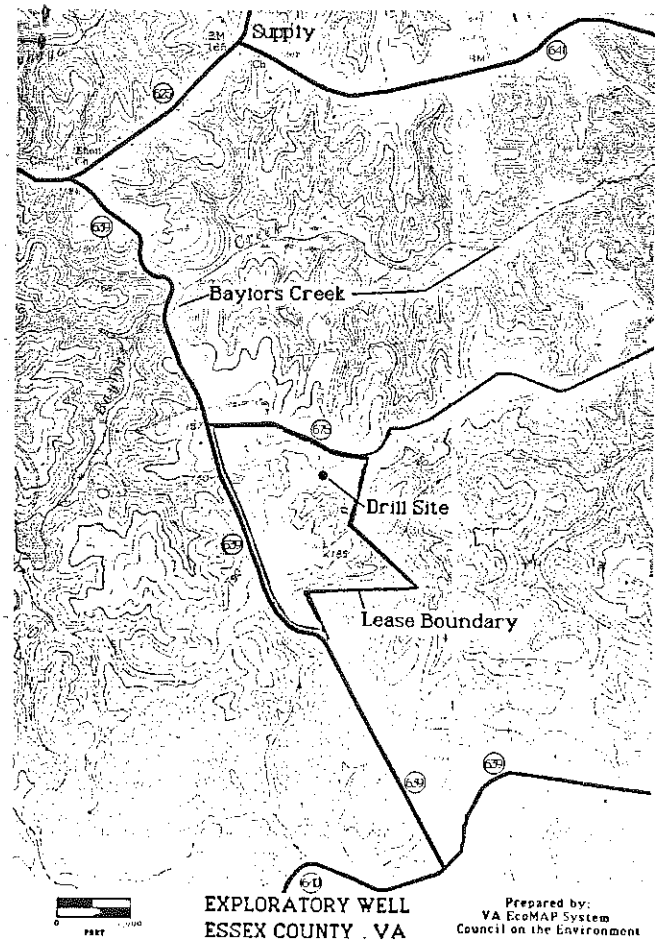
The environmental impact assessment submitted for the proposed project includes a description of the proposed well drilling site and the vicinity, a description and evaluation of the potential environmental impacts that may result if the exploratory well is constructed, an assessment of the potential environmental impact that may result from accidental release events, and control measures designed to minimize impacts form proposed drilling operations. A discussion of the types and magnitude of environmental impacts which may occur as a result of the longer-term production activities is included in the assessment should the exploratory well prove successful.

Location of the Assessment: A copy of the environmental impact assessment may be reviewed during regular business hours at the offices of the Council on the Environment, 202 North Ninth Street, 9th Floor, Suite 900, Richmond, Virginia. Another copy of the assessment will be available for review at the Essex County Public Library located in Tappahannock, Virginia, on Route 17. The library hours are 9:30 a.m. to 5 p.m. on Monday, Tuesday, and Friday; 9:30 a.m. to 7 p.m. on Wednesday and Thursday; and 10 a.m. to 1 p.m. on Saturday.

Deadline for Public Comment: Written comments on the environmental impact assessment may be submitted until 5 p.m. January 10, 1992. Comments must be addressed to:

Keith J. Buttleman
Virginia Council on the Environment
202 North Ninth Street
Richmond, Virginia 23219

Contact: For additional information, contact Jay Roberts at the address indicated above or call (804) 786-4500, SCATS 786-4500, or (804) 371–7604/TDD ☎



DEPARTMENT OF HEALTH (STATE BOARD OF)

Public Notice

The State Board of Health has received a request from a group composed of well drillers and other individuals from Tidewater to amend the Private Well Regulations pertaining to Class IV (non-drinking water) wells. They propose two major changes:

1. Reduce the minimum separation distance between Class IV wells and building foundations treated by a chemical termiticide to 10 feet. The proposed minimum separation distance in the regulations is 25 feet if certain well construction and site conditions exist.

2. Allow the issuance of a well construction permit for Class IV wells immediately upon filing an application with a site plan and payment of the application fee. This permit would be issued without the local health department conducting a site visit to determine the proposed well site suitability. The well site would be subject to a post-construction inspection and approval by the local health department.

Comments on these proposals should be submitted to Gary L. Hagy, Assistant Director, Bureau of Sewage and Water Services, Virginia Department of Health, P.O. Box 2448, Richmond, VA 23218. Comments should be received by January 3, 1992.

DEPARTMENT OF LABOR AND INDUSTRY

Notice to the Public

The Virginia State Plan for the enforcement of occupational safety and health laws (VOSH) commits the Commonwealth to adopt regulations identical to, or as effective as, those promulgated by the U.S. Department of Labor, Occupational Safety and Health Administration.

Accordingly, public participation in the formulation of such regulations must be made during the adoption of such regulations at the Federal level. Therefore, the Virginia Department of Labor and Industry is issuing the following notice:

U.S. Department of Labor

Occupational Safety and Health Administration

29 CFR Parts 1910

Docket No. H-122

RIN 1218-AB37

Occupational Exposure to Indoor Air Pollutants; Request for Information

AGENCY: Occupational Safety and Health Administration, Department of Labor.

ACTION: Request for Information.

SUMMARY: In the September 20, 1991 issue of the Federal Register, the Occupational Safety and Health Administration (OSHA) published a notice of request for information on issues pertinent to indoor air quality in occupational environments (56 FR 47892). This notice raises major issues which OSHA needs to consider in determining whether regulatory action is appropriate and feasible to control health problems related to poor indoor air quality. The issues on which comment is requested are organized into five broad categories: (1) Definition of and Health Effects Pertaining to Indoor Air Quality; (2) Monitoring and Exposure Assessment; (3) Controls; (4) Local Policies and Practices; and (5) Potential Content of Regulations.

In addition to seeking information regarding Indoor Air Quality concerns in general, issues addressed in this notice also focus on specific indoor air contaminants, such as passive tobacco smoke (PTS), radon and bioaerosols. With respect to these particular contaminants, information is requested on their relative contribution to the overall degradation of indoor air quality as well as associated health effects and methods of exposure assessment and

mitigation. The information received in response to this notice will assist OSHA to determine whether it is necessary and appropriate to pursue regulatory action concerning occupational exposures to indoor air contaminants.

DATES: Written comments concerning this notice of request for information on issues pertinent to occupational exposure to indoor air pollutants must be postmarked on or before January 21, 1992.

ADDRESSES: Comments should be submitted in quadruplicate to the Docket Officer, Docket No. H-122, room N-2625, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210, telephone (202) 523-7894.

An additional copy of your comments should be submitted to the Director of Enforcement Policy, Virginia Department of Labor and Industry, 13 South Thirteenth Street, Richmond, VA 23219.

FOR FURTHER INFORMATION CONTACT: James F. Foster, Occupational Safety and Health Administration, Office of Public Affairs, Room N-3649, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Telephone (202) 423-8151.

VIRGINIA CODE COMMISSION

NOTICE TO STATE AGENCIES

Change of Address: Our new mailing address is: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219. You may FAX in your notice; however, we ask that you do not follow-up with a mailed in copy. Our FAX number is: 371-0169.

FORMS FOR FILING MATERIAL ON DATES FOR PUBLICATION IN THE VIRGINIA REGISTER OF REGULATIONS

All agencies are required to use the appropriate forms when furnishing material and dates for publication in the Virginia Register of Regulations. The forms are supplied by the office of the Registrar of Regulations. If you do not have any forms or you need additional forms, please contact: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

FORMS:

NOTICE of INTENDED REGULATORY ACTION - RR01
NOTICE of COMMENT PERIOD - RR02
PROPOSED (Transmittal Sheet) - RR03
FINAL (Transmittal Sheet) - RR04
EMERGENCY (Transmittal Sheet) - RR05
NOTICE of MEETING - RR06
AGENCY RESPONSE TO LEGISLATIVE OR GUBERNATORIAL OBJECTIONS - RR08
DEPARTMENT of PLANNING AND BUDGET (Transmittal Sheet) - DPBRR09

Copies of the Virginia Register Form, Style and Procedure Manual may also be obtained at the above address.

ERRATA

BOARD OF AUDIOLOGY AND SPEECH PATHLOGY

Title of Regulation: **VR 155-01-2:1. Regulations of the Board of Audiology and Speech Pathlogy.**

Publication: 8:4 VA.R. 542-552 November 18, 1991

Correction to Final Regulation:

Page 545, § 3.3, add a second paragraph to read as follows:

Reinstatement fee per year of expiration.....$100

CALENDAR OF EVENTS

Symbols Key
† Indicates entries since last publication of the Virginia Register
♿ Location accessible to handicapped
☎ Telecommunications Device for Deaf (TDD)/Voice Designation

NOTICE

Only those meetings which are filed with the Registrar of Regulations by the filing deadline noted at the beginning of this publication are listed. Since some meetings are called on short notice, please be aware that this listing of meetings may be incomplete. Also, all meetings are subject to cancellation and the Virginia Register deadline may preclude a notice of such cancellation.

For additional information on open meetings and public hearings held by the Standing Committees of the Legislature during the interim, please call Legislative Information at (804) 786-6530.

VIRGINIA CODE COMMISSION

EXECUTIVE

BOARD FOR ACCOUNTANCY

† **December 16, 1991 - 10 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, 5th Floor, Richmond, Virginia. ♿

A meeting to (i) review November 1991 Uniform CPA Examination; (ii) conduct routine board business; (iii) review old business; and (iv) review new business.

Contact: Roberta L. Banning, Assistant Director, 3600 West Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8590.

Virginia Department For The Aging

DEPARTMENT FOR THE AGING

Long-Term Care Ombudsman Program Advisory Council

December 3, 1991 - 9 a.m. – Open Meeting
Beth Sholom Home of Central Virginia, 1200 Gayton Road, Richmond, Virginia. ♿

Business will include discussion of goals and objectives for 1992 and identifying priorities for the Long-Term Care Ombudsman Program.

Contact: Ms. Virginia Dize, State Ombudsman, Virginia Department for the Aging, 700 E. Franklin Street, 10th Floor, Richmond, VA 23219, telephone (804) 225-2271, toll-free 1-800-552-3402 or (804) 225-2271/TDD ☎

BOARD OF AGRICULTURE AND CONSUMER SERVICES

December 5, 1991 - 1 p.m. – Open Meeting
December 6, 1991 - 9 a.m. – Open Meeting
Washington Building, Room 204, 1100 Bank Street, Richmond, Virginia. ♿

The board will review issues relating to legislation, regulations, and fiscal matters and will receive reports from the staff of the Department of Agriculture and Consumer Services. The board may consider other matters relating to its responsibilities. At the conclusion of other business, the board will review public comments for a period not to exceed thirty minutes.

Contact: Roy Seward, Secretary to the Board, Virginia Department of Agriculture and Consumer Services, Washington Building, 1100 Bank Street, Richmond, VA 23219, telephone (804) 786-3501 or (804) 371-6344/TDD ☎

STATE AIR POLLUTION CONTROL BOARD

† **December 18, 1991 - 1 p.m.** – Public Hearing
† **December 18, 1991 - 7 p.m.** – Public Hearing
General Assembly Building, Senate Room A, 910 Capitol Street, Richmond, Virginia. ♿

The State Air Pollution Control Board is seeking public comment on air quality issues arising from medical waste incineration, specifically the following: (1) What level of public health protection should be afforded during the burning of medical waste? (2) What technology should be used to control air pollution in the burning of medical waste? (3) Should Virginia burn medical waste at all? The board is not seeking comment on specific proposed incinerators. Anyone wishing to address the board on this matter is encouraged to sign up in advance of the meeting by contacting the person named below. Groups should designate a single spokesperson to address the board on behalf of the group. Speakers will be limited to 10 minutes each so that the board can hear all speakers.

Speakers are encouraged to provide the board with six written copies of their comments as far in advance of the hearing as possible.

† **December 19, 1991 - 9 a.m.** – Open Meeting
General Assembly Building, Senate Room A, 910 Capitol Street, Richmond, Virginia. ♿

Business to be conducted at this meeting has yet to be decided. Agenda will be available two weeks before the meeting date.

Contact: Dr. Kathleen Sands, Policy Analyst, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240, telephone (804) 225-2722.

ASAP POLICY BOARD - ROCKINGHAM/HARRISONBURG

December 5, 1991 - 7 p.m. – Open Meeting
ASAP Office, 44 East Market Street, Harrisonburg, Virginia.

December quarter commission meeting.

Contact: Pam Simmons, Director, 44 East Market Street, Harrisonburg, VA 22801, telephone (703) 434-0154.

ASAP POLICY BOARD - VALLEY

December 2, 1991 - 8:30 a.m. – Open Meeting
Augusta County School Board Office, Fishersville, Virginia. ♿

A regular meeting of the local policy board to conduct business pertaining to (i) court referrals; (ii) financial reports; (iii) director's reports; and (iv) statistical reports.

Contact: Rhoda G. York, Executive Director, 2 Holiday Court, Staunton, VA 24401, telephone (703) 886-5616 or (703) 943–4405.

BOARD OF AUDIOLOGY AND SPEECH PATHOLOGY

† **January 16, 1992 - 9:30 a.m.** – Open Meeting
1601 Rolling Hills Drive, Richmond, Virginia. ♿

A regularly scheduled board meeting.

Contact: Meredyth P. Partridge, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-7390.

BOARD FOR BARBERS

† **December 9, 1991 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, 3rd Floor, Richmond, Virginia. ♿

A meeting to (i) review correspondence; (ii) review applications; (iii) review and disposition of enforcement cases; and (iv) consider routine board business.

Contact: Roberta L. Banning, Assistant Director, 3600 West Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8590.

BOARD FOR BRANCH PILOTS

December 2, 1991 - 9:30 a.m. – Open Meeting
Hasler & Company, 121 Tazewell Street, Norfolk, Virginia. ♿

A regular quarterly meeting to consider routine business.

Contact: Willie Fobbs, III, Assistant Director, Board for Branch Pilots, Department of Commerce, 3600 West Broad Street, Fifth Floor, Richmond, VA 23230-4917, telephone (804) 367-2194.

STATE BUILDING CODE TECHNICAL REVIEW BOARD

† **December 13, 1991 - 10 a.m.** – Open Meeting
State Capitol, House Room 1, Richmond, Virginia. ♿ (f interpreter for deaf provided upon request)

A meeting to (i) consider requests for interpretation of the Virginia Uniform Statewide Building Code; (ii) consider appeals from the rulings of local appeal boards regarding application of the Virginia Uniform Statewide Building Code; and (iii) approve minutes of previous meeting.

Contact: Jack A. Proctor, 205 N. 4th Street, Richmond, VA 23219, telephone (804) 371-7772.

CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

December 5, 1991 - 10 a.m. – Open Meeting
General Assembly Building, Senate Room A, 910 Capitol Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The board will conduct general business, including review of local Chesapeake Bay Preservation Area programs. The board will elect officers. Public comment will be heard early in the meeting. A tentative agenda will be available from the Chesapeake Bay Local Assistance Department by November 27, 1991.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA

23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

† **January 30, 1992 - 10 a.m.** – Open Meeting
Virginia Housing Development Authority, Conference Room #1, 601 South Belvidere Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The board will conduct general business, including review of local Chesapeake Bay Preservation Area programs. Public comment will be heard early in the meeting. A tentative agenda will be available from the Chesapeake Bay Local Assistance Department by January 23, 1992.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

† **February 27, 1992 - 10 a.m.** – Open Meeting
Virginia Housing Development Authority, Conference Room #1, 601 South Belvidere Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The board will conduct general business, including review of local Chesapeake Bay Preservation Area programs. Public comment will be heard early in the meeting. A tentative agenda will be available from the Chesapeake Bay Local Assistance Department by February 20, 1992.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Central Area Review Committee

December 9, 1991 - 1 p.m. – Open Meeting
General Assembly Building, Senate Room B, 910 Capitol Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area programs for the Central Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Northern Area Review Committee

December 11, 1991 - 10 a.m. – Open Meeting
General Assembly Building, Senate Room B, 910 Capitol Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area programs for the Northern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Southern Area Review Committee

December 4, 1991 - 10 a.m. – Open Meeting
General Assembly Building, Senate Room B, 910 Capitol Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area programs for the Southern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

CHILD DAY-CARE COUNCIL

† **December 12, 1991 - 9 a.m.** – Open Meeting
Koger Executive Center, West End, Blair Building, Conference Rooms A and B, 8007 Discovery Drive, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to discuss issues, concerns, and programs that impact child care centers, camps, school age programs, and preschool/nursery schools. A public comment period is scheduled for 1 p.m.

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

INTERDEPARTMENTAL REGULATION OF RESIDENTIAL FACILITIES FOR CHILDREN

Coordinating Committee

December 20, 1991 - 8:30 a.m. – Open Meeting
Office of Coordinator, Interdepartmental Regulation, 1603 Santa Rosa Road, Tyler Building, Suite 208, Richmond, Virginia. ♿

WITHDRAWN BY AGENCY

A regularly scheduled meeting to consider such administrative and policy issues as may be presented to the committee. A period for public comment is provided at each meeting.

Contact: John J. Allen, Jr., Coordinator, Interdepartmental Regulation, Office of the Coordinator, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-7124.

BOARD OF COMMERCE

February 24, 1992 - 10 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

A regular quarterly meeting. Agenda will likely consist of briefings from staff on the status of bills in the General Assembly that can have an impact upon agency operations, and agency regulatory programs.

ontact: Alvin D. Whitley, Secretary/Policy Analyst, Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-8564.

DEPARTMENT OF COMMERCE

December 9, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Commerce intends to repeal existing regulation VR 190-04-1 and adopt new regulations entitled: **VR 190-04-1:1. Private Security Services Businesses Regulations.** The proposed regulations have been reorganized to provide clarity in the licensing procedures, entry requirements, renewal, fees, and the requirements that all applicants for licensure are in good standing and have not been convicted of a misdemeanor for felony in any jurisdiction.

Statutory Authority: §§ 54.1-1903 and 54.1-1904 of the Code of Virginia.

Written comments may be submitted until December 9, 1991.

Contact: Geralde W. Morgan, Administrator, Department of Commerce, 3600 West Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8534.

COMPENSATION BOARD

December 19, 1991 - 5 p.m. – Open Meeting
Room 913/913A, 9th Floor, Ninth Street Office Building, 202 North Ninth Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A routine meeting to conduct business of the board.

Contact: Bruce W. Haynes, Executive Secretary, P. O. Box 3-F, Richmond, VA 23206-3886, telephone (804) 786-3886/TDD ☎

DEPARTMENT OF CONSERVATION AND RECREATION

Virginia Soil and Water Conservation Board

December 11, 1991 - 9 a.m. – Open Meeting
Roanoke Airport Marriott, Grand Ballroom, Salons A and B, 2801 Hershberger Road, Roanoke, Virginia.

A bi-monthly meeting.

Contact: Donald L. Wells, Department of Conservation and Recreation, 203 Governor St., Suite 206, Richmond, VA 23219, telephone (804) 786-2064.

BOARD FOR CONTRACTORS

Recovery Fund Committee

December 5, 1991 - 9 a.m. – Open Meeting
3600 West Broad Street, Richmond, Virginia. ♿

A meeting to consider claims filed against the Virginia Contractor Transaction Recovery Fund. This meeting is open to the public, however, a portion of the discussion may be conducted in Executive Session.

Contact: Vickie Brock, Recovery Fund Administrator, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-2394.

VIRGINIA CORN BOARD

† **December 12, 1991 - 9:30 a.m.** – Open Meeting
Williamsburg Hilton and Conference Center, 50 Kingsmill Road, Williamsburg, Virginia. ♿

The board will meet in regular quarterly session to discuss issues related to Virginia corn industry and to elect board officers. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes.

Contact: Rosser Cobb, Program Director, P.O. Box 26, Warsaw, VA 22572, telephone (804) 333-3710 or SCATS (804) 371-2163.

BOARD OF CORRECTIONS

December 11, 1991 - 10 a.m. – Open Meeting
6900 Atmore Drive, Board of Corrections Board Room, Richmond, Virginia.

A regular monthly meeting to consider such matters as may be presented to the board.

Contact: Mrs. Vivian Toler, Secretary to the Board, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3235.

DEPARTMENT OF CORRECTIONS (STATE BOARD OF)

NOTE: CHANGE IN PUBLIC HEARING DATE
February 12, 1992 - 10 a.m. – Public Hearing
6900 Atmore Drive, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Corrections intends to amend regulations entitled: **VR 230-30-006. Work/Study Release Standards for Local Facilities.** The proposed regulations establish the minimum operational standards for work or study release programs in local correctional facilities.

Statutory Authority: §§ 53.1-5 and 53.1-131 of the Code of Virginia.

Written comments may be submitted until January 3, 1992.

Contact: Mike Howerton, Chief of Operations, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3041.

DEPARTMENT OF CRIMINAL JUSTICE SERVICES (BOARD OF)

† **March 6, 1992 - 1 p.m.** – Public Hearing
Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Criminal Justice Services intends to adopt regulations entitled: **VR 240-04-3. Rules Relating to the Court-Appointed Special Advocate Program (CASA).** The purpose of the proposed regulation is to regulate the operation of local Court-Appointed Special Advocate programs.

STATEMENT

Basis: Pursuant to the provision of § 9-173.6 of the Code of Virginia, the Criminal Justices Services Board intends to promulgate Rules Relating to the Court-Appointed Special Advocate Program (CASA). Section 9-173.6 of the Code of Virginia became effective July 1, 1990, and it directs the establishment of these regulations.

Purpose: The purpose of this regulation is for the Department of Criminal Justice Services, as directed by the General Assembly, to develop rules regarding the operation of local Court Appointed Special Advocate Programs.

Substance: Section 9-173.6 of the Code of Virginia directs the Department of Criminal Justice Services to establish by regulation appropriate procedures to include, but not be limited to, those governing the qualifications of advocates. The regulations require that an advocate be at least 21 years of age and provide certification that no criminal conviction data are maintained on him in accordance with § 19.2-389 and certification that no record on him exists in the Child Abuse and Neglect Central Registry maintained pursuant to § 63.1-248.8. The department was also directed to set standards for the basic and ongoing training of advocates. The regulation additionally outlines policies regarding the administration of the local Court-Appointed Special Advocate programs and the role of the volunteer advocates.

Issues: Rules Relating to the Court-Appointed Special Advocate Program will become effective on July 1, 1992, in order to provide guidance to localities which currently operate Court-Appointed Special Advocate Programs.

Impact: These regulations will affect all local Court-Appointed Special Advocate Programs and the juvenile and domestic relations courts in localities which choose to sponsor programs.

Localities electing to develop a Court-Appointed Special Advocate Program will incur the costs of program employees, support staff, program office space and utilities, and training and promotional materials.

Statutory Authority: §§ 9-173.7 and 9-173.8 of the Code of Virginia.

Written comments may be submitted until February 3, 1992, to Francine Ecker, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219.

Contact: Paula J. Scott, Executive Assistant, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-8730.

DEPARTMENT FOR THE DEAF AND HARD OF HEARING

† **January 21, 1992 - 4 p.m.** – Public Hearing
Virginia School for the Deaf-Blind, 700 Shell Road, Hampton, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department for the Deaf and Hard of Hearing intends to amend regulations entitled: **VR 245-02-01. Regulations Governing Eligibility Standards and Application Procedures for the Distribution of Telecommunications Equipment.** The regulations are used to (i) screen individuals with hearing losses and speech problems who apply for telecommunications equipment through the Telecommunications Assistance Program; (ii) determine contributions, if any; and (iii) ensure confidentiality. It also ensures that the department retains ownership of equipment costing $5,000 or more. Consideration is being given to expanding range of telecommunications equipment.

STATEMENT

Basis, Purpose, Substance, Issues and Impact: The 1988 General Assembly, recognizing the undue financial burden regarding telephone access placed upon individuals who are deaf, hard-of-hearing, hearing/visually-impaired, deaf-blind or speech-impaired appropriated funds for the distribution of telecommunications equipment for these citizens of the Commonwealth. Since then, changes in state policy have occurred. Telecommunications equipment that cost or have a value of $5,000 or more have been deemed a capital asset by the State Comptroller's Office and the Department of Accounts and subject to ownership by the Virginia Department for the Deaf and Hard of Hearing. Additionally, experience with the Telecommunications Assistance Program since its inception has determined the need for flexibility in decisions by VDDHH as to what can be appropriately distributed to the above-mentioned citizens.

Statutory Authority: § 63.1-85.4 of the Code of Virginia.

Written comments may be submitted until February 2, 1992.

Contact: Kathy E. Vesley, Deputy Director, Department for the Deaf and Hard of Hearing, Washington Building, Capitol Square, 1100 Bank Street, 12th Floor, Richmond, Virginia 23219, telephone (804) 225-2570/Voice/TDD ☎ or toll-free 1-800-552-7917/Voice/TDD ☎

DEPARTMENT OF EDUCATION (STATE BOARD OF)

January 6, 1992 - 9 a.m. – Public Hearing
Monroe Building, 101 North 14th Street, Rooms C and D, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Education intends to adopt regulations entitled: **VR 270-01-0054. Regulations Governing Reporting of Acts of Violence and Substance Abuse in Schools.** The proposed regulations will establish a format and timelines for local school divisions to report to the Department of Education certain acts of violence and substance abuse.

Statutory Authority: § 22.1-280.1 of the Code of Virginia.

Written comments may be submitted until January 6, 1992.

Contact: H. Douglas Cox, Principal Specialist, Virginia Department of Education, P.O. Box 6-Q, Richmond, VA 23216, telephone (804) 225-2871.

STATE COUNCIL OF HIGHER EDUCATION

† **December 10, 1991 - 9:30 a.m.** – Open Meeting
General Assembly Building, House Room D, Richmond, Virginia. ♿

A general business meeting as well as a combined meeting with public college presidents. For more information contact the council.

Contact: J. Michael Mullen, Deputy Director, 101 N. 14th Street, 9th Floor, James Monroe Building, Richmond, VA 23219, telephone (804) 225-2137.

LOCAL EMERGENCY PLANNING COMMITTEE - CHESTERFIELD COUNTY

December 5, 1991 - 5:30 p.m. – Open Meeting
† **January 2, 1992 - 5:30 p.m.** – Open Meeting
† **February 6, 1992 - 5:30 p.m.** – Open Meeting
Chesterfield County Administration Building, 10001 Ironbridge Road, Chesterfield, Virginia. ♿

A meeting to meet requirements of Superfund Amendment and Reauthorization Act of 1986.

Contact: Linda G. Furr, Assistant Emergency Services, Chesterfield Fire Department, P.O. Box 40, Chesterfield, VA 23832, telephone (804) 748-1236.

LOCAL EMERGENCY PLANNING COMMITTEE - COUNTY OF PRINCE WILLIAM, CITY OF MANASSAS, AND CITY OF MANASSAS PARK

December 16, 1991 - 1:30 p.m. – Open Meeting
1 County Complex Court, Potomac Conference Room, Prince William, Virginia. ♿

A multi-jurisdictional Local Emergency Planning Committee to discuss issues related to hazardous substances in the jurisdictions. SARA Title III provisions and responsibilities for hazardous material emergency response planning.

Contact: John E. Medici, Hazardous Materials Officer, 1 County Complex Court, Prince William, VA 22192-9201, telephone (703) 792-6800.

VIRGINIA FIRE SERVICES BOARD

December 13, 1991 - 9 a.m. – Open Meeting
Embassy Suites, 2925 Emerywood Parkway, Richmond, Virginia.

A regular meeting to discuss training and fire policies. The meeting is open to the public for comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

Department of Fire Programs

December 12, 1991 - 7 p.m. – Public Hearing
Embassy Suites, 2925 Emerywood Parkway, Richmond, Virginia.

A public hearing to discuss the role of the state fire marshal within the fire services community.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

Fire/EMS Training and Education Committee

December 12, 1991 - 1 p.m. – Open Meeting
Embassy Suites, 2925 Emerywood Parkway, Richmond, Virginia.

A regular meeting to discuss training and fire policies. The meeting is open to the public for comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

Fire Prevention and Control Committee

December 12, 1991 - 9 a.m. – Open Meeting
Embassy Suites, 2925 Emerywood Parkway, Richmond, Virginia.

A regular meeting to discuss training and fire policies. The meeting is open to the public for comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

Legislative/Liaison Committee

December 12, 1991 - 1 p.m. – Open Meeting
Embassy Suites, 2925 Emerywood Parkway, Richmond, Virginia.

A regular meeting to discuss training and fire policies. The meeting is open to the public for comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

BOARD OF GAME AND INLAND FISHERIES

† **December 6, 1991 - 9 a.m.** – Open Meeting
4010 West Broad Street, Richmond, Virginia.

A meeting to consider deer farming guidelines and experimental red deer project and the agency's strategic plan. In addition, general and administrative matters, as necessary, will be discussed.

At the conclusion of the board meeting, the Finance and Liaison Committees of the board will meet jointly to review the agency's 1992-94 proposed budget.

Contact: Belle Harding, Secretary to Bud Bristow, 4010 West Broad Street, P.O. Box 11104, Richmond, Virginia 23230, telephone (804) 367-1000.

DEPARTMENT OF GENERAL SERVICES

December 6, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of General Services intends to amend regulations entitled: **VR 330-02-05. Requirements for Approval to Perform Prenatal Serological Tests for Syphilis.** The regulation defines the procedure to be followed for evaluating a laboratory's ability to perform syphilis serological testing.

Statutory Authority: § 32.1-60 of the Code of Virginia.

Written comments may be submitted until December 6, 1991.

Contact: James Blaine, Ph.D., Assistant Bureau Director, Division of Consolidated Laboratory Services, 1 North 14th Street, Richmond, VA 23219, telephone (804) 786-5453.

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† **January 31, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of General Services intends to adopt regulations entitled: **VR 330-05-01. Regulations for the Approval of Field Tests for Detection of Drugs.** The purpose of the

proposed regulation is to establish requirements for approval of field tests for drugs by the Division of Forensic Science, Department of General Services.

STATEMENT

Basis, Purpose, Substance and Impact: The regulation entitled "VR 330-05-01 Regulations for the Approval of Field Tests for Detection of Drugs" is based upon the statutory authority, § 19.2-188.1 of the Code of Virginia (effective March 1, 1992).

The purpose of these regulations is to provide a means of evaluation, approval, and publication of a list of field tests suitable for use in the Commonwealth in accordance with § 19.2-188.1 by police officers for the detection of drugs. Use of an "approved" field test will enable an officer to testify to his results in any preliminary hearing on a drug violation.

These regulations describe the approval authority within the Division of Forensic Science, division requirements of manufacturers who wish their product to become approved, criteria for approval, the approval process and the periodic publication of a list of approved field tests or field test kits in the Virginia Register of Regulations.

The immediate impact of these regulations is that the initial testing will require approximately one person-month for a Forensic Scientist to complete the testing and compile the data to result in the publication of approved tests.

In subsequent years, we do not anticipate having to retest all previously approved field tests. We expect that only new manufacturers of new field tests should have to be evaluated. We believe that this can be done within two person-weeks.

The impact of successful use of these regulations by the police agencies who desire to do so is expected to be a reduction in the time it takes to bring a drug violator to preliminary hearing. This should result in reducing the total case processing time for Virginia drug convictions and guard against undue lengthy incarceration of an individual prior to lower court hearings on drug violations.

Statutory Authority: §§ 2.1-424 and 19.2-188.1 of the Code of Virginia.

Written comments may be submitted until January 31, 1992.

Contact: Paul B. Ferrara, Division Director, Division of Forensic Science, 1 North 14th Street, Richmond, VA 23219, telephone (804) 786-2281.

State Insurance Advisory Board

† **December 12, 1991 - 10 a.m.** – Open Meeting
The College of William and Mary, Campus Center, Room C, Williamsburg, Virginia.

A quarterly meeting of the State Insurance Advisory Board.

Contact: Don LeMond, Director, 8th Street Office Building, Richmond, VA 23219, telephone (804) 225-4619.

BOARD FOR GEOLOGY

† **December 16, 1991 - 9:30 a.m.** – Open Meeting
Virginia Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

A general board meeting and examination workshop.

Contact: Nelle P. Hotchkiss, Assistant Director, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-8595.

VIRGINIA HAZARDOUS MATERIALS EMERGENCY RESPONSE ADVISORY COUNCIL

December 5, 1991 - 10 a.m. – Open Meeting
Sheraton Park South, 9901 Midlothian Turnpike, Richmond, Virginia.

The business of the meeting will consist of (i) status report of the hazardous materials emergency response program; (ii) report on Title III planning of SARA; and (iii) report from the hazardous materials training subcommittee.

Contact: Addison E. Slayton, Jr., Department of Emergency Services, 310 Turner Road, Richmond, VA 23225, telephone (804) 674-2487.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

DEPARTMENT OF HEALTH (STATE BOARD OF)

December 2, 1991 - 7 p.m. – Public Hearing
Washington County Public Library, Oak Hill and Valley Streets, Abingdon, Virginia.

December 3, 1991 - 7 p.m. – Public Hearing
Montgomery County Courthouse, 3rd Floor, Courtroom B, 1 East Main Street, Christiansburg, Virginia.

December 4, 1991 - 7 p.m. – Public Hearing
Appomattox County Courthouse, Court Street, Appomattox, Virginia.

December 9, 1991 - 7 p.m. – Public Hearing
Henrico County, Board Room, Administration Building, Parham and Hungary Springs Roads, Richmond, Virginia.

December 10, 1991 - 7 p.m. – Public Hearing
Harrisonburg Electric Commission, 2nd Floor Conference Room, 89 West Bruce Street, Harrisonburg, Virginia.

December 12, 1991 - 7 p.m. – Public Hearing
Juvenile and Domestic Relations Courtroom, Hobart Building, Routes 613 and 208, Spotsylvania, Virginia.

December 16, 1991 - 7 p.m. – Public Hearing
Old Board Chambers, 9250 Lee Avenue, Lee and Grant Avenues, Manassas, Virginia.

December 18, 1991 - 7 p.m. – Public Hearing
City Council Chambers, Municipal Center, Princess Anne & North Landing Roads, Virginia Beach, Virginia.

December 19, 1991 - 7 p.m. – Public Hearing
James City County Human Services Building, Auditorium, 5249 Olde Towne Road, Williamsburg, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Health intends to amend regulations entitled: **VR 355-34-100 (formerly 355-34-01). Private Well Regulations.** The proposed regulations establish minimum location and construction standards for private wells and establish a permitting process for all private wells.

Statutory Authority: § 32.1-176 of the Code of Virginia.

Written comments may be submitted until January 3, 1992.

Contact: Gary L. Hagy, Assistant Director, P.O. Box 2448, Richmond, VA 23218, telephone (804) 786-1750.

STATE BOARD OF HEALTH

† **December 12, 1991 - 10 a.m.** – Open Meeting
Jefferson Sheraton Hotel, Franklin and Adams Streets, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

Work session from 10 a.m. to 5 p.m. (informal dinner at 7:30 p.m. at the Jefferson Sheraton Hotel).

† **December 13, 1991 - 9 a.m.** – Open Meeting
Virginia State Health Department, 1500 East Main Street, Room 213, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

A business meeting.

Contact: Susan R. Rowland, Assistant to the Commissioner, Virginia Department of Health, P.O. Box 2448, Suite 214, Richmond, VA 23860, telephone (804) 786-3564.

VIRGINIA HEALTH SERVICES COST REVIEW COUNCIL

December 17, 1991 - 9:30 a.m. – Open Meeting

Blue Cross/Blue Shield, Virginia Room, 2015 Staples Mill Road, Richmond, Virginia. ♿

The council will conduct its monthly meeting to address financial, policy or technical matters which may have arisen since the last meeting.

Contact: G. Edward Dalton, Deputy Director, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371/TDD ☎

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January 15, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Health Services Cost Review Council intends to amend regulations entitled: **VR 370-01-001. Rules and Regulations of the Virginia Health Services Cost Review Council.** The proposed regulation will amend regulations to require health care institutions to file certified audited financial statements with the council no later than 120 days after the end of the institutions's fiscal year. A 30-day extension could be granted for extenuating circumstances. A late charge of $10 per working day would be assessed for filings submitted past the due date.

Statutory Authority: §§ 9-158, 9-159 and 9-164(2) of the Code of Virginia.

Written comments may be submitted until January 15, 1992.

Contact: G. Edward Dalton, Deputy Director, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371/TDD ☎

BOARD OF HISTORIC RESOURCES

† **December 11, 1991 - 10 a.m.** – Open Meeting

General Assembly Building, Senate Room A, 910 Capitol Street, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

A general business meeting.

Contact: Margaret Peters, 221 Governor Street, Richmond, VA, telephone (804) 786-1934.

DEPARTMENT OF HISTORIC RESOURCES

State Review Board

† **December 10, 1991 - 10 a.m.** – Open Meeting
General Assembly Building, Senate Room B, 910 Capitol Street, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

A meeting to consider the nomination of the following properties to the Virginia Landmarks Register and the National Register of Historic Places.

1. Athlone, Amherst County
2. Bellair, Albemarle County
3. Caryswood Plantation, Buckingham County
4. Kirkland Grove Campground, Northumberland County
5. Linden, Essex County
6. Rothsay, Bedford County
7. Heathsville Historic District, Northumberland County
8. Newtown/Stephensburg Historic District, Frederick County
9. Pearisburg Historic District, Giles County
10. Rosemont Historic District, City of Alexandria
11. Town of Potomac Historic District, City of Alexandria

Public Schools of Richmond, Va.:

12. Nathaniel Bacon School
13. John B. Cary School
14. Springfield School

The board will also consider the following boundary changes:

1. Prospect Hill Boundary Amendment, Spotsylvania County
2. Rosedale Boundary Increase, City of Lynchburg

Contact: Margaret Peters, 221 Governor Street, Richmond, VA, telephone (804) 786-1934.

HOPEWELL INDUSTRIAL SAFETY COUNCIL

December 3, 1991 - 9 a.m. – Open Meeting
† **January 7, 1992 - 9 a.m.** – Open Meeting
† **February 4, 1992 - 9 a.m.** – Open Meeting
Hopewell Community Center, Second and City Point Road, Hopewell, Virginia. ♿ (Interpreter for deaf provided if requested)

Local Emergency Preparedness Committee Meeting on Emergency Preparedness as required by SARA Title III.

Contact: Robert Brown, Emergency Services Coordinator, 300 North Main Street, Hopewell, VA 23860, telephone (804) 541-2298.

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

† **December 17, 1991 - 11 a.m.** – Open Meeting
601 South Belvidere Street, Richmond, Virginia. ♿

A regular meeting of the Board of Commissioners to (i) review, and, if appropriate, approve the minutes from the prior monthly meeting; (ii) consider for approval and ratification mortgage loan commitments under its various programs; (iii) review the authority's operations for the prior month; and (iv) consider such other matters and take such other actions as they may deem appropriate. Various committees of the Board of Commissioners may also meet before or after the regular meeting and consider matters within their purview. The planned agenda of the meeting will be available one week prior to the date of the meeting.

Contact: J. Judson McKellar, General Counsel, Virginia Housing Development Authority, 601 S. Belvidere Street, Richmond, VA 23220, telephone (804) 782-1986.

COUNCIL ON INFORMATION MANAGEMENT

December 9, 1991 - 9 a.m. – Open Meeting
1100 Bank Street, 9th Floor, Richmond, Virginia. ♿

A regular business meeting to consider adoption of Commonwealth of Virginia Information Technology Resource Management Policy and several Guidelines.

Contact: Linda Hening, Administrative Assistant, Council on Information Management, 1100 Bank Street, Suite 901, Richmond, VA 23219, telephone (804) 225-3622 or (804) 225-3624/TDD ☎

VIRGINIA INTERAGENCY COORDINATING COUNCIL ON EARLY INTERVENTION

December 11, 1991 - 9 a.m. – Open Meeting
Barry Robinson Center, 443 Kempsville Road, Norfolk, Virginia. (Interpreter for deaf provided if requested)

The Virginia Interagency Coordinating Council according to PL 101-476, Part H, early intervention program for disabled infants and toddlers and their families, is meeting to advise and assist the Department of Mental Health, Mental Retardation and Substance Abuse Services as lead agency to develop and implement a statewide interagency early intervention program.

Contact: Michael Fehl, Director MR Children/Youth Services, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3710.

DEPARTMENT OF LABOR AND INDUSTRY

January 14, 1992 - 7 p.m. – Public Hearing
Fourth Floor Conference Room, Powers-Taylor Building, 13 South 13th Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Labor and Industry intends to adopt regulations entitled: **VR 425-01-81. Regulations Governing the Employment of Minors on Farms, in Gardens, and in Orchards.** Provision of regulations concerning child labor in agriculture.

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

Written comments may be submitted until October 28, 1991.

Contact: John J. Crisanti, Director, Office of Enforcement Policy, Powers-Taylor Building, Department of Labor and Industry, 13 South 13th Street, Richmond, VA 23219, telephone (804) 786-2384.

LIBRARY BOARD

January 21, 1992 - 9:30 a.m. – Open Meeting
Virginia State Library and Archives, 3rd Floor, Supreme Court Room, 11th Street at Capitol Square, Richmond, Virginia. ♿

A meeting to discuss administrative matters.

Contact: Jean H. Taylor, Secretary to State Librarian, Virginia State Library and Archives, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

COMMISSION ON LOCAL GOVERNMENT

† **January 14, 1992 - 10 a.m.** – Open Meeting
Department of Planning and Budget, Ninth Street Office Building, Room 409, Richmond, Virginia.

A regular meeting to consider such matters as may be presented.

Persons desiring to participate in the Commission's oral presentations and requiring special accommodations or interpreter services should contact the Commission's offices by January 7, 1992.

Contact: Barbara W. Bingham, Administrative Assistant, 702 Eighth Street Office Building, Richmond, VA 23219, telephone (804) 786-6508 or (804) 786-1860/TDD ☎

LONG-TERM CARE COUNCIL

† **December 13, 1991 - 9 a.m.** – Open Meeting
Virginia Housing Development Authority, 601 South Belvidere Street, Conference Room 2, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

A general business meeting.

Contact: Janet Lynch, Director, 700 East Franklin Street, 10th Floor, Richmond, VA 23219, telephone (804) 225-2271.

LONGWOOD COLLEGE

Executive Committee

† **December 17, 1991 - 9 a.m.** – Open Meeting
Longwood College, Board Room, East Ruffner, Farmville, Virginia. ♿

A meeting to conduct routine business.

Contact: William F. Dorrill, President, President's Office, Longwood College, Farmville, VA 23901, telephone (804) 395-2001.

ADVISORY COMMISSION ON MAPPING, SURVEYING AND LAND INFORMATION SYSTEMS

December 5, 1991 - 10 a.m. – Open Meeting
1100 Bank Street, 9th Floor Conference Room, Richmond, Virginia. ♿

A regular business meeting to consider MAP Accuracy Standards for Virginia.

Contact: Chuck Tyger, Chief Engineer, Systems and Software Management, Council on Information Management, 1100 Bank Street, Suite 901, Richmond, VA 23219, telephone (804) 225-3622 or (804) 225-3624/TDD ☎

VIRGINIA MARINE PRODUCTS BOARD

December 3, 1991 - 5:30 p.m. – Open Meeting
The Ramada Inn, 950 J. Clyde Morris Boulevard, Newport News, Virginia.

The board will meet to receive reports from the Executive Director of the Virginia Marine Products Board on finance, marketing, past and future program planning, publicity/public relations, and old/new business. At the conclusion of other business, the board will entertain public comments for a period not to exceed 30 minutes.

Contact: Shirley Estes Berg, 97 Main Street, Suite 103, Newport News, VA 23601, telephone (804) 594-7261.

BOARD OF MEDICAL ASSISTANCE SERVICES

† **December 16, 1991 - 1 p.m.** – Open Meeting
Board Room, Suite 1300, 600 East Broad Street, Richmond, Virginia.

A meeting to discuss medical assistance services and issues pertinent to the board.

The board's Policy Committee will meet prior to the board meeting at 10 a.m. in the board room to review background information on Title XIX and to discuss the board's by-laws.

Contact: Patricia A. Sykes, Policy Analyst, Suite 1300, 600 East Broad Street, Richmond, VA 23219, telephone (804) 786-7958, toll-free 1-800-552-8627 or 1-800-343-0634/TDD

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

January 3, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **State Plan for Medical Assistance Relating to Case Management for the Elderly. VR 460-03-3.1102. Case Management Services.** This regulation proposes to make permanent policies which are substantially the same as the existing emergency regulation.

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

Written comments may be submitted until 4:30 p.m., January 3, 1992, to Ann E. Cook, Eligibility and Regulatory Consultant, Division of Policy and Research, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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January 17, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **Fee-for-Service Reimbursement for Home Health Services. VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates–Other Types of Care. VR 460-03-4.1923. Establish Rate Per Visit.** This regulation proposes to make permanent the policy providing for the fee for service reimbursement to home health agencies which is currently in place with an emergency regulation.

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

Written comments may be submitted until 4:30 p.m., January 3, 1992, to Betty Cochran, Director, Division of Quality Assurance, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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January 17, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **VR 460-03-3.1100. Amount, Duration, and Scope of Services: State Plan for Medical Assistance Relating to Reduction of Threshold Days for Hospital UR and Second Surgical Opinion Program.** The purpose of the proposed regulation is to promulgate permanent regulations to supersede the existing emergency regulations which provide for substantially the same policies.

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

Written comments may be submitted until 4:30 p.m., January 17, 1992, to Mack Brankley, Director, Division of Client Services, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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† **January 31, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).** This regulation proposes to promulgate permanent regulations to supersede three existing emergency regulations providing for mortgage debt refinancing, nursing facility rate change, and technical language changes.

STATEMENT

Basis and Authority: Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:9, for this agency's promulgation of proposed regulations subject to the Department of Planning and Budget's and Governor's reviews. Subsequent to emergency adoption actions, the agency is initiating the public notice and comment process as contained in Article 2 of the APA.

Title 42 of the Code of Federal Regulations Part 447 Subpart C provides for the reimbursement of nursing facilities.

Purpose: The purpose of this proposal is to promulgate permanent regulations to supersede existing emergency regulations providing for mortgage debt refinancing incentive, nursing facility rate change, and technical language changes.

Summary and Analysis: The sections of the State Plan for Medical Assistance which are affected by this proposed regulation are as follows: VR 460-03-4.1940:1: §§ 2.4, 2.7, and 2.8.1. The changes made by these issues are discussed in the same sequence as their VR numbers.

Section 2.4 of the NHPS methodology currently provides that mortgage refinancing is permitted where the refinancing would result in a cost savings from lower rates. In other words, refinancing is permitted when it benefits the Commonwealth, but the provider has been given no specific incentive to refinance.

A DMAS study found that 18 of the responding providers had existing mortgage rates of between 11% and 15%. Nine of these providers have rates that are capped by existing interest rate upper limit provisions of the NHPS. There are approximately nine facilities that could be affected by the amendment at this time.

Therefore, § 2.4 is being modified to encourage mortgage refinancing by providing incentive payments which will be made when the refinancing benefits both the Commonwealth and the provider, as mandated by the 1991 General Assembly. This provision was the subject of an earlier emergency regulation.

Section 2.7 contains the nursing facility reimbursement formula which provides for peer group ceilings. The peer group ceilings are derived from facilities' allowable operating rates. This amendment clarifies the phrase "from the effective date of such 'interim' ceilings" as contained in § 2.7 B 1. The phrase was intended to remove duplicative allowances for inflation during adjustment of peer group medians pursuant to § 2.7 A 5 c. For most providers, the calculation of the estimated reimbursement rate for FY '91 under § 2.7 A 5 a already has an inflation allowance forecasted in the providers' fiscal years extending into FY '92. For the remaining providers, there is a forecasted inflation allowance calculated in § 2.7 A 5 a for FY '91 which is partially duplicated by an historical inflation allowance calculated in § 2.7 A 5 b for FY '91. Without this amendment, the phrase in question could be interpreted as allowing both historical and forecasted inflation adjustments for the same period of time. This was never the intent of the methodology.

Section 2.8.1 provides for the overall reduction of nursing facility per diem operating cost rates. The amendment is being made to permit the Commonwealth of Virginia and concomitantly HCFA to participate in the benefits of cost management efficiencies achieved by NF's since 1982. DMAS is adjusting per diem operating cost rates effective on or after July 5, 1991, through June 30, 1991. The proposed rate change will reduce projected NF reimbursement by approximately 1.2% during fiscal year 1992 and will result in operating cost rates which, for the majority of NFs, are still above the peer group operating cost medians.

Impact: These three issues are discussed in the same order as established above.

Section 2.4 covers mortgage debt refinancing and requires the calculation of two index numbers for each nursing facility, the current financing index and the new financing index. The new financing index is the numerator and the current financing index is the denominator in determining the refinancing savings ratio. This ratio is subtracted from 1 to calculate the refinancing incentive factor. This factor is multiplied by the net interest savings for the FY in question to determine the refinancing incentive payment. The Commonwealth will pay the incentive to the NF upon completion of the refinancing. This payment remains subject to all other terms and conditions contained in the State Plan.

A review of information submitted by the nursing home community indicates that there are approximately nine facilities where a refinancing would benefit both the facility and the Commonwealth. The estimated gross refinancing savings over a ten-year period are approximately $8 million. After the application of the 83% weighted average Medicaid utilization rate for the nine facilities which might be affected, DMAS has estimated refinancing savings to the Medicaid program of approximately $6.6 million. The Commonwealth will have gross savings of approximately $3.3 million in General Funds over the ten-year period. The estimated financial impact of this amendment for FY 92 is a General Funds savings of $100,000, net of estimated incentive payments.

Section 2.7 changes will have no fiscal or budgetary impact. The changes made by this section will not affect any NF's peer group operating ceiling or operating rate set prior to the effective date of the preceding emergency

regulation.

Section 2.8.1 changes implement the 1991 General Assembly mandate to achieve savings in fiscal year 1992 through an adjustment of Medicaid reimbursement policies or rates for NF cost. As a result, DMAS will adjust per diem operating rates effective on or after July 1, 1991, for all NFs to produce a reduction of $5 million ($2.5 million in General Funds).

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

Written comments may be submitted until 4:30 p.m., January 31, 1992, to William R. Blakely, Jr., Director, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

BOARD OF MEDICINE

† **February 3, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled: **VR 465-03-01. Regulations Governing the Practice of Physical Therapy.** The board proposes to further define supervisory responsbilities of the licensed physical therapist for traineeship, on-site supervision of the physical therapy assistant in the work area, and further define the work settings of patient care.

STATEMENT

Basis: § 54.1-2400 of the Code of Virginia.

Statement of purpose: The proposed amendments to the current regulations, VR 465-03-01, address the needs of the Advisory Board on Physical Therapy to more clearly define the number of trainees a physical therapist may supervise at any one time in a specific work setting and the number of practice settings to accommodate the complex diverse work environment to ensure the health and welfare of the patient, and to more clearly define the complex work setting by further defining the physical therapist's supervisory responsibilities in each specific work setting of the physical therapist assistant in the management of patient care.

Estimated entities and impact.

A. Regulated entities. There are 2,110 physical therapists and 410 physical therapist assistants licensed to practice in Virginia.

B. Projected costs to regulate entities. The impact of the regulations upon the licensees and new applicants is assessed as follows:

1. Section 5.3 A, Supervisory responsibilities: The proposed amendment establishes the number of physical therapist assistants a physical therapist may supervise at any one time in specific work or practice settings. Based upon the diversity of the work setting and the current demand for physical therapy services, the proposed amendment will ease the regulatory burden of the physical therapists who provide home health care which requires traveling from patient to patient.

2. Section 5.3 E, Supervisory responsibilities: The proposed amendment more clearly defines the supervisory reesponsibilities of the physical therapist for on-site visits to be conducted jointly with assistant to ensure appropriate patient care. This amendment establishes a standard of care and will not impact the practice of physical therapy in Virginia.

3. Section 5.3 C, Supervisory responsibilities: The proposed amemdment more clearly defines the number of trainees a physical therapist may supervise. The proposed amendment may impact two physical therapists each year who fail to seek approval for such traineeships and allows the trainee to function under this supervision without approval.

4. Section 6.1 B 3, Scope of responsibilities: The proposed amendment addresses on-site supervision of the assistant by further defining the diversification of the work setting in the proposed new subsections (a) and (b) to accommodate the current patient environment. The proposed amendments will ease the regulatory burden of the physical therapists and physical therapist assistants by more clearly defining the work setting and on-site joint visits required for each work setting.

5. Section 6.1 B 3 (a) and (b), Scope of responsibilities: The proposed amendments establish new and revised joint on-site visit requirements for specific work settings. The proposed amendments will increase the scope of practice of 410 physical therapist assistants in the noncritical patient care setting. The noncritical patient care setting will allow the assistant to see and treat the patient for a specific extended period prior to the required joint visit with the therapist. The proposed amendments will reduce the regulatory burden for the therapist meeting with the assistant.

C. Projected costs to the agency for implementation and enforcement. The Board of Medicine and Advisory Board on Physical Therapy project a minimal expenditure of $3,000 in the area of investigations and resolution of complaints. Sufficient revenues are generated by licensure fees to provide for the projected costs associated with the

proposed amendments, consistent with § 54.1-113 of the Code of Virginia.

D. Source of funds. All funds of the Board of Medicine and Advisory Board on Physical Therapy are derived from fees paid by licensees and applicants for licensure.

Explanation of need of proposed regulations. The proposed amendments are needed due to the rapid growth and diversification of the patient work setting resulting from the extended health care system providing restorative patient therapy by a physical therapist.

Assurance of clarity and simplicity. Clarity and simplicity were assured in the drafting of these regulations through an editing process involving the board, its staff, and the office of the Attorney General.

Impact on small business. If the practice of physical therapy is defined as a small business, then the proposed regulations will impact small businesses as described within this statement. The proposed regulations, however, do not differentially impact small or large professional practice organizations.

Alternatives considered. The Advisory Board on Physical Therapy, following a lengthy review of the practice of physical therapy, and the rapid growth, including the diversification of the work setting, determined to redefine the rule of the physical therapist and assistant in noncritial patient care. The proposal will provide relief to the therapist by extending the number of therapy treatments the assistant may perform between joint visits with the patient. The Board of Medicine concurred with the proposed amendments.

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

Written comments may be submitted until February 3, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Dr., Richmond, VA 23229.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229, telephone (804) 662-9925.

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† **February 3, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled: **VR 465-05-01. Regulations Governing the Practice of Physician's Assistants.** The board proposes to amend §§ 3.4 and 5.1 B to require biennial renewal of license in each odd numbered year on the licensee's birth month and substitute the term "license" for "certification" to conform with the Code of Virginia, throughout the regulations.

STATEMENT

Basis: § 54.1-2400 of the Code of Virginia.

Statement of purpose: The proposed amendments to the current regulations, VR 465-05-01, address the need to change the renewal of licensure period from one year to biennial renewal, in the birth month of the licensee, in each odd-numbered year, and insert the word "license" throughout the regulations and delete the word "certified" to comply with the recodification of Title 54.1 of the Code of Virginia.

Estimated entities and impacts:

A. Regulated entities. There are 225 Physician's Assistants licensed to practice in Virginia.

B. Projected costs to regulate entities: The impact upon the licensees and new applicants of the regulations is assessed as follows:

1. Sections 2.2, 2.3, 3.1, 3.2, 3.3, and 3.4, Terms of Certification and Registration: The terms of "certificate," "certification," and "registration," through the listed sections were amended to "license" or "licensure." The proposed amendments enact those terms to comply with the recodification of Title 54.1 of the Code of Virginia. These proposed amendments will not result in harm or increase the regulatory burden to the licensee or new applicant.

2. Section 3.4 A, Renewal of license: The proposed amendment establishes an extended period of renewal to biennial renewal in each odd-numbered year in the licensee's birth month. This amendment will ease the regulatory burden by lengthening the renewal period to biennial renewal each odd-numbered year in the licensee's birth month. This will lessen the burden for the licensee by redcution in filing additional documents required for license renewal.

3. Section 5.1 B, Fees required: The proposed amendment amends the renewal fee to accommodate the increased fee for the two-year period. Since the fee has not increased based upon the one-year fee, the applicant or licensee burden will not be increased.

C. Projected costs to the agency for implementation and enforcement: The Board of Medicine anticipates a savings of $2,000 through implementation of the biennial renewal process. The biennial renewal cycle in the odd-numbered years will also allow the staff to function more effectively by receiving the license renewal applications over a period of 12 months, in lieu of the current 60 days once each year.

Explanation of need: The proposed amendments are needed to effectuate a reduction in work hours for processing license renewals and to remove the burden of physician's assistants having to renew every year. Ther

will be no reduction or increased revenue received by the board based upon the proposed amendments.

Assurance of clarity and simplicity. Clarity and simplicity were assured in the drafting of these regulations through an editing process involving the board, its staff, and the office of the Attorney General.

Impact on small business. If the practice of physical therapy is defined as a small business, then the proposed regulations will impact small businesses as described within this statement. The proposed regulations, however, do not differentially impact small or large professional practice organizations.

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

Written comments may be submitted until February 3, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Dr., Richmond, VA 23229.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229, telephone (804) 662-9925.

Credentials Committee

December 14, 1991 - 8 a.m. – Open Meeting
Department of Health Professions, Board Room 3, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to (i) conduct general business; (ii) interview and review medical credentials of applicants applying for licensure in Virginia in open and executive session; and (iii) discuss any other items which may come before the committee. Public comments will not be received.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Executive Committee

December 13, 1991 - 9 a.m. – Open Meeting
Department of Health Professions, Board Room 1, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to review closed cases, cases/files requiring administrative action, and consider any other items which may come before the committee. Public comments will not be received.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Advisory Board on Physical Therapy

January 17, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, Board Room 2, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to (i) review and discuss regulations, bylaws, procedure manuals; (ii) receive reports; and (iii) discuss other items which may come before the advisory board. Public comments will not be received.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Advisory Committee on Radiological Technology Practitioners

December 13, 1991 - 1 p.m. – Open Meeting
Department of Health Professions, Board Room 3, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to review and discuss public comments and prepare recommendations to the full board on the proposed Regulations Governing the Practice of Radiological Technology Practitioners (VR 465-10-01). The Advisory Committee will not entertain public comments.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Joint Board Liaison Committee

December 6, 1991 - 10 a.m. – Open Meeting
Department of Youth and Family Services, 700 Center Building, 7th and Franklin Streets, Richmond, Virginia.

A quarterly meeting comprised of representatives of the Boards of Corrections, Education, Health, Medical Assistance Services, Mental Health, Mental Retardation, and Substance Abuse Services, Rehabilitative Services, Social Services, and Youth and Family Services. Agenda items include topics of common interest and the development of joint policies relative to clients who are mutually served.

Contact: Jane V. Helfrich, Board Administrator, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3921.

State Human Rights Committee

† **December 13, 1991 - 9 a.m.** – Open Meeting
Department of Mental Health, Mental Retardation and Substance Abuse Services, James Madison Building, 109 Governor Street, 13th Floor Conference Room, Richmond, Virginia.

A regular meeting to discuss business relating to human rights issues. Agenda items are listed prior to the meeting.

Contact: Elsie D. Little, State Human Rights Director, Department of Mental Health, Mental Retardation and Substance Abuse Services, Office of Human Rights, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3988.

STATE MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES BOARD

December 4, 1991 - 10 a.m. – Open Meeting
Eastern State Hospital, Williamsburg, Virginia. ♿

A regular monthly meeting. The agenda will be published on November 27, and may be obtained by calling Jane Helfrich.

Tuesday: Informal Session - 6 p.m.

Wednesday: Committee Meetings - 8:45 a.m.

Wednesday: Regular Session - 10 a.m.

See agenda for location.

Contact: Jane V. Helfrich, Board Administrator, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3921.

MIDDLE VIRGINIA BOARD OF DIRECTORS AND THE MIDDLE VIRGINIA COMMUNITY CORRECTIONS RESOURCES BOARD

December 5, 1991 - 7 p.m. – Open Meeting
502 South Main Street, No. 4, Culpeper, Virginia.

From 7 p.m. to 7:30 p.m. the Board of Directors will hold a business meeting to discuss DOC contract, budget, and other related business. Then the CCRB will meet to review cases for eligibility to participate with the program. It will review the previous month's operation (budget and program related business).

Contact: Lisa Ann Peacock, Program Director, 502 South Main Street, No. 4, Culpeper, VA 22701, telephone (703) 825-4562.

DEPARTMENT OF MOTOR VEHICLES

January 3, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Motor Vehicles intends to repeal existing regulations entitled **VR 485-10-8401. Public Participation Guidelines** and adopt new regulations entitled: **VR 485-10-9101. Public Participation Guidelines for Regulation Development and Promulgation.** The board proposes to repeal the existing regulation 7nd establish new guidelines for receiving input and participation from interested citizens in the development of any regulation which the department proposes.

Statutory Authority: § 46.2-203 of the Code of Virginia.

Written comments may be submitted until January 3, 1992.

Contact: Peggy S. McCrerey, Planning Director, P.O. Box 27412, Richmond, VA 23269, telephone (804) 367-0429.

BOARD OF NURSING

Special Conference Committee

† **December 5, 1991 - 8:30 a.m.** – Open Meeting
† **December 6, 1991 - 8:30 a.m.** – Open Meeting
Department of Health Professions, Conference Room 3, 1601 Rolling Hills Drive, Richmond, Virginia. ♿
(Interpreter for deaf provided if requested)

A Special Conference Committee, comprised of three members of the Virginia Board of Nursing, will conduct informal conferences with licensees to determine what, if any, action should be recommended to the Board of Nursing. Public comment will not be received.

Contact: Corinne F. Dorsey, R.N., Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9909, toll-free 1-800-533-1560 or (804) 662-7197/TDD ☎

BOARD OF NURSING HOME ADMINISTRATORS

† **December 5, 1991 - 8:30 a.m.** – Open Meeting
1601 Rolling Hills Drive, Conference Room 1, Richmond, Virginia. ♿

A regularly scheduled board meeting and formal conferences.

† **January 9, 1992 - 9 a.m.** – Open Meeting
1601 Rolling Hills Drive, Richmond, Virginia. ♿

National and state examinations for nursing home administrators.

† **January 21, 1992 - 8:30 a.m.** – Open Meeting
† **January 22, 1992 - 8:30 a.m.** – Open Meeting
1601 Rolling Hills Drive, Richmond, Virginia. ♿

A board meeting to review continuing education submittals regarding licensure renewal.

Contact: Meredyth P. Partridge, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-9111.

BOARD OF OPTOMETRY

† **December 18, 1991 - 9 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room 4, Richmond, Virginia.

The board will conduct informal conferences.

Contact: Lisa J. Russell, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9910.

VIRGINIA OUTDOORS FOUNDATION

December 16, 1991 - 10:30 a.m. – Open Meeting
Monticello, Charlottesville, Virginia. ♿

A general business meeting.

Contact: Tyson B. Van Auken, Executive Director, 221 Governor Street, Richmond, VA 23219, telephone (804) 786-5539.

BOARD OF PHARMACY

December 5, 1991 - 9 a.m. – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room #4, Richmond, Virginia.

Informal conferences.

Contact: Scotti W. Milley, Executive Director, Virginia Board of Pharmacy, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9911.

POLYGRAPH EXAMINERS ADVISORY BOARD

† **December 17, 1991 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

This meeting is for the purpose of administering the polygraph examiners licensing examination to eligible polygraph examiner interns and to consider other matters which require board action.

Contact: Geralde W. Morgan, Administrator, Department of Commerce, 3600 West Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8534.

BOARD OF PROFESSIONAL COUNSELORS

† **December 5, 1991 - 9 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

Informal conferences. No public comments.

† **December 13, 1991 - 9 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to (i) conduct general board business; (ii) respond to correspondence; (iii) receive committee reports; and (iv) conduct regulatory review. Public comment will not be received.

Contact: Evelyn B. Brown, Executive Director, or Joyce D. Williams, Administrative Assistant, Department of Health Professions, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9912.

BOARD OF PSYCHOLOGY

† **December 19, 1991 - 9 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to conduct general board business and review regulatory comments. Public comment will not be received.

Contact: Evelyn B. Brown, Executive Director, Department of Health Professions, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-9913 or (804) 662-7197/TDD ☎

REAL ESTATE APPRAISER BOARD

December 10, 1991 - 2 p.m. – Public Hearing
Department of Commerce, 3600 West Broad Street, 3rd Floor, Room 395, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Real Estate Appraiser Board is withdrawing the proposed regulation published in 8:2 VA.R. 206-226 October 21, 1991 and will adopt new regulations entitled: **VR 583-01-03. Real Estate Appraiser Board Regulations.** The purpose of the proposed regulations is to establish the qualifications for licensure and standards of practice for real estate appraisers.

Statutory Authority: § 54.1-2013 of the Code of Virginia.

Written comments may be submitted until January 18, 1992.

Contact: Demetra Y. Kontos, Assistant Director, Real Estate Appraiser Board, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-2175.

December 10, 1991 - 9 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

A general business meeting.

Contact: Demetra Y. Kontos, Assistant Director, Real Estate Appraiser Board, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-2175.

REAL ESTATE BOARD

December 5, 1991 - 10 a.m. – Open Meeting
Fredericksburg Juvenile and Domestic Relations Court Room, 601 Caroline Street, Third Floor, Fredericksburg, Virginia.

The board will meet to conduct a formal hearing: File No. 90-02360, Real Estate Board v. Nadine A. Burt.

Contact: Gayle Eubank, Hearings Coordinator, Department of Commerce, 3600 West Broad Street, Fifth Floor, Richmond, VA 23230, telephone (804) 367-8524.

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† **January 5, 1992** – Written comments may be submitted until this date.
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Real Estate Board intends to amend regulations entitled: **VR 585-01-1. Virginia Real Estate Board Licensing Regulations.** The proposed regulations relate to the licensing and conducting of real estate business in accordance with established standards.

Statutory Authority: §§ 9-6.14:1, 54.1-201 and 54.1-2105 of the Code of Virginia.

Written comments may be submitted until January 5, 1992.

Contact: Joan L. White, Assistant Director, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-8552.

BOARD OF REHABILITATIVE SERVICES

December 5, 1991 - 10 p.m. – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The board will receive department reports, consider regulatory matters and conduct the regular business of the board.

Contact: Susan L. Urofsky, Commissioner, 4901 Fitzhugh Avenue, Richmond, VA 23230, telephone (804) 367-0319, toll-free 1-800-552-5019/TDD and Voice ☎ or (804) 367-0280/TDD ☎

Finance Committee

December 5, 1991 - 9 p.m. – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review monthly financial reports and budgetary projections.

Contact: Susan L. Urofsky, Commissioner, 4901 Fitzhugh Avenue, Richmond, VA 23230, telephone (804) 367-0319, toll-free 1-800-552-5019/TDD and Voice ☎ or (804) 367-0280/TDD ☎

Legislation Committee

December 5, 1991 - 9 p.m. – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to update legislation.

Contact: Susan L. Urofsky, Commissioner, 4901 Fitzhugh Avenue, Richmond, VA 23230, telephone (804) 367-0319, toll-free 1-800-552-5019/TDD and Voice ☎ or (804) 367-0280/TDD ☎

Program and Evaluation Committee

December 5, 1991 - 9 p.m. – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to review health care policy proposal.

Contact: Susan L. Urofsky, Commissioner, 4901 Fitzhugh Avenue, Richmond, VA 23230, telephone (804) 367-0319, toll-free 1-800-552-5019/TDD and Voice ☎ or (804) 367-0280/TDD ☎

STATE CERTIFIED SEED BOARD

December 12, 1991 - 1:30 p.m. – Open Meeting
104 F Hutcheson Hall, Blacksburg, Virginia. ♿

A meeting to report on program activities and review certification standards. Public comment will be received.

Contact: Dr. Robert Q. Cannell, Chairman, VPI and SU, 333 Smyth Hall, CSES Department, Blacksburg, VA 24061, telephone (703) 231-8653.

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

January 4, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Social Services intends to amend regulations entitled: **VR 615-33-01. Fee Requirements for Processing Applications.** This regulation contains the requirements and procedures for licensees to follow in submitting the application processing fee which is to be submitted with all new and renewal applications. It also includes a provision for a $15 fee to be charged for checks which must be returned to the applicant because of insufficient funds.

Statutory Authority: §§ 63.1-25, 63.1-174.01 and 63.1-196.5 of the Code of Virginia.

Written comments may be submitted until January 4, 1992.

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

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January 17, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Social Services intends to amend regulations entitled: **VR 615-01-36. General Relief (GR) Program - Locality Options.** The purpose of the proposed amendment is to allow local departments of Social Services to continue options for assistance provided from the General Relief Program.

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

Written comments may be submitted until January 17, 1992, to Ms. Diana Salvatore, Program Manager, Medical Assistance Unit, Virginia Department of Social Services, 8007 Discovery Drive, Richmond, Virginia 23229.

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

BOARD FOR PROFESSIONAL SOIL SCIENTISTS

† **December 5, 1991 - 10 a.m.** – Open Meeting
Virginia Department of Commerce, Conference Room 2, 3600 West Broad Street, Richmond, Virginia. ♿

December 19, 1991 - 10 a.m. – Open Meeting
Virginia Department of Commerce, Conference Room 2, 3600 West Broad Street, Richmond, Virginia. ♿

Grade examinations.

† **January 6, 1992 - 11 a.m.** – Open Meeting
Virginia Department of Commerce, Conference Room 1, 3600 West Broad Street, Richmond, Virginia. ♿

A general board meeting.

Contact: Nelle P. Hotchkiss, Assistant Director, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-8595.

GOVERNOR'S TASK FORCE ON SUBSTANCE ABUSE AND SEXUAL ASSAULT ON COLLEGE CAMPUSES

December 11, 1991 - 1 p.m. – Open Meeting
General Assembly Building, House Room D, 910 Capitol Street, Richmond, Virginia. ♿

Task force meeting.

Contact: Kris Ragan, Staff Assistant, P.O. Box 1422, Richmond, VA 23211, telephone (804) 786-6316.

VIRGINIA SWEET POTATO BOARD

† **December 11, 1991 - 6 p.m.** – Open Meeting
Town House Restaurant, Route 126, Onancock, Virginia. ♿

A meeting to discuss marketing promotion, research and education programs for the state's sweet potato industry. At the conclusion of other business, the board will entertain public comments for a period not to exceed 30 minutes.

† **March 11, 1992 - 7:30 p.m.** – Open Meeting
Eastern Shore Agriculture Experiment Station, Route 1, Box 133, Research Drive, Painter, Virginia. ♿

A meeting to discuss marketing, promotion, research and education programs for the state's sweet potato industry and to develop the board's annual budget. At the conclusion of other business, the board will entertain public comments for a period not to exceed 30 minutes.

Contact: J. William Mapp, Program Director, Box 26, Onley, VA 23418, telephone (804) 787-5867.

COMMONWEALTH TRANSPORTATION BOARD

† **December 18, 1991 - 2 p.m.** – Open Meeting
Sheraton Inn, Fredericksburg Conference Center, Fredericksburg, Virginia. ♿ (Interpreter for deaf provided upon request)

Work session of the Commonwealth Transportation Board and the Department of Transportation staff.

† **December 19, 1991 - 10 a.m.** – Open Meeting
Sheraton Inn, Fredericksburg Conference Center, Fredericksburg, Virginia. ♿ (Interpreter for deaf provided upon request)

A monthly meeting to vote on proposals presented regarding bids, permits, additions and deletions to the highway system, and any other matters requiring board approval.

Public comment will be received at the outset of the meeting on items on the meeting agenda for which the opportunity for public comment has not been afforded the public in another forum. Remarks will be limited to five minutes. Large groups are asked to select one individual to speak for the group. The board reserves the right to amend these conditions.

Contact: John G. Milliken, Secretary of Transportation, 1491 East Broad Street, Richmond, VA 23219, telephone (804) 786-6670.

VIRGINIA'S TRANSITION TASK FORCE

December 5, 1991 - 10 a.m. – Open Meeting
Cedar Lodge Training Facility, Department of Youth and Family Services, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A quarterly meeting to address interagency and community issues regarding the transition from secondary school for youths with disabilities. Public comment is invited from 11:30 to 12:30.

Contact: Dr. Sharon deFur, Associate Specialist, P.O. Box 6Q, Virginia Department of Education, Richmond, VA 23216, telephone (804) 225-3242 or 1-800-422-1098/TDD ☎

TRANSPORTATION SAFETY BOARD

NOTE: CHANGE IN MEETING TIME
January 23, 1992 - 10:30 a.m. – Open Meeting
Department of Motor Vehicles, Room 702, 2300 West Broad Street, Richmond, Virginia. ♿

A meeting to discuss various transportation safety topics and issues.

Contact: William H. Leighty, Deputy Commissioner, 2300 West Broad Street, Richmond, VA 23269, telephone (804) 367-6614 or (804) 367-1752/TDD ☎

TREASURY BOARD

December 18, 1991 - 9 a.m. – Open Meeting
James Monroe Building, 3rd Floor, 101 North 14th Street, Richmond, Virginia. ♿

A regular meeting.

Contact: Belinda Blanchard, Assistant Investment Officer, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-2142.

BOARD OF VETERINARY MEDICINE

December 4, 1991 - 8:30 a.m. – Open Meeting
Conference Room 3, 1601 Rolling Hills Drive, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

General board business, formal hearing.

Contact: Terri H. Behr, 1601 Rolling Hills Drive, Richmond, Virginia, telephone (804) 662-9915.

COMMISSION ON THE VIRGINIA ALCOHOL SAFETY ACTION PROGRAM

† **December 19, 1991 - 1 p.m.** – Open Meeting
† **December 20, 1991 - 9 a.m.** – Open Meeting
Virginia Beach Resort Center, Virginia Beach, Virginia.

A scheduled commission meeting.

Contact: William T. McCollum, Executive Director, Commission on the Virginia Alcohol Safety Action Program, Old City Hall, Richmond, Virginia, telephone (804) 786-5895.

VIRGINIA RACING COMMISSION

† **December 18, 1991 - 9:30 a.m.** – Open Meeting
VSRS Building, 1200 East Main Street, Richmond, Virginia. ♿

A regular commission meeting including a review of the application procedures for participants as well as a review of the drafts of proposed regulations relating to medication and the Virginia Breeders Fund.

Contact: William H. Anderson, Policy Analyst, Virginia Racing Commission, P.O. Box 1123, Richmond, Virginia 23208, telephone (804) 371-7363.

VIRGINIA RESOURCES AUTHORITY

† **December 10, 1991 - 9 a.m.** – Open Meeting
† **January 14, 1992 - 9 a.m.** – Open Meeting
† **February 11, 1992 - 9 a.m.** – Open Meeting
The Mutual Building, 909 East Main Street, Suite 707, Conference Room A, Richmond, Virginia.

The board will meet to (i) approve minutes of its previous meeting; (ii) review the Authority's operations for the prior months; and (iii) consider other matters and take other actions as it may deem appropriate. The planned agenda of the meeting will be available at the offices of the Authority one week prior to the date of the meeting.

Public comments will be received at the beginning of the meeting.

Contact: Mr. Shockley D. Gardner, Jr., 909 East Main Street, Suite 707, Mutual Building, Richmond, VA 23219, telephone (804) 644-3100 or FAX number (804) 644-3109.

DEPARTMENT FOR THE VISUALLY HANDICAPPED

Advisory Committee on Services

† **January 11, 1992 - 11 a.m.** – Open Meeting
Administrative Headquarters, 397 Azalea Avenue, Richmond, Virginia. ♿ (f interpreter for deaf provided upon request)

A quarterly meeting to advise the Virginia Board for the Visually Handicapped on matters related to services for blind and visually impaired citizens of the Commonwealth.

Contact: Barbara G. Tyson, Executive Secretary, 397 Azalea Avenue, Richmond, VA 23227, telephone (804) 371-3140 or toll-free 1-800-622-2155.

VIRGINIA VOLUNTARY FORMULARY BOARD

January 9, 1992 - 10:30 a.m. – Open Meeting
Washington Building, 2nd Floor Board Room, 1100 Bank Street, Richmond, Virginia.

A meeting to consider public hearing comments and review new product data for products pertaining to the Virginia Voluntary Formulary.

Contact: James K. Thomson, Director, Bureau of Pharmacy Services, 109 Governor Street, Room B1-9, Richmond, Virginia 23219, telephone (804) 786-4326.

VIRGINIA WASTE MANAGEMENT BOARD

December 5, 1991 - 9:30 a.m. – Open Meeting
The Water Control Board, 4900 Cox Road, Glen Allen, Virginia. ♿

This will be a working session from 9:30 a.m. until 11:30 a.m. The regular board meeting will start at 1 p.m.

Contact: Loraine Williams, Secretary, 101 N. 14th Street, Monroe Building, 11th Floor, Richmond, VA 23219, telephone (804) 225-2667, toll-free 1-800-552-2075 or (804) 371-8737/TDD ☎

STATE WATER CONTROL BOARD

December 6, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to adopt regulations entitled: **VR 680-16-02. Roanoke River Basin Water Quality Management Plan.** The proposed amendment would delete those portions of the Plan to be covered by adoption, through a separate regulatory action, of the Upper Roanoke River Subarea Water Quality Management Plan.

Statutory Authority: § 62.1-44.15 of the Code of Virginia.

Written comments may be submitted until 4 p.m., December 6, 1991, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Wellford S. Estes, State Water Control Board, West Central Regional Office, P.O. Box 7017, Roanoke, Virginia 24019, telephone (703) 857-7432.

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December 6, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to adopt regulations entitled: **VR 680-16-02.1. Upper Roanoke River Subarea Water Quality Management Plan.** The proposal is to adopt the Upper Roanoke River Subarea Water Quality Management Plan which updates those portions of the Roanoke River Basin Water Quality Management Plan in the Upper Roanoke River Subarea. A separate regulatory action will amend the Basin Plan to delete those areas to be covered by the Subarea Plan.

Statutory Authority: § 62.1-44.15 of the Code of Virginia.

Written comments may be submitted until 4 p.m., December 6, 1991, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Wellford S. Estes, State Water Control Board, West Central Regional Office, P.O. Box 7017, Roanoke, Virginia 24019, telephone (703) 857-7432.

† **December 9, 1991 - 2 p.m.** – Public Hearing
Innsbrook Corporate Center, 4900 Cox Road, Glen Allen,

Virginia.

A public hearing to receive comments on the proposed Virginia Pollutant Discharge Elimination System (VPDES) Permit No. VA00663177 for the City of Richmond. The purpose of the hearing is to receive comments on the proposed reissuance or denial of the permit and the effect of the discharge's proposed effluent limitations on water quality or beneficial uses of state waters.

Contact: Lori Freeman Jackson, Hearings Reporter, Office of Policy Analysis, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230-1143, telephone (804) 527-5163.

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

BOARD OF YOUTH AND FAMILY SERVICES

December 13, 1991 - 10 a.m. – Open Meeting
Abingdon, Virginia.

January 9, 1992 - 10 a.m. – Open Meeting
Fredericksburg, Virginia.

A general business meeting.

Contact: Paul Steiner, Policy Coordinator, Department of Youth and Family Services, P.O. Box 3AG, Richmond, VA 23208-1108, telephone (804) 371-0692.

DEPARTMENT OF YOUTH AND FAMILY SERVICES (BOARD OF)

December 12, 1991 - 7 p.m. – Public Hearing
Abingdon, Virginia.

January 8, 1992 - 7 p.m. – Public Hearing
Fredericksburg, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Youth and Family Services intends to adopt regulations entitled: **VR 690-30-001. Standards for Secure Detention Homes.** The purpose of the proposed regulation is to establish operating standards for the care and custody of youth in secure detention homes.

Statutory Authority: §§ 16.1-311 and 66-10 of the Code of Virginia.

Written comments may be submitted until January 31, 1992.

Contact: Paul Steiner, Policy Coordinator, Department of Youth and Family Services, P.O. Box 3AG, Richmond, VA 23208-1108, telephone (804) 371-0692.

LEGISLATIVE

VIRGINIA CODE COMMISSION

December 11, 1991 - 10 a.m. – Open Meeting
General Assembly Building, Sixth Floor Conference Room, Richmond, Virginia.

The commission will meet to discuss annual publication of the Code of Virginia, electronic publishing, and the proposed publication of a Virginia Administrative Code.

Contact: Joan W. Smith, Registrar of Regulations, 910 Capitol Street, Richmond, VA 23219, telephone (804) 786-3591.

HOUSE COMMITTEE FOR COURTS OF JUSTICE

† **December 12, 1991 - 2 p.m.** – Executive Session
† **December 13, 1991 - 9 a.m.** – Executive Session
General Assembly Building, House Room C, Richmond Virginia.

These meetings have been scheduled for the purpose of interviewing incumbent judges and will be closed to the public.

Contact: Mary Geisen, Research Associate, 910 Capitol Street, Richmond, VA 23219, telephone (804) 786-3591.

JOINT SUBCOMMITTEE STUDYING HUMAN IMMUNODEFICIENCY VIRUSES (AIDS)

December 18, 1991 - 10 a.m. – Open Meeting
General Assembly Building, House Room C, 910 Capitol Street, Richmond, Virginia.

The subcommittee will hear presentations and deliberations on issues related to testing. (HJR 438)

Contact: Norma Szakal, Staff Attorney, Division of Legislative Services, 910 Capitol St., Richmond, VA 23219, telephone (804) 786-3591.

JOINT SUBCOMMITTEE STUDYING THE EXISTING MECHANICS' LIEN LAWS

December 4, 1991 - 10 a.m. – Open Meeting
General Assembly Building, House Room C, 910 Capitol

Street, Richmond, Virginia.

The subcommittee will meet to proceed with agenda established at organizational meeting. (HJR 418)

Contact: Oscar Brinson, Staff Attorney, Division of Legislative Services, 910 Capitol St., Richmond, VA 23219, telephone (804) 786-3591.

JOINT SUBCOMMITTEE STUDYING SCHOOL DROPOUTS AND WAYS TO PROMOTE THE DEVELOPMENT OF SELF-ESTEEM IN YOUTH AND ADULTS

† **December 9, 1991 - 10 a.m.** – Open Meeting
State Capitol Building, House Room 4, Richmond, Virginia.

A general meeting. (HJR 386)

Contact: Jeff Finch, House of Delegates, telephone, (804) 786-2227 or Brenda Edwards, Research Associate, Division of Legislative Services, 910 Capitol St., Richmond, VA 23219, telephone (804) 786-3591.

YOUTH SERVICES COMMISSION

December 3, 1991 - 9 a.m. – Open Meeting
General Assembly Building, House Appropriations Committee Room, 9th Floor, 910 Capitol Street, Richmond, Virginia.

Presentations by state agencies and statewide organizations and associations on their legislative agendas on youth related issues for the 1992 General Assembly session.

December 3, 1991 - 1 p.m. – Open Meeting
General Assembly Building, House Appropriations Committee Room, 9th Floor, 910 Capitol Street, Richmond, Virginia.

Commission business meeting.

Contact: Nancy H. Ross, Executive Director, or Mary R. Simmons, General Assembly Building, Room 517B, 910 Capitol Street, Richmond, VA 23219, telephone (804) 371-2481.

CHRONOLOGICAL LIST

OPEN MEETINGS

December 2
ASAP Policy Board - Valley
Branch Pilots, Board for

December 3
Hopewell Industrial Safety Council
Marine Products Board, Virginia
Youth Services Commission

December 4
Chesapeake Bay Local Assistance Board
- Southern Area Review Committee
Mechanics' Lien Laws, Joint Subcommittee Studying the Existing
Mental Health, Mental Retardation and Substance Abuse Services Board, State
Veterinary Medicine, Board of

December 5
Aging, Department for the
- Long-Term Care Ombudsman Program Advisory Council
Agriculture and Consumer Services, Board of
ASAP Policy Board - Rockingham/Harrisonburg
Chesapeake Bay Local Assistance Board
Contractor, Board for
- Recovery Fund Committee
Emergency Planning Committee, Local - Chesterfield County
Hazardous Materials Emergency Response Advisory Council, Virginia
Mapping, Surveying and Land Information Systems, Advisory Commission on
Middle Virginia Board of Directors and the Middle Virginia Community Corrections Resources Board
† Nursing, Board of
- Special Conference Committee
† Nursing Home Administrators, Board of
Pharmacy, Board of
† Professional Counselors, Board of
† Professional Soil Scientists, Board for
Real Estate Board
Rehabilitative Services, Board of
- Finance Committee
- Legislation Committee
- Program and Evaluation Committee
Transition Task Force, Virginia's
Waste Managment Board, Virginia

December 6
Agriculture and Consumer Services, Board of
† Game and Inland Fisheries, Board of
Mental Health, Mental Retardation and Substance Abuse Services, Department of
- Joint Board Liaison Committee
† Nursing, Board of
- Special Conference Committee

December 9
† Barbers, Board for
Chesapeake Bay Local Assistance Board
- Central Area Review Committee
Council on Information Management

December 10
† Education, State Council of Higher

† Historic Resources, Department of
- State Review Board
Real Estate Appraiser Board
† Virginia Resources Authority

December 11
Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
Code Commission, Virginia
Conservation and Recreation, Department of
- Soil and Water Conservation Board
Corrections, Board of
† Historic Resources, Board of
Interagency Coordinating Council on Early Intervention, Virginia
† Sweet Potato Board, Virginia

December 12
† Child Day-Care Council
† Courts of Justice, House Committee for (Executive Session)
Fire Services Board, Virginia
- Fire/EMS Training and Education Committee
- Fire Prevention and Control Committee
- Legislative/Liaison Committee
† General Services, Department of
- State Insurance Advisory Board
† Health, State Board of
Seed Board, State Certified

December 13
† Building Code Technical Review Board, State
† Courts of Justice, House Committee for (Executive Session)
† Health, State Board of
† Long-term Care Council
Medicine, Board of
- Credentials Committee
- Executive Committee
- Advisory Committee on Radiological Technology Practitioners
† Professional Counselors, Board of
† Mental Health, Mental Retardation and Substance Abuse Services, Department of
- State Human Rights Committee
Youth and Family Services, Board of

December 16
† Accountancy Board for
Emergency Planning Committee, Local
- County of Prince William, City of Manassas and City of Manassas Park
† Geology, Board for
† Medical Assistance Services, Board of
Outdoors Foundation, Virginia

December 17
Health Services Cost Review Council, Virginia
† Housing Development Authority, Virginia
† Longwood College
- Executive Committee
† Polygraph Examiners Advisory Board

December 18
Human Immunodeficiency Viruses, Joint Subcommittee Studying
† Optometry, Board of
† Transportation Board, Commonwealth
Treasury Board
† Virginia Racing Commission

December 19
† Air Pollution Control Board, State
Compensation Board
† Professional Soil Scientists, Board for
† Psychology, Board of
† Transportation Board, Commonwealth
† Virginia Alcohol Safety Action Program, Commission on the

December 20
Residential Facilities for Children, Coordinating Committee for Interdepartmental Regulation of
† Virginia Alcohol Safety Action Program, Commission on the

January 2, 1992
† Emergency Planning Committee, Local
- Chesterfield County

January 6
† Professional Soil Scientists, Board for

January 7
† Hopewell Industrial Safety Council

January 9
† Nursing Home Administrators, Board of
Voluntary Formulary Board, Virginia
Youth and Family Services, Board of

January 11
† Visually Handicapped, Department for the
- Advisory Committee on Services

January 14
† Local Government, Commission on
† Virginia Resources Authority

January 16
† Audiology and Speech Pathology, Board of

January 17
Medicine, Board of
- Advisory Board on Physical Therapy

January 21
Library Board
† Nursing Home Administrators, Board of

January 22
† Nursing Home Administrators, Board of

January 23
Transportation Safety Board

January 30
† Chesapeake Bay Local Assistance Board

February 4
† Hopewell Industrial Safety Council

February 6
† Emergency Planning Committee, Local
- Chesterfield County

February 11
† Virginia Resources Authority

February 24
Commerce, Board of

February 27
† Chesapeake Bay Local Assistance Board

PUBLIC HEARINGS

December 2
Health, Department of

December 3
Health, Department of

December 4
Health, Department of

December 8
Health, Department of

December 9
† Water Control Board, State

December 10
Health, Department of
Real Estate Appraiser Board

December 11
Fire Services Board, Virginia
- Department of Fire Programs

December 12
Health, Department of
Youth and Family Services, Department of

December 16
Health, Department of

December 18
† Air Pollution Control Board, State
Health, Department of

December 19
Health, Department of

January 6, 1992
Education, Department of

January 8
Youth and Family Services, Department of

January 14
Labor and Industry, Department of

January 21
† Deaf and Hard of Hearing, Department for the

February 12
Corrections, Department of

March 6
† Criminal Justice Services, Department of