



# VIRGINIA

## REGISTER OF REGULATIONS

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# VIRGINIA REGISTER INFORMATION PAGE

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**THE VIRGINIA REGISTER OF REGULATIONS** is an official state publication issued every other week throughout the year. Indexes are published quarterly, and are cumulative for the year. The *Virginia Register* has several functions. The new and amended sections of regulations, both as proposed and as finally adopted, are required by law to be published in the *Virginia Register*. In addition, the *Virginia Register* is a source of other information about state government, including petitions for rulemaking, emergency regulations, executive orders issued by the Governor, and notices of public hearings on regulations.

## **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 intended regulatory action; a basis, purpose, substance and issues statement; an economic impact analysis prepared by the Department of Planning and Budget; the agency's response to the economic impact analysis; a summary; a notice giving the public an opportunity to comment on the proposal; and the text of the proposed regulation.

Following publication of the proposal in the *Virginia Register*, the promulgating agency receives public comments for a minimum of 60 days. The Governor reviews the proposed regulation to determine if it is necessary to protect the public health, safety and welfare, and if it is clearly written and easily understandable. If the Governor chooses to comment on the proposed regulation, his comments must be transmitted to the agency and the Registrar no later than 15 days following the completion of the 60-day public comment period. The Governor's comments, if any, will be published in the *Virginia Register*. Not less than 15 days following the completion of the 60-day public comment period, the agency may adopt the proposed regulation.

The Joint Commission on Administrative Rules (JCAR) or the appropriate standing committee of each house of the General Assembly may meet during the promulgation or final adoption process and file an objection with the Registrar and the promulgating agency. The objection will be published in the *Virginia Register*. Within 21 days after receipt by the agency of a legislative objection, the agency shall file a response with the Registrar, the objecting legislative body, and the Governor.

When final action is taken, the agency again publishes the text of the regulation as adopted, highlighting all changes made to the proposed regulation and explaining any substantial changes made since publication of the proposal. A 30-day final adoption period begins upon final publication in the *Virginia Register*.

The Governor may review the final regulation during this time and, if he objects, forward his objection to the Registrar and the agency. In addition to or in lieu of filing a formal objection, the Governor may suspend the effective date of a portion or all of a regulation until the end of the next regular General Assembly session by issuing a directive signed by a majority of the members of the appropriate legislative body and the Governor. The Governor's objection or suspension of the regulation, or both, will be published in the *Virginia Register*. If the Governor finds that changes made to the proposed regulation have substantial impact, he may require the agency to provide an additional 30-day public comment period on the changes. Notice of the additional public comment period required by the Governor will be published in the *Virginia Register*.

The agency shall suspend the regulatory process for 30 days when it receives requests from 25 or more individuals to solicit additional public comment, unless the agency determines that the changes have minor or inconsequential impact.

A regulation becomes effective at the conclusion of the 30-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 21-day objection period; (ii) the Governor exercises his authority to require the agency to provide for additional public comment, in which event the regulation,

unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the period for which the Governor has provided for additional public comment; (iii) the Governor and the General Assembly exercise their authority to suspend the effective date of a regulation until the end of the next regular legislative session; or (iv) the agency suspends the regulatory process, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 30-day public comment period and no earlier than 15 days from publication of the readopted action.

A regulatory action may be withdrawn by the promulgating agency at any time before the regulation becomes final.

## **FAST-TRACK RULEMAKING PROCESS**

Section 2.2-4012.1 of the Code of Virginia provides an exemption from certain provisions of the Administrative Process Act for agency regulations deemed by the Governor to be noncontroversial. To use this process, Governor's concurrence is required and advance notice must be provided to certain legislative committees. Fast-track regulations will become effective on the date noted in the regulatory action if no objections to using the process are filed in accordance with § 2.2-4012.1.

## **EMERGENCY REGULATIONS**

Pursuant to § 2.2-4011 of the Code of Virginia, an agency, upon consultation with the Attorney General, and at the discretion of the Governor, may adopt emergency regulations that are necessitated by an emergency situation. An agency may also adopt an emergency regulation when Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment. 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 to no more than 18 months in duration; however, may be extended for six months under certain circumstances as provided for in § 2.2-4011 D. Emergency regulations are published as soon as possible in the *Register*. During the time the emergency status is in effect, the agency may proceed with the adoption of permanent regulations through the usual procedures. To begin promulgating the replacement regulation, the agency must (i) file the Notice of Intended Regulatory Action with the Registrar within 60 days of the effective date of the emergency regulation and (ii) file the proposed regulation with the Registrar within 180 days of the effective date of the emergency regulation. If the agency chooses not 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 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2 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. **29:5 VA.R. 1075-1192 November 5, 2012**, refers to Volume 29, Issue 5, pages 1075 through 1192 of the *Virginia Register* issued on November 5, 2012.

*The Virginia Register of Regulations* is published pursuant to Article 6 (§ 2.2-4031 et seq.) of Chapter 40 of Title 2.2 of the Code of Virginia.

Members of the Virginia Code Commission: **John S. Edwards**, Chair; **James M. LeMunyon**, Vice Chair; **Gregory D. Habeeb**; **Ryan T. McDougle**; **Robert L. Calhoun**; **Carlos L. Hopkins**; **Leslie L. Lilley**; **E.M. Miller, Jr.**; **Thomas M. Moncure, Jr.**; **Christopher R. Nolen**; **Timothy Oksman**; **Charles S. Sharp**; **Mark J. Vucci**.

Staff of the Virginia Register: **Jane D. Chaffin**, Registrar of Regulations; **Karen Perrine**, Assistant Registrar; **Anne Bloomsburg**, Regulations Analyst; **Rhonda Dyer**, Publications Assistant; **Terri Edwards**, Operations Staff Assistant.

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## PUBLICATION SCHEDULE AND DEADLINES

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This schedule is available on the *Register's* Internet home page (<http://register.dls.virginia.gov>).

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### February 2017 through February 2018

<u>Volume: Issue</u>	<u>Material Submitted By Noon*</u>	<u>Will Be Published On</u>
33:12	January 18, 2017	February 6, 2017
33:13	February 1, 2017	February 20, 2017
33:14	February 15, 2017	March 6, 2017
33:15	March 1, 2017	March 20, 2017
33:16	March 15, 2017	April 3, 2017
33:17	March 29, 2017	April 17, 2017
33:18	April 12, 2017	May 1, 2017
33:19	April 26, 2017	May 15, 2017
33:20	May 10, 2017	May 29, 2017
33:21	May 24, 2017	June 12, 2017
33:22	June 7, 2017	June 26, 2017
33:23	June 21, 2017	July 10, 2017
33:24	July 5, 2017	July 24, 2017
33:25	July 19, 2017	August 7, 2017
33:26	August 2, 2017	August 21, 2017
34:1	August 16, 2017	September 4, 2017
34:2	August 30, 2017	September 18, 2017
34:3	September 13, 2017	October 2, 2017
34:4	September 27, 2017	October 16, 2017
34:5	October 11, 2017	October 30, 2017
34:6	October 25, 2017	November 13, 2017
34:7	November 8, 2017	November 27, 2017
34:8	November 21, 2017 ( <b>Tuesday</b> )	December 11, 2017
34:9	December 6, 2017	December 25, 2017
34:10	December 19, 2017 ( <b>Tuesday</b> )	January 8, 2018
34:11	January 3, 2018	January 22, 2018
34:12	January 17, 2018	February 5, 2018

\*Filing deadlines are Wednesdays unless otherwise specified.

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# PETITIONS FOR RULEMAKING

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## TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

### DEPARTMENT OF HEALTH PROFESSIONS

#### Initial Agency Notice

**Title of Regulation: 18VAC60-21. Regulations Governing the Practice of Dentistry.**

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

**Name of Petitioner:** Dr. Jacqueline Carney.

**Nature of Petitioner's Request:** To amend 18VAC60-21-280, 18VAC60-21-291, and 18VAC60-21-301, relating to administration and monitoring of sedation and anesthesia.

**Agency Plan for Disposition of Request:** The petition will be published on February 6, 2017, in the Virginia Register of Regulations and also posted on the Virginia Regulatory Town Hall at [www.townhall.virginia.gov](http://www.townhall.virginia.gov) to receive public comment ending March 8, 2017. The request to amend regulations and any comments for or against the petition will be considered by the board at the first scheduled meeting after close of comment, which will be March 10, 2017.

**Public Comment Deadline:** March 8, 2017.

**Agency Contact:** Elaine J. Yeatts, Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4688, or email [elaine.yeatts@dhp.virginia.gov](mailto:elaine.yeatts@dhp.virginia.gov).

VA.R. Doc. No. R17-10; Filed January 15, 2017, 1:11 p.m.

#### Agency Decision

**Title of Regulation: 18VAC60-21. Regulations Governing the Practice of Dentistry.**

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

**Name of Petitioner:** Dr. Christine Barry.

**Nature of Petitioner's Request:** To add to the listing of approved providers of continuing education, "and other continuing education organizations as approved by the Board."

**Agency Decision:** Request denied.

**Statement of Reason for Decision:** At its meeting on December 9, 2016, the board discussed the request and attached documentation. Board members were also given a copy of the one public comment on the petition. The board has decided not to initiate rulemaking for two reasons: (i) the board has neither the expertise nor the resources to appropriately evaluate each course for course content, credentials of the presenter, and quality of provider; it must largely rely on established professional associations and education institutions to perform those tasks; and (ii) persons or entities that offer continuing education, such as National

Provider Compliance Corporation, have the opportunity to submit courses for approval by one of the associations or institutions currently listed in regulation, provided the courses are "continuing education programs...directly relevant to the treatment and care of patients" (18VAC60-21-250 B).

**Agency Contact:** Elaine J. Yeatts, Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4688, or email [elaine.yeatts@dhp.virginia.gov](mailto:elaine.yeatts@dhp.virginia.gov).

VA.R. Doc. No. R17-01; Filed January 18, 2017, 5:04 p.m.

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# NOTICES OF INTENDED REGULATORY ACTION

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## TITLE 9. ENVIRONMENT

### STATE WATER CONTROL BOARD

#### Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Water Control Board intends to consider amending **9VAC25-193, General Virginia Pollutant Discharge Elimination System (VPDES) Permit for Concrete Products Facilities**. The purpose of the proposed action is to amend and reissue the existing general permit that expires on September 30, 2018. The general permit will establish limitations and monitoring requirements for point source discharge of treated wastewaters from concrete products facilities to surface waters to maintain water quality. This regulatory action is necessary for existing and new concrete products permittees to be covered under this general permit regulation.

In addition, pursuant to Executive Order 17 (2014) and § 2.2-4007.1 of the Code of Virginia, the agency is conducting a periodic review and small business impact review of this regulation to determine whether this regulation should be terminated, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; (iii) is designed to achieve its intended objective in the most efficient, cost-effective manner; (iv) is clearly written and easily understandable; and (v) overlaps, duplicates, or conflicts with federal or state law or regulation. Public comment is also sought on whether technology, economic conditions, or other factors have changed in the area affected by the regulation since the last review.

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

Statutory Authority: § 62.1-44.15 of the Code of Virginia; § 402 of the Clean Water Act; 40 CFR Parts 122, 123, and 124.

Public Comment Deadline: March 8, 2017.

Agency Contact: Eleanore M. Daub, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4111, FAX (804) 698-4032, or email [elleanore.daub@deq.virginia.gov](mailto:elleanore.daub@deq.virginia.gov).

VA.R. Doc. No. R17-5019; Filed January 11, 2017, 1:23 p.m.

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# REGULATIONS

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For information concerning the different types of regulations, see the Information Page.

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## Symbol Key

Roman type indicates existing text of regulations. Underscored language indicates proposed new text. Language that has been stricken indicates proposed text for deletion. Brackets are used in final regulations to indicate changes from the proposed regulation.

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## TITLE 2. AGRICULTURE

### BOARD OF AGRICULTURE AND CONSUMER SERVICES

#### Proposed Regulation

Title of Regulation: **2VAC5-425. Vapor Pressure Requirements for Gasoline Ethanol Blends (adding 2VAC5-425-10, 2VAC5-425-20).**

Statutory Authority: §§ 59.1-153 and 59.1-156 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: April 7, 2017.

Agency Contact: Joel Maddux, Program Manager, Office of Weights and Measures, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-1274, FAX (804) 786-1571, or email joel.maddux@vdacs.virginia.gov.

Basis: Section 3.2-109 of the Code of Virginia establishes the Board of Agriculture and Consumer Services as a policy board.

Section 59.1-153 of the Code of Virginia adopts ASTM International specifications, which are adopted by the National Conference of Weights and Measures (NCWM) and published by the National Institute of Standards and Technology (NIST) in Handbook 130, Uniform Laws and Regulations in the Areas of Legal Metrology and Engine Fuel Quality, as the specifications for the inspection and testing of motor fuel and for lubricating oil. Section 59.1-153 also allows the board to amend these specifications following an informational proceeding. Additionally, subsection A of § 59.1-156 of the Code of Virginia authorizes the board to adopt regulations necessary for the inspection and testing of motor fuel and lubricating oil.

Purpose: The proposed regulation addresses the vapor pressure of ethanol blended gasoline. Currently, vapor pressure limits are established in ASTM Standard D4814 and adopted by NIST into Handbook 130. Virginia's Motor Fuels and Lubricating Oils Law incorporates NIST Handbook 130 and ASTM standards into the law. Currently, NIST provides a 1.0 psi exception to ASTM's established vapor pressure for ethanol blended gasoline. The sunset date for the psi exception provided for in NIST Handbook 130 was May 1, 2016; however, at the NCWM meeting in July 2016, the sunset date for the psi exception was extended to May 1, 2017. In March 2016, the board adopted an emergency

regulation in preparation for the May 1, 2016, sunset date. The emergency regulation became effective on April 19, 2016, and will expire on October 18, 2017. Concurrent to its adoption of an emergency regulation, the board approved a notice of intended regulatory action for the pending regulatory action.

The vapor pressure of ethanol blended gasoline is a measure of the fuel's volatility or evaporation characteristics. This pressure is regulated and manipulated by refineries to comply with federal and ASTM standards. The goal of this regulation is to continue to provide a 1.0 psi exception above the maximum vapor pressure set by ASTM to maintain the current regulatory framework for gasoline in Virginia beyond the expiration of Virginia's emergency regulation. Virginia utilizes the Colonial Pipeline, a gasoline pipeline that originates in Texas and ends in New Jersey. Without the existing emergency regulation and this proposed identical permanent regulation, Virginia would be the only state in the Colonial Pipeline that will not have a 1.0 psi exception past the sunset date prescribed in NIST Handbook 130, as the other states have either granted a waiver or adopted a regulation with the exception. This regulation protects the welfare of Virginia's citizens and businesses by ensuring that the gasoline in the Colonial Pipeline can continue to flow into and through Virginia after the expiration of Virginia's emergency regulation.

Substance: This regulation addresses the vapor pressure of ethanol blended gasoline. The vapor pressure of ethanol blended gasoline is a measure of the fuel's volatility or evaporation characteristics. Vapor pressure limits are established in ASTM Standard D4814 and adopted by NIST into Handbook 130. Vapor pressure is regulated and manipulated by refineries to comply with federal and ASTM standards. Virginia's Motor Fuels and Lubricating Oils Law incorporates NIST Handbook 130 and ASTM standards into the law. Currently, NIST provides a 1.0 psi exception to ASTM's established vapor pressure for ethanol blended gasoline. The 1.0 psi exception will expire on May 1, 2017. The proposed regulation will allow the Virginia Department of Agriculture and Consumer Services to continue to provide a 1.0 psi exception above the maximum vapor pressure set by ASTM to maintain the current regulatory framework for gasoline in Virginia.

Issues: This regulatory action is advantageous to the public and businesses. The 1.0 psi exception to the ASTM standard authorized by NIST Handbook 130 will expire on May 1, 2017, and Virginia's related emergency regulation will expire in October 2017. This regulatory action is necessary to maintain the current regulatory framework for gasoline that

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# Regulations

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businesses are accustomed to operating under in Virginia. There are no disadvantages to the public or the Commonwealth.

## Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The proposed regulation will permanently extend a one-pound per square inch exception to the ethanol blended gasoline vapor pressure standards currently in effect under an emergency regulation.

Result of Analysis. The benefits likely exceed the costs for all proposed changes.

Estimated Economic Impact. The vapor pressure in ethanol blended gasoline must conform to certain standards for proper engine operation. It must be high enough to ensure ease of engine starting; but it must be low enough to avoid an engine vapor lock or excessive evaporative emissions. Ethanol in gasoline affects the vapor pressure. A 10% ethanol content in gasoline increases the vapor pressure by about one pound per square inch.<sup>1</sup> Beginning in 1992, the Environmental Protection Agency (EPA) started to permit a one-pound exception to the vapor pressure standards to encourage consumption of ethanol blended gasoline. Similarly the National Institute of Standards and Technology (NIST), whose standards determine Virginia's standards, adopted a one-pound exception in 1994.<sup>2</sup> However, that exception to the vapor pressure was originally set to be discontinued by NIST as of May 1, 2016, but later was kept until May 1, 2017. In anticipation of the May 1, 2016, sunset date, an emergency regulation<sup>3</sup> was adopted continuing the exception in order to ensure that gasoline can legally continue to flow into and through Virginia in the Colonial Pipeline. As with many other states, Virginia relies on the Colonial Pipeline, which originates in Texas and ends in New Jersey for transportation of gasoline from the refineries. The proposed regulation will adopt the American Society for Testing and Materials (ASTM) standards (upon which NIST standards are based) directly and provide a permanent one-pound exception to the ASTM standards.

According to Virginia Department of Agriculture and Consumer Services (VDACS), all of the other states where the pipeline passes through have either granted a waiver or adopted a regulation with the exception. Without the one-pound exception, Virginia gasoline suppliers may not be able to use the Colonial Pipeline and may have to resort to other costlier modes of gasoline transportation. Any such additional costs would then likely be at least partially passed on to consumers. In addition, the one-pound exception had been allowed since 1994 without any known problems.<sup>4</sup> The main impact of the proposed regulation is avoidance of costlier modes of gasoline transportation without a discernible impact on proper engine operation. Therefore, the proposed regulation should produce a net economic benefit. However, it should be noted that no significant economic change is

expected upon promulgation of this regulation as it will continue the status quo.

Businesses and Entities Affected. VDACS estimates that there are approximately 155 motor fuel distributors or dealers in Virginia. About 40 to 60 percent of them are estimated to be small businesses. In addition, avoidance of higher transportation costs would benefit the ethanol blended gasoline consumers.

Localities Particularly Affected. The proposed changes apply statewide.

Projected Impact on Employment. No impact on employment is expected upon promulgation of the proposed regulation.

Effects on the Use and Value of Private Property. No impact on the use and value of private property is expected.

Real Estate Development Costs. No impact on real estate development costs is expected.

### Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million."

Costs and Other Effects. About 40 to 60 percent of the motor fuel distributors or dealers are estimated to be small businesses.<sup>5</sup> The proposed regulation does not impose costs on any entities, but it will benefit distributors or dealers by allowing them to legally use the Colonial Pipeline for transportation of gasoline.

Alternative Method that Minimizes Adverse Impact. No adverse impact on small businesses is expected.

### Adverse Impacts:

Businesses. The proposed amendments do not have an adverse impact on non-small businesses.

Localities. The proposed amendments will not adversely affect localities.

Other Entities. The proposed amendments will not adversely affect other entities.

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<sup>1</sup> Source: EPA

<sup>2</sup> Virginia's vapor pressure tolerances for gasoline ethanol blends are set in § 59.1-153 of the Motor Fuels and Lubricating Oils Law, which incorporates the National Institute of Standards and Technology Handbook 130, which utilizes the ASTM standards. See <http://law.lis.virginia.gov/vacode/title59.1/chapter12/section59.1-153/> for Virginia Code § 59.1-153.

<sup>3</sup> <http://townhall.virginia.gov/ViewStage.cfm?stageid=7500>

<sup>4</sup> Source: VDACS

<sup>5</sup> Source: VDACS

Agency's Response to Economic Impact Analysis: The agency concurs with the analysis of the Department of Planning and Budget.

**Summary:**

*The proposed regulatory action establishes a new chapter, 2VAC5-525, to address the vapor pressure requirements for ethanol blended gasoline in Virginia. Specifically, it provides a 1.0 pounds per square inch exception to the maximum vapor pressure set by ASTM International as currently outlined in the National Institute of Standards and Technology Handbook 130, Section 2.1.2., which is incorporated into Virginia's motor fuels and lubricating oils law.*

**CHAPTER 425****VAPOR PRESSURE REQUIREMENTS FOR GASOLINE  
ETHANOL BLENDS****2VAC5-425-10. Definitions.**

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

"ASTM D4806-16a" means the Standard Specification for Denatured Fuel Ethanol for Blending with Gasolines for Use as Automotive Spark-Ignition Engine Fuel published by ASTM International in February 2016.

"ASTM D4814-16a" means the Standard Specification for Automotive Spark-Ignition Engine Fuel published by ASTM International in February 2016.

"psi" means pounds per square inch.

"Volatility class A" means fuel with a vapor pressure and distillation designation of "A" set forth in Table 1 Vapor Pressure and Distillation Class Requirements of ASTM D4814-16a.

"Volatility class B" means fuel with a vapor pressure and distillation designation of "B" set forth in Table 1 Vapor Pressure and Distillation Class Requirements of ASTM D4814-16a.

"Volatility class C" means fuel with a vapor pressure and distillation designation of "C" set forth in Table 1 Vapor Pressure and Distillation Class Requirements of ASTM D4814-16a.

"Volatility class D" means fuel with a vapor pressure and distillation designation of "D" set forth in Table 1 Vapor Pressure and Distillation Class Requirements of ASTM D4814-16a.

"Volatility class E" means fuel with a vapor pressure and distillation designation of "E" set forth in Table 1 Vapor Pressure and Distillation Class Requirements of ASTM D4814-16a.

**2VAC5-425-20. Vapor pressure requirements; exceptions.**

When gasoline is blended with ethanol, the ethanol shall meet the requirements of ASTM D4806-16a and the blend shall meet the requirements of ASTM D4814-16a, with following permissible exceptions:

1. For blends containing nine to 10 volume percent ethanol, the maximum vapor pressure shall not exceed the

ASTM D4814-16a limits by more than 1.0 psi during the period of June 1 through September 15.

2. For blends containing one or more volume percent ethanol for volatility class A, B, C, or D, the maximum vapor pressure shall not exceed ASTM D4814-16a limits by more than 1.0 psi during the period of September 16 through May 31.

3. For blends containing one or more volume percent ethanol for volatility class E, the maximum vapor pressure shall not exceed ASTM D4814-16a limits by more than 0.5 psi during the period of September 16 through May 31.

**DOCUMENTS INCORPORATED BY REFERENCE  
(2VAC5-425)**

[Standard Specification for Automotive Spark-Ignition Engine Fuel, ASTM D4814-16a, February 2016, ASTM International, P.O. Box C700, West Conshohocken, PA 19428, www.astm.org](#)

[Standard Specification for Denatured Fuel Ethanol for Blending with Gasolines for Use as Automotive Spark-Ignition Engine Fuel, ASTM D4806-16a, February 2016, ASTM International, P.O. Box C700, West Conshohocken, PA 19428, www.astm.org](#)

VA.R. Doc. No. R16-4644; Filed January 17, 2017, 2:49 p.m.

**TITLE 3. ALCOHOLIC BEVERAGES****ALCOHOLIC BEVERAGE CONTROL BOARD****Fast-Track Regulation**

**Title of Regulation:** 3VAC5-70. **Other Provisions (amending 3VAC5-70-10).**

**Statutory Authority:** §§ 4.1-103 and 4.1-111 of the Code of Virginia.

**Public Hearing Information:** No public hearings are scheduled.

**Public Comment Deadline:** March 31, 2017.

**Effective Date:** April 15, 2017.

**Agency Contact:** LaTonya D. Hucks, Legal Liaison, Department of Alcoholic Beverage Control, 2901 Hermitage Road, Richmond, VA 23220, telephone (804) 213-4698, FAX (804) 213-4574, or email latonya.hucks@abc.virginia.gov.

**Basis:** Section 4.1-103 of the Code of Virginia authorizes the Alcoholic Beverage Control Board to promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and § 4.1-111 of the Code of Virginia.

Section 4.1-111 of the Code of Virginia authorizes the board the authority to promulgate reasonable regulations necessary to carry out the provision of Title 4.1 of the Code of Virginia.



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# Regulations

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Section 4.1-212 of the Code of Virginia grants the board the authority to issue permits for the transportation of alcoholic beverages within or through the Commonwealth.

Purpose: The purpose of the amendments is to eliminate the requirement for the agency to issue a permit to commercial carriers (now motor carriers) regularly engaged in the transportation of alcoholic beverages within or through the Commonwealth. The amendment adds language to require motor carriers transporting alcoholic beverages to have in their possession a bill of lading or other commercial document describing the alcoholic beverages being transported and showing the names and addresses of the consignor and consignee who may lawfully ship and receive such shipment and requires that such documentation be provided to special agents of the board or any law-enforcement officer for inspection upon request.

Currently transportation permits are issued without cost. The agency has no electronic means to track these permits and as such they are not readily accessible to law-enforcement agencies. The amended language will bring regulation into conformity with current practice of the agency of deeming shipments of alcoholic beverages to be legal provided the motor carrier has bill of lading or other commercial document in its possession.

The amendments will have no impact on the public's safety. The proposed amendment will provide law enforcement the ability to quickly determine the legality of the shipment of alcoholic beverages.

Rationale for Using Fast-Track Rulemaking Process: This proposal is expected to be noncontroversial as it reduces a regulatory requirement on the transportation industry.

Substance: The amendments eliminate the requirement for motor carriers to obtain a transportation permit to lawfully transport alcoholic beverages within or through the Commonwealth provided that they have a bill of lading or other commercial document in their possession while transporting alcoholic beverages.

Issues: The primary advantage for the agency and the transportation industry is to conform current language to standard practices of this industry and eliminate a regulatory burden on motor carriers. The agency benefits by not having to expend personnel resources in issuing the no cost permits. There are no disadvantages to the public or the Commonwealth.

## Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Alcoholic Beverage Control Board (Board) proposes to amend its Other Provisions regulation to eliminate the requirement that commercial carriers engaged in the regular transport of alcoholic beverages within or through Virginia obtain a Board permit for such transportation. Instead of requiring a permit, the Board proposes to allow carriers to use

bills of lading<sup>1</sup> or other commercial memorandum describing what is being shipped and the addresses and names of who is shipping the alcohol and who is receiving it.

Result of Analysis. Benefits outweigh costs for all proposed changes.

Estimated Economic Impact. Current regulation requires commercial carriers who will be transporting alcohol in or through Virginia to first obtain a permit from the Board to do so. This permit allows the Board to know what is being shipped and allows special agents of the board and law-enforcement officers to check shipments when necessary to ensure that the permit matches the cargo. Although there is no fee charged to commercial carriers for Board issued permits, they still incur time costs for obtaining this extra document. The Board also incurs costs for staff time to issue such permits.

The Board proposes to eliminate the requirement that commercial carriers obtain a permit and instead let them use bills of lading and other commercial memorandum that they would have in their possession as a matter of course when completing the commercial transaction of shipping cargo in the same manner that permits are now used. Commercial carriers will be required to have this documentation in their possession and present it to special agents of the Board or law-enforcement officers if asked. Since carriers already have documentation of their shipments for verification of receipt and delivery of cargo, no entities are likely to incur costs on account of this proposed regulation. Both commercial carriers and Board staff are likely to see small saving for time not spent on obtaining or issuing permits.

Businesses and Entities Affected. These proposed regulatory changes will affect all commercial carriers who transport alcoholic beverages in or through the Commonwealth of Virginia.

Localities Particularly Affected. No locality is likely to be particularly affected by these proposed regulatory changes.

Projected Impact on Employment. These proposed regulatory changes are unlikely to affect employment in the Commonwealth.

Effects on the Use and Value of Private Property. These proposed regulatory changes are unlikely to affect the use or value of private property in the Commonwealth.

Real Estate Development Costs. These proposed regulatory changes are unlikely to affect real estate development costs in the Commonwealth.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million."

Costs and Other Effects. No small businesses will be adversely affected by these proposed regulatory changes.

Alternative Method that Minimizes Adverse Impact. No small businesses will be adversely affected by these proposed regulatory changes.

Adverse Impacts:

Businesses. No businesses will be adversely affected by these proposed regulatory changes.

Localities. Localities in the Commonwealth are unlikely to see any adverse impacts on account of these proposed regulatory changes.

Other Entities. No other entities are likely to be adversely affected by these proposed changes.

<sup>1</sup> A bill of lading is a document issued by a carrier or its agent to acknowledge receipt of cargo for shipment.

Agency's Response to Economic Impact Analysis: The Department of Alcoholic Beverage Control concurs with the economic impact analysis prepared by the Department of Planning and Budget.

Summary:

*The amendments eliminate the requirement for the board to issue a permit to commercial carriers engaged in the regular transportation of alcoholic beverages within or through the Commonwealth by adding the requirement that (i) motor carriers transporting alcoholic beverages have in their possession a bill of lading or other commercial memorandum describing the alcoholic beverages being shipped and the name and address of the consignor and consignee who lawfully may ship and receive such alcoholic beverages and (ii) a motor carrier transporting alcoholic beverages make the bill of lading or commercial memorandum available for inspection by special agents of the board or any law-enforcement officer upon request.*

**3VAC5-70-10. Transportation of alcoholic beverages; noncommercial permits; commercial carrier permits; refusal, suspension or revocation of permits; exceptions; out-of-state limitation not affected.**

A. The transportation within or through this Commonwealth of alcoholic beverages lawfully purchased within this Commonwealth is prohibited, except upon a permit issued by the board, when in excess of the following limits:

1. Wine and beer. No limitation.
2. Alcoholic beverages other than those described in subdivision 1 of this subsection. Three gallons; provided, however, that not more than one gallon thereof shall be in containers containing less than ~~&frac15;~~ 1/5 of a gallon.

If any part of the alcoholic beverages being transported is contained in a metric-sized container, the three-gallon limitation shall be construed to be 12 liters, and not more than four liters shall be in containers smaller than 750 milliliters.

The transportation within, into, or through this Commonwealth of alcoholic beverages lawfully purchased outside of this Commonwealth is prohibited, except upon a

permit issued by the board, when in excess of the following limits:

Alcoholic beverages, including wine and beer. One gallon (four liters if any part is in a metric-sized container).

If satisfied that the proposed transportation is otherwise lawful, the board shall issue a transportation permit, which shall accompany the alcoholic beverages at all times to the final destination.

B. Commercial carriers desiring to engage regularly in the transportation of alcoholic beverages within, into, or through this Commonwealth shall, except as hereinafter noted, ~~file application in writing for a transportation permit~~ obtain a transportation permit from the board or otherwise possess acceptable documentation as required by the following provisions.

A transportation permit may be obtained by filing an application in writing upon forms furnished by the board. If satisfied that the proposed transportation is otherwise lawful, the board shall issue a transportation permit. Such permit shall not be transferable and shall authorize the carrier to engage in the regular transportation of alcoholic beverages upon condition that there shall accompany each such transporting vehicle: ~~1. A bill of lading or other memorandum describing the alcoholic beverages being transported, and showing the names and addresses of the consignor and consignee, who shall be lawfully entitled to make and to receive the shipment; and 2. Except for express companies and carriers by rail or air, a certified photocopy of the carrier's transportation permit.~~ Such a bill of lading or other memorandum may serve as a transportation permit so long as it is made available for inspection to special agents of the board or any law-enforcement officer upon request.

C. The board may refuse, suspend, or revoke a carrier's transportation permit, including the use of a bill of lading or other memorandum as a transportation permit as provided in subsection B of this section, if it shall have reasonable cause to believe that alcoholic beverages have been illegally transported by such carrier or that such carrier has violated any condition of a permit. Before refusing, suspending, or revoking such permit, the board shall accord the carrier involved the same notice, and opportunity to be heard, and follow the same administrative procedures accorded an applicant or licensee under Title 4.1 of the Code of Virginia.

D. There shall be exempt from the requirements of this section:

1. Common carriers by water engaged in transporting lawfully acquired alcoholic beverages for a lawful consignor to a lawful consignee;
2. Persons transporting wine, beer, or cider purchased from the board or a licensee;
3. Persons transporting alcoholic beverages ~~which that~~ which that may be manufactured and sold without a license;

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4. A licensee transporting lawfully acquired alcoholic beverages he is authorized to sell in a vehicle owned or leased by the licensee;

5. Persons transporting alcoholic beverages to the board, or to licensees, provided that a bill of lading or a complete and accurate memorandum accompanies the shipment, and provided further, in the case of the licensee, that the merchandise is such as his license entitles him to sell;

6. Persons transporting alcoholic beverages as a part of their official duties as federal, state, or municipal officers or employees; and

7. Persons transporting lawfully acquired alcoholic beverages in a passenger vehicle, other than those alcoholic beverages referred to in subdivisions D 2 and D 3 of this section, provided the same are in the possession of the bona fide owners thereof; and that no occupant of the vehicle possesses any alcoholic beverages in excess of the maximum limitations set forth in subsection A of this section.

E. This section shall not be construed to alter the one-gallon (four liters if any part is in a metric-sized container) limitation upon alcoholic beverages which that may be brought into the Commonwealth pursuant to § 4.1-310 E of the Code of Virginia.

VA.R. Doc. No. R17-4755; Filed January 18, 2017, 2:15 p.m.



## TITLE 4. CONSERVATION AND NATURAL RESOURCES

### MARINE RESOURCES COMMISSION

#### Final Regulation

**REGISTRAR'S NOTICE:** The Marine Resources Commission is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 11 of the Code of Virginia; however, the commission is required to publish the full text of final regulations.

**Title of Regulation:** 4VAC20-252. Pertaining to the Taking of Striped Bass (amending 4VAC20-252-150).

**Statutory Authority:** § 28-2.201 of the Code of Virginia.

**Effective Date:** January 25, 2017.

**Agency Contact:** Jennifer Farmer, Regulatory Coordinator, Marine Resources Commission, 2600 Washington Avenue, 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, or email jennifer.farmer@mrc.virginia.gov.

**Summary:**

*The amendments lower the individual commercial harvest quota from 138,640 to 136,141 pounds.*

#### 4VAC20-252-150. Individual commercial harvest quota.

A. The commercial harvest quota for the Chesapeake area shall be determined annually by the Marine Resources Commission. The total allowable level of all commercial harvest of striped bass from the Chesapeake Bay and its tributaries and the Potomac River tributaries of Virginia for all open seasons and for all legal gear shall be 1,064,997 pounds of whole fish. At such time as the total commercial harvest of striped bass from the Chesapeake area is projected to reach 1,064,997 pounds, and announced as such, it shall be unlawful for any person to land or possess striped bass caught for commercial purposes from the Chesapeake area.

B. The commercial harvest quota for the coastal area of Virginia shall be determined annually by the Marine Resources Commission. The total allowable level of all commercial harvest of striped bass from the coastal area for all open seasons and for all legal gear shall be ~~138,640~~ 136,141 pounds of whole fish. At such time as the total commercial harvest of striped bass from the coastal area is projected to reach ~~138,640~~ 136,141 pounds, and announced as such, it shall be unlawful for any person to land or possess striped bass caught for commercial purposes from the coastal area.

C. For the purposes of assigning an individual's tags for commercial harvests in the Chesapeake area as described in 4VAC20-252-160, the individual commercial harvest quota of striped bass in pounds shall be converted to an estimate in numbers of fish per individual harvest quota based on the average weight of striped bass harvested by the permitted individual during the previous fishing year. The number of striped bass tags issued to each individual will equal the estimated number of fish to be landed by that individual harvest quota, plus a number of striped bass tags equal to 10% of the total allotment determined for each individual.

D. For the purposes of assigning an individual's tags for commercial harvests in the coastal area of Virginia as described in 4VAC20-252-160, the individual commercial harvest quota of striped bass in pounds shall be converted to a quota in numbers of fish per individual commercial harvest quota, based on the reported average coastal area harvest weight of striped bass harvested by the permitted individual during the previous fishing year, except as described in subsection E of this section. The number of striped bass tags issued to each individual will equal the estimated number of fish to be landed by that individual harvest quota, plus a number of striped bass tags equal to 10% of the total allotment determined for each individual.

E. For any individual whose reported average coastal area harvest weight of striped bass in the previous fishing year was less than 12 pounds, a 12-pound minimum weight shall be used to convert that individual's harvest quota of striped bass, in pounds of fish, to harvest quota in number of fish.

VA.R. Doc. No. R17-5022; Filed January 24, 2017, 4:28 p.m.



**TITLE 9. ENVIRONMENT**

**VIRGINIA WASTE MANAGEMENT BOARD**

**Forms**

REGISTRAR'S NOTICE: A form used in administering the following regulation has been filed by the Virginia Waste Management Board. The form is not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of the form to access it. The form is also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

Title of Regulation: **9VAC20-130. Solid Waste Planning and Recycling Regulations.**

Contact Information: Debra Harris, Department of Environmental Quality, Policy and Planning Specialist, 629 East Main Street, Richmond, VA 23219, telephone (804) 698-4209, or email [debra.harris@deq.virginia.gov](mailto:debra.harris@deq.virginia.gov).

FORMS (9VAC20-130)

~~Locality Recycling Rate Report for Calendar Year 2014, DEQ Form 50-30 (rev. 10/14)~~

[Locality Recycling Rate Report for Calendar Year 2016, DEQ Form 50-30 \(rev. 12/2016\)](#)

VA.R. Doc. No. R17-5001; Filed January 12, 2017, 10:31 a.m.



**TITLE 12. HEALTH**

**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

**Final Regulation**

Titles of Regulations: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-130).**

**12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-25).**

**12VAC30-70. Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services (amending 12VAC30-70-201, 12VAC30-70-321; adding 12VAC30-70-415, 12VAC30-70-417).**

**12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-21).**

**12VAC30-130. Amount, Duration and Scope of Selected Services (amending 12VAC30-130-850, 12VAC30-130-890).**

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Effective Date: March 8, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email [emily.mcclellan@dmas.virginia.gov](mailto:emily.mcclellan@dmas.virginia.gov).

Summary:

*As a result of a federal court decision, the Department of Medical Assistance Services (DMAS) is changing the requirements for inpatient psychiatric facilities (IPFs) and providers that offer certain services, such as physician, medical, psychological, vision, dental, and emergency services, to residents of IPFs. The affected IPFs are state freestanding psychiatric hospitals, private freestanding psychiatric hospitals, and residential treatment facilities (Level C). Item 307 CCC of Chapter 3 of the 2012 Acts of Assembly, Special Session I, directs DMAS to develop changes to requirements for nonfacility services furnished to individuals residing in IPFs to comply with the court order and a prospective payment methodology to reimburse institutions treating mental disease (residential treatment centers and freestanding psychiatric hospitals) for services furnished by the facility and by others.*

*Item 307 CCC of Chapter 806 of the 2013 Acts of Assembly directs DMAS to require that institutions that treat mental diseases provide referral services to their inpatients when an inpatient needs ancillary services. Item 301 XX of Chapter 3 of the 2014 Acts of Assembly, Special Session I, and Item 301 XX of Chapter 665 of the 2015 Acts of Assembly direct DMAS to revise reimbursement for services furnished to Medicaid members in residential treatment centers and freestanding psychiatric hospitals to include professional, pharmacy, and other services to be reimbursed separately as long as the services are in the plan of care developed by the residential treatment center or the freestanding psychiatric hospital and arranged by the residential treatment center or the freestanding psychiatric hospital.*

*The amendments conform the regulations to these requirements.*

Summary of Public Comments and Agency's Response: No public comments were received by the promulgating agency.

**12VAC30-50-130. Skilled ~~nursing~~ Nursing facility services, EPSDT, including school health services and family planning.**

A. ~~Skilled nursing~~ 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.

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

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1. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

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

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

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

5. Community mental health services. These services in order to be covered (i) shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and (ii) are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.

"Adolescent or child" means the individual receiving the services described in this section. For the purpose of the use of these terms, adolescent means an individual 12-20 years of age; a child means an individual from birth up to 12 years of age.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Certified prescriber" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

"EPSDT" means early and periodic screening, diagnosis, and treatment.

"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Licensed mental health professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous

compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed.

Progress notes shall be documented for each service that is billed.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

"Services provided under arrangement" means the same as defined in 12VAC30-130-850.

b. Intensive in-home services (IIH) to children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and

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when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

(1) These services shall be limited annually to 26 weeks. Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

(2) Service authorization shall be required for services to continue beyond the initial 26 weeks.

(3) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(4) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

c. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family counseling.

(1) Service authorization shall be required for Medicaid reimbursement.

(2) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

Requirements for service-specific provider intakes and ISPs are set out in this section.

(3) These services may be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

d. Community-based services for children and adolescents under 21 years of age (Level A) pursuant to 42 CFR 440.130(d).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual<sup>®</sup> Criteria or an equivalent standard authorized in advance by DMAS, shall be required for this service.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

(3) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(4) Authorization shall be required for Medicaid reimbursement. Services that were rendered before the date of service authorization shall not be reimbursed.

(5) Room and board costs shall not be reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), ~~Standards for Interim Regulation of Children's Residential Facilities (6VAC35-51)~~ Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), or Regulations for Children's Residential Facilities (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week.

Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, stress management, and any care coordination activities.

(8) The facility/group home must coordinate services with other providers. Such care coordination shall be documented in the individual's medical record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

(9) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(10) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

e. Therapeutic behavioral services (Level B) pursuant to 42 CFR 440.130(d).

(1) Such services must be therapeutic services rendered in a residential setting that ~~provides~~ provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual<sup>®</sup> Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.

(2) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.

(3) Room and board costs shall not be reimbursed. Facilities that only provide independent living services are not reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(4) These residential providers must be licensed by the Department of Behavioral Health and Developmental

Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

(6) The individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

(7) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(8) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services that are based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(9) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

(10) The facility/group home shall coordinate necessary services with other providers. Documentation of this care coordination shall be maintained by the facility/group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays in inpatient psychiatric facilities described in 42 CFR 440.160(b)(1) and (b)(2) for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by: ~~a. A~~ (i) a psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or (ii) a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations; or the Commission on Accreditation of Rehabilitation Facilities; the Council on Accreditation of Services for Families and Children or the Council on Quality and Leadership. b. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of ~~Amount, Duration and Scope of Selected Services~~ 12VAC30-130.



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a. The inpatient psychiatric services benefit for individuals younger than 21 years of age shall include services defined at 42 CFR 440.160 that are provided under the direction of a physician pursuant to a certification of medical necessity and plan of care developed by an interdisciplinary team of professionals and shall involve active treatment designed to achieve the child's discharge from inpatient status at the earliest possible time. The inpatient psychiatric services benefit shall include services provided under arrangement furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient psychiatric facility (i) arranges for and oversees the provision of all services, (ii) maintains all medical records of care furnished to the individual, and (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral.

b. Eligible services provided under arrangement with the inpatient psychiatric facility shall vary by provider type as described in this subsection. For purposes of this section, emergency services means the same as is set out in 12VAC30-50-310 B.

(1) State freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) pharmacy services and (ii) emergency services.

(2) Private freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) outpatient hospital services; (iii) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (iv) laboratory and radiology services; (v) vision services; (vi) dental, oral surgery, and orthodontic services; (vii) transportation services; and (viii) emergency services.

(3) Residential treatment facilities, as defined at 42 CFR 483.352, shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) pharmacy services; (iii) outpatient hospital services; (iv) physical

therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (v) laboratory and radiology services; (vi) durable medical equipment; (vii) vision services; (viii) dental, oral surgery, and orthodontic services; (ix) transportation services; and (x) emergency services.

c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with (i) 42 CFR Part 441 Subpart D, as ~~contained in~~ specifically 42 CFR 441.151(a) and (b) and 441.152 through 441.156, and (ii) the conditions of participation in 42 CFR Part 483 Subpart G. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

d. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT.

7. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

## C. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Service providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Service providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers; but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services;

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as

physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with intellectual disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialist, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D (12VAC30-50-530). Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

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g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

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

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

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

## **12VAC30-60-25. Utilization control: freestanding psychiatric hospitals.**

A. Psychiatric services in freestanding psychiatric hospitals shall only be covered for eligible persons younger than 21 years of age and older than 64 years of age.

B. Prior authorization required. DMAS shall monitor, consistent with state law, the utilization of all inpatient freestanding psychiatric hospital services. All inpatient hospital stays shall be preauthorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

C. All Medicaid services are subject to utilization review and audit. Absence of any of the required documentation may result in denial or retraction of any reimbursement. In each case for which payment for freestanding psychiatric hospital services is made under the State Plan:

1. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a freestanding psychiatric hospital consistent with 42 CFR 456.160.

2. The physician, physician assistant, or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician, must recertify at least every 60 days that the individual continues to require inpatient services in a psychiatric hospital.

3. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must perform a medical evaluation of the individual and appropriate professional personnel must make a psychiatric and social evaluation as cited in 42 CFR 456.170.

4. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each recipient patient as cited in 42 CFR 441.155 and 456.180. The plan shall also include a list of services provided under written contractual arrangement with the freestanding psychiatric hospital (see 12VAC30-50-130) that will be furnished to the patient through the freestanding psychiatric hospital's referral to an employed or contracted provider, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought.

D. If the eligible individual is 21 years of age or older, then, in order to qualify for Medicaid payment for this service, he must be at least 65 years of age.

E. If younger than 21 years of age, it shall be documented that the individual requiring admission to a freestanding psychiatric hospital is under 21 years of age, that treatment is medically necessary, and that the necessity was identified as a result of an early and periodic screening, diagnosis, and treatment (EPSDT) screening. Required patient documentation shall include, but not be limited to, the following:

1. An EPSDT physician's screening report showing the identification of the need for further psychiatric evaluation and possible treatment.

2. A diagnostic evaluation documenting a current (active) psychiatric disorder included in the DSM-III-R that supports the treatment recommended. The diagnostic evaluation must be completed prior to admission.

3. For admission to a freestanding psychiatric hospital for psychiatric services resulting from an EPSDT screening, a certification of the need for services as defined in 42 CFR 441.152 by an interdisciplinary team meeting the requirements of 42 CFR 441.153 or 441.156 and ~~the~~ The Psychiatric Inpatient Treatment of Minors Act (§ 16.1-335 et seq. of the Code of Virginia).

F. If a Medicaid eligible individual is admitted in an emergency to a freestanding psychiatric hospital on a Saturday, Sunday, holiday, or after normal working hours, it shall be the provider's responsibility to obtain the required authorization on the next work day following such an admission.

G. The absence of any of the required documentation described in this subsection shall result in DMAS' denial of the requested preauthorization and coverage of subsequent hospitalization.

~~F.~~ H. To determine that the DMAS enrolled mental hospital providers are in compliance with the regulations governing mental hospital utilization control found in the 42 CFR 456.150, an annual audit will be conducted of each enrolled hospital. This audit may be performed either on site or as a desk audit. The hospital shall make all requested records

available and shall provide an appropriate place for the auditors to conduct such review if done on site. The audits shall consist of review of the following:

1. Copy of the mental hospital's Utilization Management Plan to determine compliance with the regulations found in the 42 CFR 456.200 through 456.245.
2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in the 42 CFR 456.205 and 456.206.
3. Verification of Utilization Management Committee meetings, including dates and list of attendees to determine that the committee is meeting according to their utilization management meeting requirements.
4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with 42 CFR 456.241 through 456.245.
5. Topic of one ongoing Medical Care Evaluation Study to determine the hospital is in compliance with 42 CFR 456.245.
6. From a list of randomly selected paid claims, the freestanding psychiatric hospital must provide a copy of the certification for services, a copy of the physician admission certification, a copy of the required medical, psychiatric, and social evaluations, and the written plan of care for each selected stay to determine the hospital's compliance with §§ 16.1-335 through 16.1-348 of the Code of Virginia and 42 CFR 441.152, 456.160, 456.170, 456.180 and 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may be retracted.

I. The freestanding psychiatric hospital shall not receive a per diem reimbursement for any day that:

1. The initial or comprehensive written plan of care fails to include within three business days of the initiation of the service provided under arrangement all services that the individual needs while at the freestanding psychiatric hospital and that will be furnished to the individual through the freestanding psychiatric hospital's referral to an employed or contracted provider of services under arrangement;
2. The comprehensive plan of care fails to include within three business days of the initiation of the service the prescribed frequency of such service or includes a frequency that was exceeded;
3. The comprehensive plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;
4. The referral to the service provided under arrangement was not present in the patient's freestanding psychiatric hospital record;

5. The service provided under arrangement was not supported in that provider's records by a documented referral from the freestanding psychiatric hospital;

6. The medical records from the provider of services under arrangement (i.e., admission and discharge documents, treatment plans, progress notes, treatment summaries, and documentation of medical results and findings) (i) were not present in the patient's freestanding psychiatric hospital record or had not been requested in writing by the freestanding psychiatric hospital within seven days of completion of the service or services provided under arrangement or (ii) had been requested in writing within seven days of completion of the service or services, but had not been received within 30 days of the request, and had not been re-requested;

7. The freestanding psychiatric hospital did not have a fully executed contract or an employee relationship with the provider of services under arrangement in advance of the provision of such services. For emergency services, the freestanding psychiatric hospital shall have a fully executed contract with the emergency services hospital provider prior to submission of the ancillary provider's claim for payment.

J. The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service billed prior to receiving a referral from the freestanding psychiatric hospital or in excess of the amounts in the referral.

K. The hospitals may appeal in accordance with the Administrative Process Act (§ ~~9-6.14:1~~ 2.2-4000 et seq. of the Code of Virginia) any adverse decision resulting from such audits ~~which that~~ results in retraction of payment. The appeal must be requested ~~within 30 days of the date of the letter notifying the hospital of the retraction~~ pursuant to the requirements of 12VAC30-20-500 et seq.

Part V

Inpatient Hospital Payment System

Article 1

Application of Payment Methodologies

**12VAC30-70-201. Application of payment methodologies.**

A. The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12VAC30-70-221 et seq.) of this part describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12VAC30-70-400 et seq.) of this part describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998; and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals shall be

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subject to the provisions of Supplement 3 (12VAC30-70-10 through 12VAC30-70-130).

C. Inpatient hospital facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) shall be reimbursed costs except for inpatient psychiatric services furnished under early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals younger than age 21. These inpatient services shall be reimbursed according to 12VAC30-70-415 and shall be provided according to the requirements set forth in 12VAC30-50-130 and 12VAC30-60-25 H. Facilities may also receive disproportionate share hospital (DSH) payments. The criteria for DSH eligibility and the payment amount shall be based on subsection F of 12VAC30-70-50. If the DSH limit is exceeded by any facility, the excess DSH payments shall be distributed to all other qualifying DBHDS facilities in proportion to the amount of DSH they otherwise receive.

D. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre-hospitalization and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

E. Reduction of payments methodology.

1. For state fiscal years 2003 and 2004, the Department of Medical Assistance Services (DMAS) shall reduce payments to hospitals participating in the Virginia Medicaid Program by \$8,935,825 total funds, and \$9,227,815 total funds respectively. For purposes of distribution, each hospital's share of the total reduction amount shall be determined as provided in this subsection.

2. Determine base for revenue forecast.

a. DMAS shall use, as a base for determining the payment reduction distribution for hospitals Type I and Type II, net Medicaid inpatient operating reimbursement and outpatient reimbursed cost, as recorded by DMAS

for state fiscal year 1999 from each individual hospital settled cost reports. This figure is further reduced by 18.73%, which represents the estimated statewide HMO average percentage of Medicaid business for those hospitals engaged in HMO contracts, to arrive at net baseline proportion of non-HMO hospital Medicaid business.

b. For freestanding psychiatric hospitals, DMAS shall use estimated Medicaid revenues for the six-month period (January 1, 2001, through June 30, 2001), times two, and adjusted for inflation by 4.3% for state fiscal year 2002, 3.1% for state fiscal year 2003, and 3.7% for state fiscal year 2004, as reported by DRI-WEFA, Inc.'s, hospital input price level percentage moving average.

3. Determine forecast revenue.

a. Each Type I hospital's individual state fiscal year 2003 and 2004 forecast reimbursement is based on the proportion of non-HMO business (see subdivision 2 a of this subsection) with respect to the DMAS forecast of SFY 2003 and 2004 inpatient and outpatient operating revenue for Type I hospitals.

b. Each Type II, including freestanding psychiatric, hospital's individual state fiscal year 2003 and 2004 forecast reimbursement is based on the proportion of non-HMO business (see subdivision 2 of this subsection) with respect to the DMAS forecast of SFY 2003 and 2004 inpatient and outpatient operating revenue for Type II hospitals.

4. Each hospital's total yearly reduction amount is equal to ~~the~~ its respective state fiscal year 2003 and 2004 forecast reimbursement as described in subdivision 3 of this subsection, times 3.235857% for state fiscal year 2003, and 3.235857%, for the first two quarters of state fiscal year 2004 and 2.88572% for the last two quarters of state fiscal year 2004, not to be reduced by more than \$500,000 per year.

5. Reductions shall occur quarterly in four amounts as offsets to remittances. Each hospital's payment reduction shall not exceed that calculated in subdivision 4 of this subsection. Payment reduction offsets not covered by claims remittance by May 15, 2003, and 2004, will be billed by invoice to each provider with the remaining balances payable by check to the Department of Medical Assistance Services before June 30, 2003, or 2004, as applicable.

F. Consistent with 42 CFR 447.26 and effective July 1, 2012, the Commonwealth shall not reimburse inpatient hospitals for provider-preventable conditions (PPCs), which include:

1. Health care-acquired conditions (HCACs). HCACs are conditions occurring in any hospital setting, identified as a hospital-acquired condition (HAC) by Medicare other than deep vein thrombosis (DVT)/pulmonary embolism (PE)

following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

2. Other provider preventable conditions (OPPCs) as follows: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; or (iii) surgical or other invasive procedure performed on the wrong patient.

**12VAC30-70-321. Hospital specific operating rate per day.**

A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12VAC30-70-341, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per day.

B. For rural hospitals, the hospital's Medicare wage index used in this section shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher.

C. Effective July 1, 2008, and ending after June 30, 2010, the hospital specific operating rate per day shall be reduced by 2.683%.

~~D. The hospital specific rate per day for freestanding psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of this section plus the hospital specific capital rate per day for freestanding psychiatric cases.~~

~~E. The hospital specific capital rate per day for freestanding psychiatric cases shall be equal to the Medicare geographic adjustment factor for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12VAC30-70-271.~~

~~F. The statewide capital rate per day for freestanding psychiatric cases shall be equal to the weighted average of the GAF standardized capital cost per day of freestanding psychiatric facilities licensed as hospitals.~~

~~G. The capital cost per day of freestanding psychiatric facilities licensed as hospitals shall be the average charges per day of psychiatric cases times the ratio total capital cost to total charges of the hospital, using data available from Medicare cost report.~~

**12VAC30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT.**

A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12VAC30-70-321 plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's

geographic area times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12VAC30-70-271.

C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio total of capital cost to total charges of the hospital, using data available from Medicare cost report.

E. Effective July 1, 2014, services provided under arrangement, as defined in subdivisions B 6 a and B 6 b of 12VAC30-50-130, shall be reimbursed directly by DMAS, according to the reimbursement methodology prescribed for each provider in 12VAC30-80 or elsewhere in the State Plan, to a provider of services under arrangement if all of the following are met:

1. The services are included in the active treatment plan of care developed and signed as described in subdivision C 4 of 12VAC30-60-25; and

2. The services are arranged and overseen by the freestanding psychiatric hospital treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the freestanding psychiatric hospital or under contract for services provided under arrangement.

**12VAC30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT.**

A. Effective January 1, 2000, DMAS shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers under the terms and payment methodology described in this section.

B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by DMAS based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all services provided under arrangement that are reimbursed in the manner described in subsection D of this section.

C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by DMAS at such time as required by DMAS. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, DMAS shall take action in accordance with its policies to assure that an overpayment is not being made.

D. Effective July 1, 2014, services provided under arrangement, as defined in subdivisions B 6 a and B 6 b of 12VAC30-50-130, shall be reimbursed directly by DMAS to

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a provider of services provided under arrangement according to the reimbursement methodology prescribed for that provider type elsewhere in the State Plan if all of the following are met:

1. The services provided under arrangement are included in the active written treatment plan of care developed and signed as described in section 12VAC30-130-890; and
2. The services provided under arrangement are arranged and overseen by the residential treatment facility treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the residential treatment facility or under contract for services provided under arrangement.

**NOTICE:** The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

## FORMS (12VAC30-70)

Computation of Inpatient Operating Cost, HCFA-2552-92 D-1 (12/92).

Apportionment of Cost of Services Rendered by Interns and Residents, HCFA-2552-92 D-2 (12/92).

Cost Reporting Forms for Hospitals (Map 783 Series), eff. 10/15/93

- Certification by Officer or Administrator of Provider
- Analysis of Interim Payments for Title XIX Services
- Computation of Title XIX Ratio of Cost to Charges
- Computation of Inpatient and Outpatient Ancillary Service Costs
- Computation of Outpatient Capital Reduction
- Computation of Title XIX Outpatient Costs
- Computation of Charges for Lower of Cost or Charge Comparison
- Computation of Title XIX Reimbursement Settlement
- Computation of Net Medicaid Inpatient Operating Cost Adjustment
- Calculation of Medicaid Inpatient Profit Incentive for Hospitals
- Plant Costs
- Education Costs
- Obstetrical Care Requirements Certification
- Computation for Separating the Allowable Plant and Education Cost (pass-throughs) from the Inpatient Medicaid Hospital Costs

[Cost Reporting Form Residential Treatment Facilities, RTF-608 \(undated, filed 9/2016\)](#)

## **12VAC30-80-21. Inpatient psychiatric services in residential treatment facilities (under EPSDT). Reimbursement for services furnished individuals residing in a freestanding psychiatric hospital or residential treatment center (Level C).**

A. Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described in this section.

B. Methodology. Effective January 1, 2000, payment will be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute payment for all residential psychiatric treatment facility services, excluding all professional services.

C. Data collection. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by the state agency at such time as required by the agency. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, the Program shall take action in accordance with its policies to assure that an overpayment is not being made.

A. Reimbursement for all services furnished to individuals younger than 21 years of age who are residing in a freestanding psychiatric hospital shall be based on the freestanding psychiatric hospital reimbursement described in 12VAC30-70-415 and the reimbursement of services provided under arrangement described in 12VAC30-80.

B. Reimbursement for all services furnished to individuals younger than 21 years of age who are residing in a residential treatment center (Level C) shall be based on the [ ~~the~~ ] residential treatment center (Level C) reimbursement described in 12VAC30-70-417 and the reimbursement of services provided under arrangement described in 12VAC30-80.

## Part XIV

### Residential Psychiatric Treatment for Children and Adolescents

## **12VAC30-130-850. Definitions.**

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

"Active treatment" means implementation of a professionally developed and supervised individual plan of care that must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

"Certification" means a statement signed by a physician that inpatient services in a residential treatment facility are or were needed. The certification must be made at the time of admission, or, if an individual applies for assistance while in a mental hospital or residential treatment facility, before the Medicaid agency authorizes payment.

"Comprehensive individual plan of care" or "CIPOC" means a written plan developed for each recipient in accordance with 12VAC30-130-890 to improve his condition to the extent that inpatient care is no longer necessary.

"Emergency services" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

"Individual" or "individuals" means a child or adolescent younger than 21 years of age who is receiving a service covered under this part of this chapter.

"Initial plan of care" means a plan of care established at admission, signed by the attending physician or staff physician, that meets the requirements in 12VAC30-130-890.

"Inpatient psychiatric facility" or "IPF" means a private or state-run freestanding psychiatric hospital or psychiatric residential treatment center.

"Recertification" means a certification for each applicant or recipient that inpatient services in a residential treatment facility are needed. Recertification must be made at least every 60 days by a physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician.

"Recipient" or "recipients" means the child or adolescent younger than 21 years of age receiving this covered service.

"RTC-Level C" means a psychiatric residential treatment facility (Level C).

"Services provided under arrangement" means services including physician and other health care services that are furnished to children while they are in an IPF that are billed by the arranged practitioners separately from the IPF per diem.

**12VAC30-130-890. Plans of care; review of plans of care.**

A. All Medicaid services are subject to utilization review and audit. The absence of any required documentation may result in denial or retraction of any reimbursement.

B. For Residential Treatment Services (Level C) (RTS-Level C), an initial plan of care must be completed at admission and a Comprehensive Individual Plan of Care (CIPOC) must be completed no later than 14 days after admission.

~~B. C.~~ Initial plan of care (Level C) must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the ~~recipient~~ individual;

3. Treatment objectives with short-term and long-term goals;

4. Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the ~~patient~~ individual and a list of services provided under arrangement (see 12VAC30-50-130 for eligible services provided under arrangement) that will be furnished to the individual through the RTC-Level C's referral to an employed or a contracted provider of services under arrangement, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought;

5. Plans for continuing care, including review and modification to the plan of care;

6. Plans for discharge; and

7. Signature and date by the physician.

~~C. D.~~ The CIPOC for Level C must meet all of the following criteria:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the ~~recipient's~~ individual's situation and must reflect the need for inpatient psychiatric care;

2. Be developed by an interdisciplinary team of physicians and other personnel specified under subsection ~~F G~~ of this section, who are employed by, or provide services to, patients in the facility in consultation with the ~~recipient~~ individual and his parents, legal guardians, or appropriate others in whose care he will be released after discharge;

3. State treatment objectives that must include measurable short-term and long-term goals and objectives, with target dates for achievement;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; ~~and~~

5. Include a list of services provided under arrangement (described in 12VAC30-50-130) that will be furnished to the individual through referral to an employee or a contracted provider of services under arrangement, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought; and

6. Describe comprehensive discharge plans and coordination of inpatient services and post-discharge plans with related community services to ensure continuity of care upon discharge with the ~~recipient's~~ individual's family, school, and community.

~~D. E.~~ Review of the CIPOC for Level C. The CIPOC must be reviewed every 30 days by the team specified in subsection ~~F G~~ of this section to:



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1. Determine that services being provided are or were required on an inpatient basis; and
2. Recommend changes in the plan as indicated by the ~~recipient's~~ individual's overall adjustment as an inpatient.

~~E.~~ F. The development and review of the plan of care for Level C as specified in this section satisfies the facility's utilization control requirements for recertification and establishment and periodic review of the plan of care, as required in 42 CFR 456.160 and 456.180.

~~F.~~ G. Team developing the CIPOC for Level C. The following requirements must be met:

1. At least one member of the team must have expertise in pediatric mental health. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of all of the following:

- a. Assessing the ~~recipient's~~ individual's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- b. Assessing the potential resources of the ~~recipient's~~ individual's family;
- c. Setting treatment objectives; and
- d. Prescribing therapeutic modalities to achieve the plan's objectives.

2. The team must include, at a minimum, either:

- a. A board-eligible or board-certified psychiatrist;
- b. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- c. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

3. The team must also include one of the following:

- a. A psychiatric social worker;
- b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals;
- c. An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals; or
- d. A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

~~G. All Medicaid services are subject to utilization review. Absence of any of the required documentation may result in denial or retraction of any reimbursement.~~ H. The RTC-Level C shall not receive a per diem reimbursement for any day that:

1. The initial or comprehensive written plan of care fails to include within three business days of the initiation of the service provided under arrangement:

~~[ (a) a. ]~~ The prescribed frequency of treatment of such service, or includes a frequency that was exceeded; or

~~[ (b) b. ]~~ All services that the individual needs while residing at the RTC-Level C and that will be furnished to the individual through the RTC-Level C referral to an employed or contracted provider of services under arrangement [ ; ]

2. The initial or comprehensive written plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;

3. The referral to the service provided under arrangement was not present in the individual's RTC-Level C record;

4. The service provided under arrangement was not supported in that provider's records by a documented referral from the RTC-Level C;

5. The medical records from the provider of services under arrangement (i.e., admission and discharge documents, treatment plans, progress notes, treatment summaries, and documentation of medical results and findings) (i) were not present in the individual's RTC-Level C record or had not been requested in writing by the RTC-Level C within seven days of discharge from or completion of the service or services provided under arrangement or (ii) had been requested in writing within seven days of discharge from or completion of the service or services provided under arrangement, but not received within 30 days of the request, and not re-requested; or

6. The RTC-Level C did not have a fully executed contract or employee relationship with an independent provider of services under arrangement in advance of the provision of such services. For emergency services, the RTC-Level C shall have a fully executed contract with the emergency services provider prior to submission of the emergency service provider's claim for payment.

7. A physician's order for the service under arrangement is not present in the record.

8. The service under arrangement is not included in the individual's CIPOC within 30 calendar days of the physician's order.

I. The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service provided under arrangement that was (i) furnished prior to receiving a referral or (ii) in excess of the amounts in the referral. Providers of services under arrangement shall be required to reimburse DMAS for the cost of any such services provided under arrangement that were rendered in the absence of an employment or contractual relationship.

~~H. I.~~ For Therapeutic Behavioral Services therapeutic behavioral services for Children children and Adolescents

adolescents under 21 (Level B), the initial plan of care must be completed at admission by the licensed mental health professional (LMHP) and a CIPOC must be completed by the LMHP no later than 30 days after admission. The assessment must be signed and dated by the LMHP.

~~I. K.~~ For ~~Community Based Services~~ community-based services for ~~Children~~ children and ~~Adolescents~~ adolescents under 21 (Level A), the initial plan of care must be completed at admission by the QMHP and a CIPOC must be completed by the QMHP no later than 30 days after admission. The individualized plan of care must be signed and dated by the program director.

~~J. L.~~ Initial plan of care for Levels A and B must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the ~~child~~ individual;
3. Treatment objectives with short-term and long-term goals;
4. Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;
5. Plans for continuing care, including review and modification to the plan of care; and
6. Plans for discharge.

~~K. M.~~ The CIPOC for Levels A and B must meet all of the following criteria:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the ~~child's~~ individual's situation and must reflect the need for residential psychiatric care;
2. The CIPOC for both levels must be based on input from school, home, other ~~healthcare~~ health care providers, the ~~child individual~~ and family (or legal guardian);
3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;
4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and
5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the ~~child's~~ individual's family, school, and community.

~~L. N.~~ Review of the CIPOC for Levels A and B. The CIPOC must be reviewed, signed, and dated every 30 days by the QMHP for Level A and by the LMHP for Level B. The review must include:

1. The response to services provided;

2. Recommended changes in the plan as indicated by the ~~child's~~ individual's overall response to the plan of care interventions; and
3. Determinations regarding whether the services being provided continue to be required.

Updates must be signed and dated by the service provider.

~~M. All Medicaid services are subject to utilization review. Absence of any of the required documentation may result in denial or retraction of any reimbursement.~~

VA.R. Doc. No. R14-3714; Filed January 13, 2017, 2:05 p.m.

### Fast-Track Regulation

Titles of Regulations: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-100, 12VAC30-50-110, 12VAC30-50-130, 12VAC30-50-140, 12VAC30-50-150, 12VAC30-50-180, 12VAC30-50-491, 12VAC30-50-510; repealing 12VAC30-50-228).**

**12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-185; adding 12VAC30-60-181; repealing 12VAC30-60-147, 12VAC30-60-180).**

**12VAC30-70. Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services (amending 12VAC30-70-201; adding 12VAC30-70-415, 12VAC30-70-417).**

**12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-32).**

**12VAC30-130. Amount, Duration and Scope of Selected Services (adding 12VAC30-130-5000, 12VAC30-130-5010, 12VAC30-130-5020, 12VAC30-130-5030, 12VAC30-130-5040, 12VAC30-130-5050, 12VAC30-130-5060, 12VAC30-130-5070, 12VAC30-130-5080, 12VAC30-130-5090, 12VAC30-130-5100, 12VAC30-130-5110, 12VAC30-130-5120, 12VAC30-130-5130, 12VAC30-130-5140, 12VAC30-130-5150; repealing 12VAC30-130-540, 12VAC30-130-565, 12VAC30-130-580, 12VAC30-130-590).**

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: March 8, 2017.

Effective Date: April 1, 2017.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

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Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia authorizes the Director of the Department of Medical Services to administer and amend the Plan for Medical Assistance according to the board's requirements. The Medicaid authority as established by § 1902(a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

The 2016 Acts of the Assembly, Chapter 780, Item 306 MMMM directed:

"1. The Department of Medical Assistance Services, in consultation with the appropriate stakeholders, shall amend the state plan for medical assistance and/or seek federal authority through an 1115 demonstration waiver, as soon as feasible, to provide coverage of inpatient detoxification, inpatient substance abuse treatment, residential detoxification, residential substance abuse treatment, and peer support services to Medicaid individuals in the Fee-for-Service and Managed Care Delivery Systems. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

2. The Department of Medical Assistance Services shall make programmatic changes in the provision of all Substance Abuse Treatment Outpatient, Community Based and Residential Treatment services (group homes and facilities) for individuals with substance abuse disorders in order to ensure parity between the substance abuse treatment services and the medical and mental health services covered by the department and to ensure comprehensive treatment planning and care coordination for individuals receiving behavioral health and substance use disorder services. The department shall take action to ensure appropriate utilization and cost efficiency, and adjust reimbursement rates within the limits of the funding appropriated for this purpose based on current industry standards. The department shall consider all available options including, but not limited to, service definitions, prior authorization, utilization review, provider qualifications, and reimbursement rates for the following Medicaid services: substance abuse day treatment for pregnant women, substance abuse residential treatment for pregnant women, substance abuse case management, opioid treatment, substance abuse day treatment, and substance abuse intensive outpatient. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

3. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance and any

waivers thereof to include peer support services to children and adults with mental health conditions and/or substance use disorders. The department shall work with its contractors, the Department of Behavioral Health and Developmental Services, and appropriate stakeholders to develop service definitions, utilization review criteria and provider qualifications. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

4. The Department of Medical Assistance Services shall, prior to the submission of any state plan amendment or waivers to implement paragraphs MMMM 1, MMMM 2, and MMMM 3, submit a plan detailing the changes in provider rates, new services added and any other programmatic changes to the Chairmen of the House Appropriations and Senate Finance Committees."

Purpose: The Commonwealth is currently experiencing a crisis of substance use of overwhelming proportions. More Virginians died from drug overdose in 2013 than from automobile accidents. In 2014, 80% of the people who died from drug overdoses (986 people) died from prescription opioid or heroin overdoses. Virginia's 1.1 million Medicaid/FAMIS members are affected disproportionately by this substance use epidemic as demonstrated by DMAS claims history data showing 216,555 Medicaid members with a substance use diagnosis in state fiscal year 2015. This regulatory action has a direct, specific impact on the health, safety, and welfare of the Commonwealth's Medicaid individuals.

This action implements a comprehensive program of community-based addiction and recovery treatment services in response to the Governor's bipartisan Task Force on Prescription Drug and Heroin Addiction's numerous recommendations. A major recommendation of this task force was to increase access to treatment for opioid addiction for the Commonwealth's Medicaid members by increasing Medicaid reimbursement rates for these services, because data shows that these individuals are being disproportionately impacted by the substance use epidemic.

Rationale for Using Fast-Track Rulemaking Process: This regulatory action is being promulgated as a fast-track rulemaking action because public comments received have been positive about the general concept and features that have been specified to date. The comprehensive Addiction and Recovery Treatment Services (ARTS) proposal is such a substantial improvement over the current fragmented approach to substance use treatment that the affected entities are actively participating with DMAS in its redesign and transformation efforts.

Substance: The regulations affected by this action are the newly created Addiction and Recovery Treatment Services (12VAC30-130-5000 et seq.) and sections of the State Plan

for Medical Assistance (and related regulations). Sections recommended for modification or repeal are as follows: Chapter 50 Amount, Duration, and Scope of Services: Inpatient Hospital Services (12VAC30-50-100); EPSDT (12VAC30-50-130); Physician Services (12VAC30-50-140); Other Practitioners (12VAC30-50-150); Clinic Services (12VAC30-50-180); Axis I Case Management (12VAC30-50-491); Expanded Pre-natal Care (12VAC30-50-510); Chapter 60: Utilization control Substance Use Treatment (12VAC30-60-147); Utilization control Community Substance Use Treatment (12VAC30-60-180); Utilization control Case Management (12VAC30-60-185); Chapter 80: Reimbursement for Substance Abuse Services (12VAC30-80-32); Chapter 130: Community Mental Health Mental Retardation Services (12VAC30-130-540 through 12VAC30-130-590) (repealed).

Current policy. DMAS covers approximately 1.1 million individuals: 80% of members receive care through contracted managed care organizations (MCOs) and 20% of members receive care through fee-for-service (FFS). The majority of members enrolled in Virginia's Medicaid and FAMIS programs include children, pregnant women, and individuals who meet the disability category of being aged, blind, or disabled. The 20% of the individuals receiving care through fee-for-service do so because they meet one of 16 categories of exception to MCO participation, for example: (i) inpatients in state mental hospitals, long-stay hospitals, nursing facilities, or ICF/IIDs; (ii) individuals on spend down; (iii) individuals younger than 21 years of age who are in residential treatment facility Level C programs; (iv) newly eligible individuals in their third trimester of pregnancy; (v) individuals who permanently live outside their area of residence; (vi) individuals receiving hospice services; (vii) individuals with other comprehensive group or individual health insurance; (viii) individuals eligible for Individuals with Disabilities Education Act (IDEA) Part C services; (ix) individuals whose eligibility period is less than three months or is retroactive; and (x) individuals enrolled in the Virginia Birth-Related Neurological Injury Compensation Program.

Historically, Virginia funded only limited kinds of substance use treatment services to limited populations of Medicaid eligible individuals (for example, pregnant women and children). The Commonwealth now has compelling reasons to provide Medicaid coverage for the identification and treatment of substance use disorders: individuals with substance use disorders and co-morbid medical conditions account for high Medicaid costs. Beyond health care risk, the economic costs associated with substance use disorders are significant. States and the federal government spend billions of tax dollars every year on the collateral impact associated with substance use disorders, including criminal justice, public assistance, and lost productivity costs. From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics nearly quadrupled across the nation.

Within the current system, nontraditional community-based addiction treatment services are "carved out" (excluded from coverage) of the MCOs and managed by Magellan, the Behavioral Health Service Administrator (BHSA) contractor for DMAS. For members enrolled in FFS, Magellan covers all traditional and nontraditional addiction treatment services. The nontraditional services include (i) residential treatment, (ii) opioid treatment (outpatient counseling with medication-assisted treatment), (iii) day treatment, (iv) crisis intervention, (v) intensive outpatient treatment, and (vi) case management.

The "carve out" of the community-based addiction treatment services from MCOs contributed to Virginia's historically fragmented system in which poorly funded community-based addiction treatment services are delivered in distinct siloes separated from traditional mental health and physical health services. Providers who deliver these services have complained that the Medicaid reimbursement rates are lower than the cost of providing care and have struggled to understand who to bill for services. Patients have struggled to understand where to seek services.

Furthermore, the rate structure for addiction treatment services has not been adjusted since 2007 when DMAS first started reimbursing for addiction treatment services. Low reimbursement rates have severely limited the number of providers willing to provide these services to Medicaid and FAMIS members and resulted in inadequate access to treatment. DMAS only spent approximately \$2 million on community-based addiction treatment services in State Fiscal Year 2015 and served an average of 734 people per month, demonstrating the underutilization of these services considering the number of Virginians being seen in hospitals/emergency rooms with substance use diagnoses.

If DMAS continues reimbursing at the current low rates for substance use disorder treatment, low utilization of this benefit will continue, and it will only be available to limited groups of members (children and pregnant women). If DMAS continues the current benefit package, it will continue to not provide coverage of peer support services for any members and would not cover inpatient and short-term residential detoxification and outpatient substance use disorder treatment for any nonpregnant adult members.

Medicaid, FAMIS, and FAMIS MOMS members with diagnoses of substance use disorders (SUD) will continue to experience high rates of hospitalizations and hospital emergency department visits that could be prevented if adequate residential treatment, outpatient treatment, and peer supports were available and accessible.

Recommendations. To address the fragmentation of services and siloes, Virginia sought the authority to fully integrate physical and behavioral health services for individuals with SUD and to expand access to the full array of services for individuals with SUD. DMAS obtained approval from the Governor and General Assembly to "carve in" community-based SUD/ARTS treatment services into managed care plans

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for members who are already enrolled in MCOs. The Centers for Medicare and Medicaid Services (CMS) recommends the use evidence-based practice for the treatment of addictive, substance-related conditions as published by the American Society of Addiction Medicine (ASAM).

Since the MCOs already manage all the physical health services as well as the inpatient services, outpatient services, and medications for mental health and substance use, "carving in" the community-based ARTS services will allow the health plans to provide their enrolled members with the full array of all services based on a member's level of need. Magellan will continue to cover these services for those Medicaid members who are enrolled in FFS.

The ARTS waiver was necessary to provide Virginia the authority, and related federal financial participation, to provide coverage of short-term inpatient detox and residential substance use disorder in treatment facilities with greater than 16 beds. This will align Medicaid FFS residential treatment coverage with the CMS Medicaid and CHIP Managed Care Final Rule (CMS-2390-F). The expanded coverage of residential detoxification and residential substance use disorder treatment will be available for all Medicaid enrolled members and will be integrated with the full continuum of addiction treatment services. Seamless care transitions will occur from residential treatment to lower levels of care such as intensive outpatient and outpatient treatment with medications and long-term recovery supports available to all Medicaid enrolled members.

Addiction is a primary, chronic disease of the brain's reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in

recovery activities, addiction is progressive and typically results in disability or premature death.

DMAS recommends the application of the ASAM criteria that describe a wide range of levels and types of care for addiction and substance-related conditions and establish clinical guidelines for making the most appropriate treatment and placement recommendations for individuals who demonstrate specific signs, symptoms, and behaviors of addiction. Application across the Commonwealth of this comprehensive system of multidimensional assessment, broad and flexible continuum of care, interdisciplinary team approach to care, and outcome-driven clinical treatment is expected to substantially reduce the consequences of the current addiction epidemic.

The comprehensive addiction treatment benefit approved previously by the Governor and General Assembly includes the following core components:

- Expanded coverage of inpatient detoxification and inpatient substance abuse treatment (ASAM Level 4.0) for all Medicaid members (previously only available to children).
- Expanded coverage of residential detoxification and residential substance abuse treatment (ASAM levels 3.1, 3.3, 3.5, and 3.7) for all Medicaid members (previously delivered using outdated, state-defined program rules).
- Increased rates for existing substance abuse treatment services currently covered by DMAS by 50% for Case Management and by 400% for Partial Hospitalization (ASAM Level 2.5), Intensive Outpatient (ASAM Level 2.1), and the counseling component (Opioid Treatment) of MAT to align with current industry standards.
- Added coverage of Peer Supports for individuals with SUD, mental health conditions, or both. Reimbursement will be provided for peers certified by the Department of Behavioral Health and Developmental Services (DBHDS) who will provide intensive recovery coaching to individuals with SUD at all ASAM levels of care and to those who need recovery supports, which will be added to the Medicaid benefit in July 2017.

Major changes under this benefit are illustrated below.

Addiction Treatment Service	Children < 21	Adults*	Pregnant Women
Traditional Services			
Inpatient (ASAM Level 4.0)	X	Added	Added
Outpatient (ASAM Level 1.0)	X	X	X
Treatment using medication – medication component	X	X	X
Non-Traditional Services			
Residential (ASAM Levels 3.1, 3.3, 3.5, and 3.7)	X	Added	50% rate increase
Partial Hospitalization (ASAM	400% rate increase	400% rate increase	400% rate increase

Addiction Treatment Service	Children < 21	Adults*	Pregnant Women
Level 2.5)			
Intensive Outpatient (ASAM Level 2.1)	400% rate increase	400% rate increase	400% rate increase
Opioid Treatment – counseling component of treatment using medication (ASAM Level 1.0)	400% rate increase	400% rate increase	400% rate increase
Case Management	50% rate increase	50% rate increase	50% rate increase
Peer Recovery Coaching (DBHDS-certified peers)	Added**	Added**	Added

X = service was previously covered

Added = service will be covered under the comprehensive addiction treatment benefit passed by the General Assembly starting on April 1, 2017. Rate increases were also included in addiction treatment benefit and will take effect on April 1, 2017.

\* Dual eligible individuals have coverage for inpatient and residential treatment services through Medicare.

\*\* Peer recovery support services for adults and family support partners for children and families will be added when DBHDS finalizes the peer certification standards and DMAS is able to ensure that CMS requirements are met for peer support services.

The concept of medical necessity is used throughout the DMAS regulations as the basis for service coverage. Services that are not medically necessary are not covered (not reimbursed) by Medicaid. Because substance use, addiction, and mental disorders are biopsychosocial in etiology and expression, treatment and care management are most effective if they are also biopsychosocial and based on a multidimensional assessment rather than a single diagnosis. DMAS proposes to implement a system that takes into account the biopsychosocial nature of substance use, addiction, and mental health disorders to result in a more holistic and evidence-based approach to service delivery and care.

Issues: There are no disadvantages identified in providing the full continuum of treatment needed to address the substance use crisis and reverse the opioid epidemic in Virginia. The ARTS benefit and waiver are needed to ensure the success of Virginia's delivery system transformation in expanding access to the addiction treatment services that will save lives, improve patient outcomes, and decrease costs. There are no disadvantages to affected providers as their rates of reimbursement are recommended for increase.

The advantages to Medicaid-eligible individuals are discussed above.

Federal demonstration waivers have significant data reporting and evaluation components. CMS will require an independent evaluation of the ARTS waiver to demonstrate any improved outcomes for Medicaid members and cost savings from reducing emergency department visits and inpatient hospital utilization. This evaluation will help the Commonwealth demonstrate the impact of the ARTS benefit and waiver on

the lives of its citizens, both Medicaid eligible and noneligible, as well as on the Commonwealth's economy.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 780 (Item 306 MMMM) of the 2016 Acts of the Assembly,<sup>1</sup> and on behalf of the Board of Medical Assistance Services (Board), the Director of the Department of Medical Assistance (DMAS) proposes to newly promulgate a comprehensive regulation for addiction and recovery treatment services (ARTS) as well as amend several other regulations to harmonize them with the new ARTS regulation. DMAS also proposes to change the qualifications for substance abuse case managers eligible to provide Medicaid billable substance abuse case management.

Result of Analysis. Benefits likely outweigh costs for all regulatory changes that harmonize these regulations with the current legislative mandate. Costs will likely outweigh benefits for eliminating pathways to case manager qualification to provide Medicaid billable services.

Estimated Economic Impact. Item 306 MMMM of Chapter 780 directs DMAS to "to provide coverage of inpatient detoxification, inpatient substance abuse treatment, residential detoxification, residential substance abuse treatment and peer support services in the Fee-for-Service and Managed Care Delivery Systems." Budget language also directed DMAS to make programmatic changes so that substance abuse treatment services are paid the same as medical and mental health services (within the limits of the funding appropriated for that purpose).

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Board staff reports that currently and until April 1, 2017, Virginia only funds limited kinds of substance abuse services for limited groups of Medicaid eligible individuals (mostly children up to the age of 21 and pregnant women). Board staff reports that currently many community-based treatment services such as residential treatment, opioid treatment, day treatment, crisis intervention, intensive outpatient treatment and case management services are excluded from coverage by Medicaid managed care organizations. Such treatments were, instead, managed by DMAS's contracted behavioral health services administrator Magellan. DMAS staff reports that, because of these exclusions and alternate arrangements for substance abuse, substance abuse treatment for Medicaid recipients has historically been fragmented and piecemeal. The rate structure for substance abuse treatment services has not been changed since 2007. Consequently, low reimbursement rates have severely limited the number of providers willing to treat Medicaid patients.

To address these issues, and to meet its budget mandate, DMAS now proposes to bring substance abuse treatment services under the managed care umbrella, expand covered services to all Medicaid eligible individuals, increase the types of services covered and increase the rates paid for these services. Specifically, coverage for inpatient detoxification, inpatient substance abuse treatment, residential detoxification and residential substance abuse treatment will be expanded to all Medicaid eligible individuals (on April 1, 2017), payment rates will increase 50% for case management services and 400% for partial hospitalization, intensive outpatient treatment and the counseling component of medication assisted treatment (on April 1, 2017) and coverage for peer recovery coaching will be added (on July 1, 2017).

DMAS reports that a disproportionately high number of Medicaid covered individuals have substance abuse issues. Currently 1.1 million Virginians are covered by Medicaid or FAMIS. In state fiscal year 2015, DMAS reports that 216,555 of those individuals had an (illicit) substance use diagnosis. Expanding coverage and increasing payment rates will likely induce more providers to treat drug affected Medicaid recipients. This treatment may, in turn decrease future Medicaid and other welfare payments if treated individuals are able to take on more personal responsibility for meeting their own life needs. Since drug affected individuals disproportionately require hospitalization and/or stabilization in hospital emergency rooms, providing for more substance abuse treatment may cut down on the costs incurred in those areas. These possible benefits must be weighed against the costs for increased treatment/payment rates. The General Assembly appropriated \$5,204,824 (half general fund and half non-general fund) to pay for these changes during fiscal year 2017. For fiscal year 2018, they appropriated \$16,752,518 (again, half general fund and half non-general fund).

In addition to making changes mandated by Chapter 780, DMAS also proposes to change the qualifications that would

allow individuals to provide Medicaid billable substance abuse case manager services. Currently, such individuals must meet one of the following sets of criteria:<sup>2</sup>

Have at least a bachelor's degree in social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation or human services counseling and have at least one year of substance abuse related clinical experience providing services for persons with a diagnosis of mental illness or substance abuse,

Be licensed by the Commonwealth as a registered nurse or as a practical nurse and have at least one year of clinical experience or

Have at least a bachelor's degree in any field and have certification as a certified substance abuse counselor (CSAC) or have a bachelor's degree in any field and have certification as a certified addictions counselor (CAC).

DMAS proposes to amend these allowable qualifications so that licensed practical nurses and those with a bachelor's degree in any field and who are CAC certified will no longer be qualified to provide Medicaid billable substance abuse case management services. DMAS reports that these changes were recommended by the ad hoc committee that advised DMAS on these regulations and that these changes were recommended to make this regulation consistent with American Society of Addiction Medicine (ASAM) standards. DMAS reports that this will affect at least one locally run Community Services Board (CSB) who has a licensed practical nurse employed as a case manager. These amendments may also affect other CSBs or the one Behavioral Health Authority (BHA) in the Commonwealth if they too have staff that are currently employed as case managers that meet current qualifications but would not meet the more restrictive proposed qualifications.

To the extent that CSBs and BHAs now have case management staff that perform substance abuse case management and have qualifications that DMAS proposes to disallow, these organizations would either have to hire staff who have the new more stringent qualifications or get current staff eligible under the proposed regulation by, for instance, getting them qualified to sit for the Board of Counselors CSAC exam. DMAS staff reports that they do not know if CSBs and BHAs pay for staff training or certification but, if they do, the proposed qualification standards would drive up costs for localities and those costs would not be paid for with the money already appropriated by the General Assembly to support the new ARTS program. If there are individuals who meet current qualification requirements to provide Medicaid billable substance abuse case management services but who would not meet the narrower proposed qualification requirements, these individuals and the organizations they work for will be adversely impacted by these changes. Although ASAM considers the proposed qualifications to be best practice standards, other standards may be more appropriate if staff that are currently providing quality case

management services now, or would be capable of providing quality services in the future, are precluded from doing so by these proposed changes. Additionally, since fewer providers will likely meet these more restrictive qualifications, these changes may have the effect of making case management services more scarce and more expensive to procure. Absent evidence that these individuals have been doing their jobs poorly, costs likely outweigh benefits for these proposed changes.

**Businesses and Entities Affected.** These proposed regulatory changes will affect locally run CSBs/BHAs, inpatient hospitals, some physicians and nurse practitioners, case managers, residential treatment facilities, group homes and outpatient clinics as well as all Medicaid recipients. DMAS reports that there are currently 1.1 million Medicaid recipients in the Commonwealth and that there are 39 CSBs and one BHA run by various localities in the Commonwealth.

**Localities Particularly Affected.** Locally run CSBs/BHAs or their staff may incur costs because of proposed qualifications for case managers who provide Medicaid billable case management services.

**Projected Impact on Employment.** To the extent that expanding substance abuse services coverage and increasing payment rates for Medicaid recipients increase utilization and expand the number of providers willing to take Medicaid patients, more individuals may be employed as substance abuse treatment providers or support staff for providers in the Commonwealth.

**Effects on the Use and Value of Private Property.** These proposed regulatory changes are unlikely to affect the use or value of private property in the Commonwealth.

**Real Estate Development Costs.** These proposed regulatory changes are unlikely to affect real estate development costs in the Commonwealth.

**Small Businesses:**

**Definition.** Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million."

**Costs and Other Effects.** Small business substance abuse treatment providers may see increased revenue from Medicaid patients on account of this proposed regulation.

**Alternative Method that Minimizes Adverse Impact.** No small businesses will be adversely affected by these proposed regulatory changes.

**Adverse Impacts:**

**Businesses.** Businesses in the Commonwealth are unlikely to experience any adverse impacts on account of this proposed regulation.

**Localities.** Locally run CSBs/BHAs or their staff may incur costs because of proposed qualifications for case managers who provide Medicaid billable case management services.

**Other Entities.** At least one licensed practical nurse who currently provides case management services at a CSB, and likely others, will be adversely affected by these proposed regulations. Affected individuals will have to incur costs for becoming a CSAC assistant and will no longer be able to do their job independently (without supervision) as they can now by virtue of being licensed as practical nurses. This will make them less desirable employees as CSBs would have to have another employee qualified to supervise these individuals.

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<sup>1</sup> More information on this mandate can be found at <http://townhall.virginia.gov/L/viewmandate.cfm?mandateid=743>

<sup>2</sup> Please see 12-30-50-491 E.2 for these requirements.

**Agency's Response to Economic Impact Analysis:** The agency has reviewed the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning Addiction and Recovery Treatment Services (ARTS) (12VAC30-130-5000 et seq.) and agrees with parts of the overall conclusions.

The regulatory changes provided for in this action establish the coverage of addiction and recovery treatment services, based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria and evidence-based best practices, in response to the Commonwealth's crisis of substance use of overwhelming proportions. In 2014, 80% of the people who died from drug overdoses (986 people) died from prescription opioid or heroin overdoses. Virginia's 1.1 million Medicaid/FAMIS members are affected disproportionately by this substance use epidemic as demonstrated by DMAS claims history data showing 216,555 Medicaid members with substance use diagnoses in SFY 2015. DMAS has complied with its Appropriations Act mandate, as partially set out below, using an ad hoc advisory committee, established in § 2.2-4007.02 of the Code of Virginia comprised of affected entities.

DMAS was directed, by the referenced Appropriations Act mandate in Chapter 780, Item 306 MMMM of the 2016 Acts of Assembly follows:

"2. The Department of Medical Assistance Services shall make programmatic changes in the provision of all Substance Abuse Treatment Outpatient, Community Based and Residential Treatment services (group homes and facilities) for individuals with substance abuse disorders in order to ensure parity between the substance abuse treatment services and the medical and mental health services covered by the department and to ensure comprehensive treatment planning and care coordination for individuals receiving behavioral health and substance use disorder services. The department shall take action to ensure appropriate utilization and cost efficiency, and adjust reimbursement rates within the limits of the funding appropriated for this purpose based on current



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industry standards. The department shall consider all available options including, but not limited to, service definitions, prior authorization, utilization review, provider qualifications, and reimbursement rates for the following Medicaid services: substance abuse day treatment for pregnant women, substance abuse residential treatment for pregnant women, substance abuse case management (emphasis added), opioid treatment, substance abuse day treatment, and substance abuse intensive outpatient. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change."

This regulatory action has a direct, specific impact on the health, safety, and welfare of the Commonwealth's Medicaid individuals. Substance use disorders are complex illnesses to resolve and therefore demand that treating professionals be appropriately educated and certified. This new Medicaid coverage is designed to save lives.

The department developed its case management provider qualifications with the assistance and input of an ad hoc advisory group, as supported by § 2.2-4007.02 of the Code of Virginia, comprised of members of the affected entities, local Community Services Boards, Behavioral Health Authorities, and the Department of Behavioral Health and Developmental Services. This ad hoc advisory group supported DMAS efforts to tailor these provider requirements to better meet the needs of individuals with substance use and addiction disorders.

In developing its case management provider qualifications, DMAS considered the impact on licensed practical nurses (LPNs) cited by DPB. There are only a small number of LPNs currently rendering substance abuse case management services in CSBs. DMAS is significantly increasing the payment rate to CSBs for case management services to enable these local agencies to hire professionals who meet higher education and certification standards.

Securing the CSAC-Assistant certification will be very easy for these affected LPNs. They may apply for and obtain their CSAC-A certifications from the Board of Counseling before April 1, 2017, so they can continue providing substance use case management services for Medicaid reimbursement. The LPNs already meet the majority of education and experience requirements (by virtue of being an LPN) for the CSAC-A and will have adequate time to submit documentation to the Board of Counseling and pass the CSAC-A exam which is offered year round.

## Summary:

*The regulatory action establishes a comprehensive program for addiction and recovery treatment services to provide a community-based continuum of addiction and recovery treatment services. The services will include (i) inpatient withdrawal management services; (ii) residential treatment services; (iii) partial hospitalization; (iv)*

*intensive outpatient treatment; (v) outpatient treatment including medication assisted treatment; and (vi) peer recovery supports. The regulatory action is pursuant to Item 306 MMMM of Chapter 780 of the 2016 Acts of Assembly and also amends existing regulations for consistency with the new program.*

## Part III

### Amount, Duration, and Scope of Services

#### **12VAC30-50-100. Inpatient hospital services provided at general acute care hospitals and freestanding psychiatric hospitals; enrolled providers.**

A. Preauthorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals and freestanding psychiatric hospitals. Nonauthorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS). Preauthorization shall be based on criteria specified by DMAS. In conjunction with preauthorization, an appropriate length of stay will be assigned using the HCIA, Inc., Length of Stay by Diagnosis and Operation, Southern Region, 1996, as guidelines.

#### 1. Admission review.

a. Planned/scheduled admissions. Review shall be done prior to admission to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned at the time of this review. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

b. Unplanned/urgent or emergency admissions. These admissions will be permitted before any prior authorization procedures. Review shall be performed within one working day to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned for those admissions which have been determined to be appropriate. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

2. Concurrent review shall end for nonpsychiatric claims with dates of admission and services on or after July 1, 1998, with the full implementation of the DRG reimbursement methodology. Concurrent review shall be done to determine that inpatient hospitalization continues to be medically necessary. Prior to the expiration of the previously assigned initial length of stay, the provider shall be responsible for obtaining authorization for continued inpatient hospitalization. If continued inpatient hospitalization is determined necessary, an additional length of stay shall be assigned. Concurrent review shall continue in the same manner until the discharge of the patient from acute inpatient hospital care. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

3. Retrospective review shall be performed when a provider is notified of a patient's retroactive eligibility for Medicaid coverage. It shall be the provider's responsibility to obtain authorization for covered days prior to billing DMAS for these services. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

4. Reconsideration process.

a. Providers requesting reconsideration must do so upon verbal notification of denial.

b. This process is available to providers when the nurse reviewers advise the providers by telephone that the medical information provided does not meet DMAS specified criteria. At this point, the provider must request by telephone a higher level of review if he disagrees with the nurse reviewer's findings. If higher level review is not requested, the case will be denied and a denial letter generated to both the provider and recipient identifying appeal rights.

c. If higher level review is requested, the authorization request will be held in suspense and referred to the Utilization Management Supervisor (UMS). The UMS shall have one working day to render a decision. If the UMS upholds the adverse decision, the provider may accept that decision and the case will be denied and a denial letter identifying appeal rights will be generated to both the provider and the recipient. If the provider continues to disagree with the UMS' adverse decision, he must request physician review by DMAS medical support. If higher level review is requested, the authorization request will be held in suspense and referred to DMAS medical support for the last step of reconsideration.

d. DMAS medical support will review all case specific medical information. Medical support shall have two working days to render a decision. If medical support upholds the adverse decision, the request for authorization will then be denied and a letter identifying appeal rights will be generated to both the provider and the recipient. The entire reconsideration process must be completed within three working days.

5. Appeals process.

a. Recipient appeals. Upon receipt of a denial letter, the recipient shall have the right to appeal the adverse decision. Under the Client Appeals regulations, Part I (12VAC30-110-10 et seq.) of 12VAC30-110, the recipient shall have 30 days from the date of the denial letter to file an appeal.

b. Provider appeals. If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the date of the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider

for services already rendered. The appeal shall be held in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

B. Out-of-state inpatient general acute care hospitals and freestanding psychiatric hospitals, enrolled providers. In addition to meeting all of the preauthorization requirements specified in subsection A of this section, out-of-state hospitals must further demonstrate that the requested admission meets at least one of the following additional standards. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; or

4. It is the general practice for recipients in a particular locality to use medical resources in another state.

C. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

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

E. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be authorized for payment. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically indicated. Except as previously noted, regardless of authorization for the hospitalization, the claims will be processed in accordance with the limit for 21 days in a 60-day period. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days for nonpsychiatric admissions shall cease with dates of service on or after July 1, 1998.

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

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general hospitals and freestanding psychiatric hospitals 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 or psychological, as appropriate, examination. The admission and length of stay must be medically justified and preauthorized via the admission and concurrent or retrospective review processes described in subsection A of this section. Medically unjustified days in such hospitalizations shall not be authorized for payment.

## F. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

G. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section and 12VAC30-50-105.

H. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS medical support. Inpatient hospitalization related to kidney transplantation will require preauthorization at the time of admission and, concurrently,

for length of stay. Cornea transplants do not require preauthorization of the procedure, but inpatient hospitalization related to such transplants will require preauthorization for admission and, concurrently, for length of stay. 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. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

I. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review. Hospitals must submit the required DMAS forms corresponding to the procedures. Regardless of authorization for the hospitalization during which these procedures were performed, the claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

J. Addiction and recovery treatment services shall be covered in inpatient facilities consistent with 12VAC30-130-5000 et seq.

## **12VAC30-50-110. Outpatient hospital and rural health clinic services.**

### A. 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 42 CFR 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 42 CFR 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 life to the mother if the fetus was carried to term.

3. The following limits and requirements shall apply to DMAS coverage of outpatient observation beds.

a. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment.

b. Nonroutine observation for underlying medical complications, as explained in documentation attached to the provider's claim for payment, after surgery or

diagnostic services shall be covered. Routine use of an observation bed shall not be covered. Noncovered routine use shall be:

- (1) Routine preparatory services and routine recovery time for outpatient surgical or diagnostic testing services (e.g., services for routine post-operative monitoring during a normal recovery period (four to six hours)).
- (2) Observation services provided in conjunction with emergency room services, unless, following the emergency treatment, there are clear medical complications which must be managed by a physician other than the original emergency physician.
- (3) Any substitution of an outpatient observation service for a medically appropriate inpatient admission.

c. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient precertification, where applicable.

d. When inpatient admission is required following observation services and prior approval has been obtained for the inpatient stay, observation charges must be combined with the appropriate inpatient admission and be shown on the inpatient claim for payment. Observation bed charges and inpatient hospital charges shall not be reimbursed for the same day.

4. Addiction and recovery treatment services shall be covered in outpatient hospital facilities consistent with 12VAC30-130-5000 et seq.

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

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

2. Addiction and recovery treatment services shall be covered in rural health clinics consistent with 12VAC30-130-5000 et seq.

C. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with § 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

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

2. Addiction and recovery treatment services shall be covered in FQHCs consistent with 12VAC30-130-5000 et seq.

**12VAC30-50-130. Skilled nursing facility services, EPSDT, school health services, and family planning.**

A. 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.

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

1. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

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

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

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

5. Community mental health services. These services in order to be covered (i) shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and (ii) are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.

"Adolescent or child" means the individual receiving the services described in this section. For the purpose of the use of these terms, adolescent means an individual 12-20 years of age; a child means an individual from birth up to 12 years of age.

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"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Certified prescriber" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Licensed mental health professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed psychiatric nurse practitioner, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii)

18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or

units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

b. Intensive in-home services (IIH) to children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All

interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

(1) These services shall be limited annually to 26 weeks. Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

(2) Service authorization shall be required for services to continue beyond the initial 26 weeks.

(3) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(4) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

c. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family counseling.

(1) Service authorization shall be required for Medicaid reimbursement.

(2) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

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Requirements for service-specific provider intakes and ISPs are set out in this section.

(3) These services may be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

d. Community-based services for children and adolescents under 21 years of age (Level A).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual<sup>®</sup> Criteria or an equivalent standard authorized in advance by DMAS, shall be required for this service.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

(3) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(4) Authorization shall be required for Medicaid reimbursement. Services that were rendered before the date of service authorization shall not be reimbursed.

(5) Room and board costs shall not be reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), Standards for Interim Regulation of Children's Residential Facilities (6VAC35-51), or Regulations for Children's Residential Facilities (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living

skills, communication skills, stress management, and any care coordination activities.

(8) The facility/group home must coordinate services with other providers. Such care coordination shall be documented in the individual's medical record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

(9) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(10) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

e. Therapeutic behavioral services (Level B).

(1) Such services must be therapeutic services rendered in a residential setting that provides structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual<sup>®</sup> Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.

(2) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.

(3) Room and board costs shall not be reimbursed. Facilities that only provide independent living services are not reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(4) These residential providers must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include, but is not

limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

(6) The individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

(7) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(8) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services that are based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(9) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

(10) The facility/group home shall coordinate necessary services with other providers. Documentation of this care coordination shall be maintained by the facility/group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:

a. A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or the Council on Quality and Leadership.

b. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of Amount, Duration and Scope of Selected Services.

c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with 42 CFR Part 441 Subpart D, as contained in 42 CFR 441.151 (a) and (b) and 441.152 through 441.156. Each

admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

7. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

8. Addiction and recovery treatment services shall be covered under EPSDT consistent with 12VAC30-130-5000 et seq.

C. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Service providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Service providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers, but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.



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e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services.

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with intellectual disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may

render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialist, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D. Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

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

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.
2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

**12VAC30-50-140. 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. Outpatient psychiatric services.

1. Psychiatric services are limited to an initial availability of 26 sessions, without prior authorization during the first treatment year. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding year when prior authorized by DMAS or its designee. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary psychiatric services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening.
2. Psychiatric services can be provided by psychiatrists or by a licensed clinical social worker, licensed professional counselor, licensed clinical nurse specialist-psychiatric, or a licensed marriage and family therapist under the direct supervision of a psychiatrist.‡
3. Psychological and psychiatric services shall be medically prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by either a psychiatrist or by a licensed psychiatric nurse practitioner, licensed clinical social worker, licensed professional counselor, licensed clinical nurse specialist-psychiatric, or licensed marriage and

family therapist under the direct supervision of a psychiatrist.‡

4. Psychological or psychiatric services shall be considered appropriate when an individual meets the following criteria:

- a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels that have been impaired;
- b. Exhibits deficits in peer relations, dealing with authority; is hyperactive; has poor impulse control; is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, ability to learn, or ability to participate in employment, educational, or social activities;
- c. Is at risk for developing or requires treatment for maladaptive coping strategies; and
- d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

5. Psychological or psychiatric services may be provided in an office or a mental health clinic.

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 life to the mother if the fetus was carried to term.

G. Physician visits to inpatient hospital patients over the age of 21 are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses or treatment plan and is further restricted to medically necessary authorized (for enrolled providers)/approved (for nonenrolled providers) 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 general hospitals and freestanding psychiatric 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 shall be limited to medically necessary inpatient hospital days.

H. (Reserved.)

I. Reimbursement shall not be provided for physician services provided to recipients in the inpatient setting whenever the facility is denied reimbursement.

J. (Reserved.)

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered

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for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. 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. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If prior authorized, breast reconstruction surgery and prostheses may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorized, for all medically necessary indications. Such procedures shall be considered noncosmetic.

2. Breast reconstruction or enhancements for cosmetic reasons shall not be covered. Cosmetic reasons shall be defined as those which are not medically indicated or are intended solely to preserve, restore, confer, or enhance the aesthetic appearance of the breast.

M. Admitting physicians shall comply with the requirements for coverage of out-of-state inpatient hospital services. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the Commonwealth of Virginia shall only be reimbursed under at least one the following conditions. It shall be the responsibility of the hospital, when requesting prior authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; or
4. It is general practice for recipients in a particular locality to use medical resources in another state.

N. In compliance with 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of the required DMAS forms corresponding to the procedures. The claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

O. Prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. The referring physician ordering nonemergency outpatient Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT) scans, or Positron Emission Tomography (PET) scans must obtain prior authorization from the Department of Medical Assistance Services (DMAS) for those scans. The servicing provider will not be reimbursed for the scan unless proper prior authorization is obtained from DMAS by the referring physician.

~~P. Outpatient substance abuse treatment services shall be limited to an initial availability of 26 therapy sessions without prior authorization during the first treatment year. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 therapy sessions each succeeding year when prior authorized by DMAS or its designee. Outpatient substance abuse treatment services are further restricted to no more than three sessions in any given seven day period. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening and the above limits have been exceeded.~~

- ~~1. Outpatient substance abuse services shall be provided by medical doctors or by doctors of osteopathy who have completed three years of post graduate residency training in psychiatry; or by a physician or doctor of osteopathy who is certified in addiction medicine. The provider must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities. Outpatient substance abuse treatment services are further defined in 12VAC30-50-228.~~

- ~~2. Psychological and psychiatric substance abuse services shall be prescribed treatment that is directly and~~

~~specifically related to an active written plan designed and signature dated by one of the professionals listed in subdivision 1 of this subsection.~~

~~3. Psychological or psychiatric substance abuse services shall be considered appropriate when an individual meets the criteria for an Axis I substance related disorder. Nicotine or caffeine abuse or dependence shall not be covered. The Axis I substance related disorder shall meet American Society of Addiction Medicine (ASAM) Level of Care Criteria as prescribed in Patient Placement Criteria for the Treatment of Substance Related Disorders (ASAM PPC 2R), Second Edition.~~

~~4. Psychological or psychiatric substance abuse services may be provided in an office or a clinic under the direction of a physician.~~

~~\*Licensed clinical social workers, licensed professional counselors, licensed clinical nurse specialists psychiatric, and licensed marriage and family therapists may also directly enroll or be supervised by psychologists as provided for in 12VAC30-50-150.~~

P. Addiction and recovery treatment services shall be covered in physician services consistent with 12VAC30-130-5000 et seq.

**12VAC30-50-150. Medical care by other licensed practitioners within the scope of their practice as defined by state law.**

A. Podiatrists' services.

1. Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by state law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity or for utilization control, or both.

B. Optometrists' services. Diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services are not provided.

D. Other practitioners' services; psychological services, psychotherapy. Limits and requirements for covered services are found under Outpatient Psychiatric Services (see 12VAC30-50-140 D).

1. These limitations apply to psychotherapy sessions provided, within the scope of their licenses, by licensed clinical psychologists or licensed clinical social workers/licensed professional counselors/licensed clinical nurse specialists-psychiatric/licensed marriage and family therapists who are either independently enrolled or under the direct supervision of a licensed clinical psychologist. Psychiatric services are limited to an initial availability of 26 sessions without prior authorization. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding treatment year when prior authorized by DMAS or its designee. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

2. Psychological testing is covered when provided, within the scope of their licenses, by licensed clinical psychologists or licensed clinical social workers/licensed professional counselors/licensed clinical nurse specialists-psychiatric, marriage and family therapists who are either independently enrolled or under the direct supervision of a licensed clinical psychologist.

~~E. Outpatient substance abuse services are limited to an initial availability of 26 sessions without prior authorization during the first treatment year. An additional extension of up to 26 sessions is available during the first treatment year and must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding year when prior authorized by DMAS or its designee. Outpatient substance abuse services are further restricted to no more than three sessions in any given seven-day period. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening and the above limits have been exceeded.~~

~~1. Outpatient substance abuse services shall be provided by a licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, a licensed substance abuse treatment practitioner, or an individual who holds a bachelor's degree and certification as a substance abuse counselor (CSAC) who is under the direct supervision of one of the licensed practitioners listed in this section, or an individual who holds a bachelor's degree and is a certified addictions counselor (CAC) who is under the direct supervision of one of the licensed practitioners listed in this section. The provider must also be qualified in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client,~~

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~~family, and community education; documentation; and professional and ethical responsibilities. Outpatient substance abuse treatment services are further defined in 12VAC30-50-228.~~

~~2. Psychological and psychiatric substance abuse services shall be prescribed treatment that is directly and specifically related to an active written plan designed and signature dated by one of the professionals listed in subdivision 1 of this subsection.~~

~~3. Psychological or psychiatric substance abuse services shall be considered appropriate when an individual meets criteria for an Axis I substance related disorder. Nicotine or caffeine abuse or dependence shall not be covered. The Axis I substance related disorder shall meet American Society of Addiction Medicine (ASAM) Level of Care Criteria as prescribed in Patient Placement Criteria for the Treatment of Substance Related Disorders (ASAM PPC-2R), Second Edition.~~

~~4. Psychological or psychiatric substance abuse services may be provided in an office or a clinic.~~

E. Addiction and recovery treatment services shall be covered in other licensed practitioner services consistent with 12VAC30-130-5000 et seq.

## **12VAC30-50-180. Clinic services.**

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of life to the mother if the fetus were 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 CFR 440.165, are furnished by or under the direction of a physician or dentist.

C. Reimbursement to community mental health clinics for medical psychotherapy services is provided only when performed by a qualified therapist. For purposes of this section, a qualified therapist is:

1. A licensed physician who has completed three years of post-graduate residency training in psychiatry;
2. An individual licensed by one of the boards administered by the Department of Health Professions to provide medical psychotherapy services including: licensed clinical psychologists, licensed psychiatric nurse practitioners, licensed clinical social workers, licensed professional counselors, clinical nurse specialists-psychiatric, or licensed marriage and family therapists; or
3. An individual who holds a master's or doctorate degree, who has completed all coursework necessary for licensure

by one of the appropriate boards as specified in subdivision 2 of this subsection, and who has applied for a license but has not yet received such license, and who is currently supervised in furtherance of the application for such license, in accordance with requirements or regulations promulgated by DMAS, by one of the licensed practitioners listed in subdivisions 1 and 2 of this subsection.

~~D. Coverage of community mental health clinics for substance abuse treatment services, as further defined in 12VAC30-50-228, is provided only when performed by a qualified therapist and consistent with an active written plan designed and signature dated. For purposes of providing this service a qualified therapist shall be:~~

~~1. Physicians and doctors of osteopathy who have completed three years of post-graduate residency training in psychiatry or by a physician or doctor of osteopathy who is certified in addiction medicine.~~

~~2. A licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, or a licensed substance abuse treatment practitioner. The provider must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities.~~

~~3. An individual who holds a master's or doctorate degree, who has completed all coursework necessary for licensure by the respective board, and who has applied for a license but has not yet received such license, and who is currently supervised in furtherance of the application for such license, in accordance with requirements or regulations promulgated by DMAS, by one of the licensed practitioners listed in this subsection.~~

~~4. An individual who holds a bachelor's degree in any field and certification as a substance abuse counselor (CSAC) or an individual who holds a bachelor's degree and is a certified addictions counselor (CAC) who is under the direct supervision of one of the licensed practitioners listed in subdivision C 1 or 2 of this subsection.~~

D. Addiction and recovery treatment services shall be covered in clinics consistent with 12VAC30-130-5000 et seq.

## **12VAC30-50-228. Community substance abuse treatment services. (Repealed.)**

~~A. Services to be covered shall include crisis intervention, day treatment services in nonresidential settings, intensive outpatient services, and opioid treatment services. These services shall be rendered to Medicaid recipients consistent with the criteria specified in 12VAC30-60-250. Individuals shall not receive any combination of day treatment, opioid~~

treatment, and intensive outpatient services concurrently. To be reimbursed by Medicaid, covered services shall meet the following definitions:

1. ~~Emergency (crisis) intervention. This service shall provide immediate substance abuse care, available 24 hours a day, seven days per week, to assist recipients who are experiencing acute dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the recipient or others, and to provide treatment in the context of the least restrictive setting. This service includes therapeutic intervention, stabilization, and referral assistance over the telephone or face to face for individuals seeking services for themselves or others. Services are provided in clinics, offices, homes, and other community locations.~~

~~a. An assessment must be conducted to assess the crisis situation. The assessment must document the need for the service.~~

~~b. Crisis intervention activities, limited annually to 180 hours, may include short term counseling designed to stabilize the recipient, providing access to further immediate assessment and follow up, and linking the recipient with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, telephone contacts, and face to face support or monitoring or other client related activities for the prevention of institutionalization.~~

~~c. Assessment and counseling may be provided by a Qualified Substance Abuse Professional (QSAP) as defined in 12VAC30-60-180, or a certified prescriber described in 12VAC30-50-226.~~

~~d. Monitoring and face to face support may be provided by a QSAP, a certified prescriber, or a paraprofessional. A paraprofessional, as described in 12VAC30-50-226, must be under the supervision of a QSAP and provide services in accordance with a plan of care.~~

2. ~~Substance abuse day treatment, intensive outpatient, and opioid treatment services. These services shall include the major psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; or occupational and recreational therapy, or other therapies. Family therapy must be focused on the Medicaid eligible individual. To be reimbursed by Medicaid, these covered services shall meet the following definitions:~~

~~a. Day treatment services shall be provided in a nonresidential setting and shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week to provide a minimum of 20 hours up to a maximum of 30 hours of skilled treatment services per week. This service should be~~

~~provided to those recipients who do not require the intensive level of care of inpatient or residential services but require more intensive services than outpatient services. Day treatment is the provision of coordinated, intensive, comprehensive, and multidisciplinary treatment to individuals through a combination of diagnostic, medical psychiatric and psychosocial interventions. The maximum annual limit is 1,300 hours. Day treatment services may not be provided concurrently with intensive outpatient services or opioid treatment services.~~

~~b. Intensive outpatient services for recipients are provided in a nonresidential setting and may be scheduled multiple times per week, with a maximum of 19 hours of skilled treatment services per week. This service should be provided to those recipients who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. Intensive outpatient services are provided in a concentrated manner, and generally involve multiple outpatient visits per week over a period of time for individuals requiring stabilization. These services include monitoring and multiple group therapy sessions during the week, and individual and family therapy which are focused on the Medicaid eligible individual. The maximum annual limit is 600 hours. Intensive outpatient services may not be provided concurrently with day treatment services or opioid treatment services.~~

~~c. Opioid treatment means an intervention strategy that combines treatment with the administering or dispensing of opioid agonist treatment medication. An individual specific, physician ordered dose of medication is administered or dispensed either for detoxification or maintenance treatment. Opioid treatment shall be provided in daily sessions with a maximum of 600 hours per year. Day treatment and intensive outpatient services may not be provided concurrently with opioid treatment. Opioid treatment service covers psychological and psycho-educational services. Medication costs for opioid agonists shall be billed separately. An individual-specific, physician ordered dose of medication may be administered or dispensed either for detoxification or maintenance treatment.~~

~~d. Staff qualifications for day treatment, intensive outpatient, and opioid treatment services shall be as follows:~~

~~(1) Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.~~

~~(2) A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention;~~

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and occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.

(3) Paraprofessionals must participate in supervision as described in 12VAC30-60-250.

**B. Evaluations required.** Prior to initiation of day treatment, intensive outpatient, or opioid treatment services, an evaluation shall be conducted by at least a QSAP. The minimum evaluation will consist of a structured objective assessment of the impact of substance use or dependence on the recipient's functioning in the following areas: drug use, alcohol use, legal system involvement, employment and/or school issues, and medical, family social, and psychiatric issues. If indicated by history or structured assessment, a psychological examination and psychiatric examination shall be included as part of this evaluation. The assessment must be a written report as specified at 12VAC30-60-250 and must document the medical necessity for the service.

**C. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989,** medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening and the above limits have been exceeded.

## **12VAC30-50-491. Case Substance use case management services for individuals who have an Axis I substance-related a primary diagnosis of substance use disorder.**

**A. Target group:** The Medicaid eligible recipient individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (DSM-5) diagnostic criteria for an Axis I substance-related a substance use disorder. Nicotine Tobacco-related disorders or caffeine abuse or dependence caffeine-related disorders and nonsubstance-related disorders shall not be covered. An active client for Substance use case management shall mean a recipient for whom there is a plan of care in effect which include an active individual service plan (ISP) that requires regular direct or recipient related contacts or communication or activity with the recipient, family or service providers, including a minimum of two substance use case management service activities each month and at least one face-to-face contact with the recipient individual at least every 90 calendar days.

**B. Services** will be provided to the entire state.

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

**D. Definition of services:** Substance abuse use case management services assist recipients individuals and their family members in accessing needed medical, psychiatric, psychological, social, educational, vocational, recovery, and other supports essential to meeting the individual's basic

needs. The maximum service limit for case management services is 52 hours per year. Case management services are not reimbursable for recipients residing in institutions, including institutions for mental disease. Substance use case management is reimbursable on a monthly basis only when the minimum substance use case management service activities are met. Substance use case management services are not reimbursable for individuals while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period. Tobacco-related disorders or caffeine-related disorders and nonsubstance-related disorders shall not be covered. Substance use case management does not include maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs. Substance use case management services are to be person centered, individualized, and culturally and linguistically appropriate to meet the individual's and family member's needs.

Services Substance use case management service activities to be provided shall include:

1. Assessment and planning services, to include developing an Individual Service Plan (does not include performing assessments for severity of substance abuse or dependence, medical, psychological and psychiatric assessment, but does include referral for such assessment);
2. Linking the recipient to services and supports specified in the Individual Service Plan. When available, assessment and evaluation information should be integrated into the Individual Service Plan within two weeks of completion. The Individual Service Plan shall utilize accepted patient placement criteria and shall be fully completed within 30 days of initiation of service;
3. Assisting the recipient directly for the purpose of locating, developing, or obtaining needed services and resources;
4. Coordinating services and service planning with other agencies and providers involved with the recipient;
5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;
6. Making collateral contacts with the recipients' significant others to promote implementation of the service plan and community adjustment;
7. Follow up and monitoring to assess ongoing progress and to ensure services are delivered; and
8. Education regarding the need for services identified in the Individualized Service Plan (ISP).

Nicotine or caffeine abuse or dependence shall not be covered.

1. Assessing needs and planning services to include developing a substance use case management individual service plan (ISP). The ISP shall utilize accepted placement criteria and shall be fully completed within 30 calendar days of initiation of service;
2. Enhancing community integration through increased opportunities for community access and involvement and enhancing community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;
3. Making collateral contacts with the individual's significant others with properly authorized releases to promote implementation of the individual's ISP and his community adjustment;
4. Linking the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative, recovery, and life goals of the individual as developed in the ISP;
5. Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;
6. Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.
7. Monitoring service delivery through contacts with individuals receiving services and service providers and site and home visits to assess the quality of care and satisfaction of the individual;
8. Providing follow-up instruction, education, and counseling to guide the individual and develop a supportive relationship that promotes the ISP;
9. Advocating for individuals in response to their changing needs, based on changes in the ISP;
10. Planning for transitions in the individual's life;
11. Knowing and monitoring the individual's health status, any medical condition, and medications and potential side effects and assisting the individual in accessing primary care and other medical services, as needed; and
12. Understanding the capabilities of services to meet the individual's identified needs and preferences and to serve the individual without placing the individual, other participants, or staff at risk of serious harm.

E. Qualifications of providers:

1. The provider of substance ~~abuse~~ use case management services must meet the following criteria:
  - a. The enrolled provider must have the administrative and financial management capacity to meet state and federal requirements;

- b. The enrolled provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;
- c. The enrolled provider must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of substance abuse case management services.

2. Providers may bill Medicaid for substance ~~abuse~~ use case management only when the services are provided by a professional or professionals who meet at least one of the following criteria:

- a. At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least either (i) one year of substance ~~abuse~~ use related ~~clinical~~ direct experience providing ~~direct~~ services to ~~persons~~ individuals with a diagnosis of ~~mental illness~~ or substance ~~abuse~~ use disorder or (ii) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness;
- b. Licensure by the Commonwealth as a registered nurse ~~or as a practical nurse~~ with (i) at least one year of clinical substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or (ii) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or
- c. ~~At least a bachelor's degree in any field and certification as a substance abuse counselor~~ Certification as a Board of Counseling Certified Substance Abuse Counselor (CSAC) or has at least a bachelor's degree in any field and is a certified addictions counselor (CAC) or CSAC-Assistant under supervision as defined in 18VAC115-30-10 et seq.

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

1. Eligible ~~recipients~~ individuals shall have free choice of the providers of substance use case management services.
2. Eligible ~~recipients~~ individuals shall have free choice of the providers of other services under the plan.

G. Payment for substance ~~abuse treatment~~ use case management or substance use care coordination services under the Plan does not duplicate payments for other case management made to public agencies or private entities under other Title XIX program authorities for this same purpose.

H. The state assures that the individual will not be compelled to receive substance use case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of



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other Medicaid services on receipt of case management services.

I. The state assures that providers of substance use case management service do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

J. The state assures that substance use case management is only provided by and reimbursed to community case management providers.

K. The state assures that substance use case management does not include the following:

1. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
2. Activities for which an individual may be eligible, that are integral to the administration of another nonmedical program, except for case management that is included in an individualized education program or individualized family service plan consistent with § 1903(c) of the Social Security Act.

## Part V

### Expanded Prenatal Care Services

#### **12VAC30-50-510. Requirements and limits applicable to specific services: expanded prenatal care services.**

A. Comparability of services: Services are not comparable in amount, duration and scope. Authority of § 9501(b) of COBRA 1985 allows an exception to provide service to pregnant women without regard to the requirements of § 1902(a)(10)(B).

B. Definition of services: Expanded prenatal care services will offer a more comprehensive prenatal care services package to improve pregnancy outcome. The expanded prenatal care services provider may perform the following services:

1. Patient education. Includes six classes of education for pregnant women in a planned, organized teaching environment including but not limited to topics such as body changes, danger signals, substance abuse, labor and delivery information, and courses such as planned parenthood, Lamaze, smoking cessation, and child rearing. Instruction must be rendered by Medicaid certified providers who have appropriate education, license, or certification.
2. Homemaker. Includes those services necessary to maintain household routine for pregnant women, primarily in third trimester, who need bed rest. Services include, but are not limited to, light housekeeping, child care, laundry, shopping, and meal preparation. Must be rendered by Medicaid certified providers.
3. Nutrition. Includes nutritional assessment of dietary habits, and nutritional counseling and counseling follow-up. All pregnant women are expected to receive basic

nutrition information from their medical care providers or the WIC Program. Must be provided by a Registered Dietitian (R.D.) or a person with a master's degree in nutrition, maternal and child health, or clinical dietetics with experience in public health, maternal and child nutrition, or clinical dietetics.

4. Blood glucose meters. Effective on and after July 1, 1993, blood glucose test products shall be provided when they are determined by the physician to be medically necessary for pregnant women suffering from a condition of diabetes which is likely to negatively affect their pregnancy outcomes. The women authorized to receive a blood glucose meter must also be referred for nutritional counseling. Such products shall be provided by Medicaid enrolled durable medical equipment providers.

~~5. Residential substance abuse treatment services for pregnant and postpartum women. Includes comprehensive, intensive residential treatment for pregnant and postpartum women to improve pregnancy outcomes by eliminating the substance abuse problem. Must be provided consistent with standards established to assure high quality of care in 12VAC30-60. Residential substance abuse treatment services for pregnant and postpartum women shall provide intensive intervention services in residential facilities other than inpatient facilities and shall be provided to pregnant and postpartum women (up to 60 days postpartum) with serious substance abuse disorders, for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug free lifestyle. The woman may keep her infant and other dependent children with her at the treatment center. The daily rate is inclusive of all services which are provided to the pregnant woman in the program. A unit of service shall be one day. The maximum number of units to be covered per pregnancy is 300 days, not to exceed 60 days postpartum. These services must be reauthorized every 90 days and after any absence of less than 72 hours which was not first authorized by the program director. The program director must document the reason for granting permission for any absences in the clinical record of the recipient. An unauthorized absence of more than 72 hours shall terminate Medicaid reimbursement for this service. Unauthorized hours absent from treatment shall be included in this lifetime service limit.~~

~~This type of treatment shall provide the following types of services or activities in order to be eligible to receive reimbursement by Medicaid:~~

- ~~a. Substance abuse rehabilitation, counseling and treatment must include, but is not necessarily limited to, education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; smoking cessation classes if needed; education about relapse~~

prevention to recognize personal and environmental cues which may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

b. Training about pregnancy and fetal development shall be provided at a level and in a manner comprehensible by the participating women to include, but is not necessarily limited to, the impact of alcohol and other drugs on fetal development, normal physical changes associated with pregnancy as well as training in normal gynecological functions, personal nutrition, delivery expectations, and infant nutrition.

e. Initial and ongoing assessments shall be provided specifically for substance abuse, including, but not limited to, psychiatric and psychological assessments.

d. Symptom and behavior management as appropriate for co-existing mental illness shall be provided, including medication management and ongoing psychological treatment.

e. Personal health care training and assistance shall be provided. Such training shall include:

(1) Educational services and referral services for testing, counseling, and management of HIV, provided as described in 42 USC § 300x 24(b)(6)(A) and (B), including early intervention services as defined in 42 USC § 300x 24(b)(7) and in coordination with the programs identified in 45 CFR 96.128;

(2) Educational services and referral services for testing, counseling, and management of tuberculosis, including tuberculosis services as described in 42 USC § 300x 24(a)(2) (1992) and in coordination with the programs identified in 45 CFR 96.127; and

(3) Education services and referral services for testing, counseling, and management of hepatitis.

f. Case coordination with providers of primary medical care shall be provided, including obstetrical/gynecological services for the recipient.

g. Training in decision making, anger management and conflict resolution shall be provided.

h. Extensive discharge planning shall be provided in collaboration with the recipient, any appropriate significant others, and representatives of appropriate service agencies.

6. Substance abuse day treatment for pregnant and postpartum women. Includes comprehensive, intensive day treatment for pregnant and postpartum women to improve pregnancy outcomes by eliminating the substance abuse problem. Must be provided consistent with the standards established to assure high quality of care in 12VAC30-60.

Substance abuse day treatment services for pregnant and postpartum women shall provide intensive intervention services at a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week, to pregnant and postpartum women (up to 60 days postpartum) with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, and achieving and maintaining a sober and drug free lifestyle. The pregnant woman may keep her infant and other dependent children with her at the treatment center. One unit of service shall equal two but no more than 3.99 hours on a given day. Two units of service shall equal at least four but no more than 6.99 hours on a given day. Three units of service shall equal seven or more hours on a given day. The limit on this service shall be 400 units per pregnancy, not to exceed 60 days post partum. Services must be reauthorized every 90 days and after any absence of five consecutive days from scheduled treatment without staff permission. More than two episodes of five day absences from scheduled treatment without prior permission from the program director or one absence exceeding seven days of scheduled treatment without prior permission from the program director shall terminate Medicaid funding for this service. The program director must document the reason for granting permission for any absences in the clinical record of the recipient. Unauthorized hours absent from treatment shall be included in the lifetime service limit. In order to be eligible to receive Medicaid payment the following types of services shall be provided:

a. Substance abuse rehabilitation, counseling and treatment shall be provided, including education about the impact of alcohol and other drugs on the fetus and on the maternal relationship, smoking cessation classes if needed; relapse prevention to recognize personal and environmental cues which may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

b. Training about pregnancy and fetal development shall be provided at a level and in a manner comprehensible by the participating women to include, but not necessarily be limited to, the impact of alcohol and other drugs on fetal development; normal physical changes associated with pregnancy, as well as training in normal gynecological functions; personal nutrition; delivery expectations; and infant nutrition.

e. Initial and ongoing assessments shall be provided specifically for substance abuse, including psychiatric and psychological assessments.

d. Symptom and behavior management as appropriate for co-existing mental illness shall be provided, including

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medication management and ongoing psychological treatment.

e. Personal health care training and assistance shall be provided. Such training shall include:

(1) Educational services and referral services for testing, counseling, and management of HIV, provided as described in 42 USC § 300x 24(b)(6)(A) and (B), including early intervention services as defined in 42 USC § 300x 24(b)(7) and in coordination with the programs identified in 45 CFR 96.128;

(2) Educational services and referral services for testing, counseling, and management of tuberculosis, including tuberculosis services as described in 42 USC § 300x 24(a)(2) (1992) and in coordination with the programs identified in 45 CFR 96.127; and

(3) Educational services and referral services for testing, counseling, and management of hepatitis.

f. Case coordination with providers of primary medical care shall be provided, including obstetrics and gynecology services for the recipient.

g. Training in decision making, anger management and conflict resolution shall be provided.

h. Extensive discharge planning shall be provided in collaboration with the recipient, any appropriate significant others, as well as representatives of appropriate service agencies.

5. Addiction and recovery treatment services shall be covered in expanded prenatal care services consistent with 12VAC30-130-5000 et seq.

## C. Qualified providers.

1. Any duly enrolled provider which the department determines to be qualified who has signed an agreement may provide expanded prenatal care services.

2. The qualified providers will provide prenatal care services regardless of their capacity to provide any other services under the Plan.

3. Providers of substance abuse treatment services must be licensed and approved by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). Substance abuse services providers shall be required to meet the standards and criteria established by DMHMRSAS and the following additional requirements:

a. The provider shall ensure that recipients have access to emergency services on a 24 hour basis seven days per week, 365 days per year, either directly or via an on-call system.

b. Services must be authorized following face to face evaluation/diagnostic assessment conducted by one of the following professionals who must not be the same individual providing nonmedical clinical supervision:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or

rehabilitation who is also either certified as a substance abuse counselor by the Board of Counselors, as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

e. A provider of substance abuse treatment services for pregnant and postpartum women must meet the following requirements for day treatment services for pregnant and postpartum women:

(1) Medical care must be coordinated by a nurse case manager who is a registered nurse licensed by the Board of Nursing and who demonstrates competency in the following areas:

(a) Health assessment;

(b) Mental health;

(c) Substance abuse;

(d) Obstetrics and gynecology;

(e) Case management;

(f) Nutrition;

(g) Cultural differences; and

(h) Counseling.

(2) The nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical services, specifically with each obstetrician providing services to the women. In addition, the nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.

Providers of addiction and recovery treatment services shall meet the requirements of 12VAC30-130-5000 et seq.

**12VAC30-60-147. Substance abuse treatment services utilization review criteria. (Repealed.)**

~~A. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services that must be provided to participants, linkages to other programs tailored to specific individual needs, and program staff qualifications. The following services must be rendered to program participants and documented in their case files in order for this residential service to be reimbursed by Medicaid.~~

~~1. Services must be authorized following face to face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in 12VAC30 50 510.~~

~~a. To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically Managed Medium Intensity Residential Treatment) or Level III.5 (Clinically Managed Medium/High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically Managed Medium Intensity Residential Treatment) or Level III.5 (Clinically Managed Medium High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.~~

~~b. Utilization reviews shall verify, but not be limited to, the presence of these 90 day reauthorizations as well as the appropriate reauthorizations after absences.~~

~~c. Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.~~

~~d. The Individual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two-week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.~~

~~e. The ISP shall be reviewed and updated every two weeks.~~

~~f. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.~~

~~g. Face to face therapeutic contact with the woman which is directly related to her Individual Service Plan shall be documented at least twice per week.~~

~~h. While the woman is participating in this substance abuse residential program, reimbursement shall not be made for any other community mental health, intellectual disability, or substance abuse rehabilitation services concurrently rendered to her.~~

~~i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.~~

~~2. Linkages to other services. Access to the following services shall be provided and documented in either the woman's record or the program documentation:~~

~~a. The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine of the Virginia Department of Health Professions.~~

~~b. The program must also have a documented agreement with a high risk pregnancy unit of a tertiary care hospital to provide 24 hour access to services for the woman and ongoing training and consultation to the staff of the program.~~

~~e. In addition, the provider must provide access to the following services either through staff at the residential program or through contract:~~

~~(1) Psychiatric assessments as needed, which must be performed by a physician licensed to practice by the Virginia Board of Medicine.~~

~~(2) Psychological assessments as needed, which must be performed by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.~~

~~(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Board of Medicine in consultation with the high risk pregnancy unit, if appropriate.~~

~~(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision~~

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provided by a clinical psychologist licensed to practice by the Board of Psychology.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., other Medicaid-sponsored primary health care programs).

3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by DBHDS to provide residential substance abuse services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of Counseling of the Virginia Department of Health Professions or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. Residential facility capacity shall be limited to 16 adults. Dependent children who accompany the woman into the residential treatment facility and neonates born while the woman is in treatment shall not be included in the 16-bed capacity count. These children shall not receive any treatment for substance abuse or psychiatric disorders from the facility.

d. The minimum ratio of clinical staff to women should ensure that sufficient numbers of staff are available to adequately address the needs of the women in the program.

B. Substance abuse day treatment services for pregnant and postpartum women. This subsection provides for required services that must be provided to women, linkages to other

programs tailored to specific needs, and program and staff qualifications.

1. The following services must be rendered and documented in case files in order for this day treatment service to be reimbursed by Medicaid:

a. Services must be authorized following a face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed professionals as specified in 12VAC30-50-510.

b. To assess whether the woman will benefit from the treatment provided by this service, the licensed health professional shall utilize the Adult Patient Placement Criteria for Level II.1 (Intensive Outpatient Treatment) or Level II.5 (Partial Hospitalization) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of these appropriately authorized professionals, based on documented assessment using Level II.1 (Adult Continued Service Criteria for Intensive Outpatient Treatment) or Level II.5 (Adult Continued Service Criteria for Partial Hospitalization Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the appropriately authorized professionals if the patient is absent for five consecutively scheduled days of services without staff permission. All of the authorized professionals shall demonstrate competency in the use of these criteria. This individual shall not be the same individual providing nonmedical clinical supervision in the program.

c. Utilization reviews shall verify, but not be limited to, the presence of these 90 day reauthorizations, as well as the appropriate reauthorizations after absences.

d. Documented assessment regarding the woman's need for the intense level of services; the assessment must have occurred within 30 days prior to admission.

e. The Individual Service Plan (ISP) shall be developed within 14 days of admission and an obstetric assessment completed and documented within a 30-day period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

f. The ISP shall be reviewed and updated every four weeks.

g. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

h. Face to face therapeutic contact with the woman, which is directly related to her ISP, shall be documented at least once per week.

i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning shall seek to begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug free environment and treatment supports for the woman.

j. While participating in this substance abuse day treatment program, the only other mental health, intellectual disability, or substance abuse rehabilitation services which can be concurrently reimbursed shall be mental health emergency services or mental health crisis stabilization services.

2. Linkages to other services or programs. Access to the following services shall be provided and documented in the woman's record or program documentation:

a. The program must have a contractual relationship with an obstetrician/gynecologist. The obstetrician/gynecologist must be licensed by the Virginia Board of Medicine as a medical doctor.

b. The program must have a documented agreement with a high risk pregnancy unit of a tertiary care hospital to provide 24 hour access to services for the women and ongoing training and consultation to the staff of the program.

e. In addition, the program must provide access to the following services (either by staff in the day treatment program or through contract):

(1) Psychiatric assessments, which must be performed by a physician licensed to practice by the Board of Medicine of the Virginia Department of Health Professions.

(2) Psychological assessments, as needed, which must be performed by clinical psychologist licensed to practice by the Virginia Board of Psychology.

(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Virginia Board of Medicine in consultation with the high risk pregnancy unit, if appropriate.

(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the

women in the program through other means (e.g., other Medicaid sponsored primary health care programs).

3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by DBHDS to provide either substance abuse outpatient services or substance abuse day treatment services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following appropriately licensed professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Virginia Board of Counseling or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

e. The minimum ratio of clinical staff to women should ensure that adequate staff are available to address the needs of the women in the program.

**12VAC30-60-180. Utilization review of community substance abuse treatment services. (Repealed.)**

A. To be eligible to receive these substance abuse treatment services, Medicaid recipients must meet the Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR) diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria as prescribed in Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders (ASAM PPC 2R) shall be used to determine the appropriate level of treatment. Referrals for medical examinations shall be made consistent with the Early Periodic Screening and Diagnosis Screening Schedule.

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## B. Provider qualifications:

1. ~~For Medicaid reimbursed Substance Abuse Day Treatment, Substance Abuse Intensive Outpatient Services, Opioid Treatment Services, a Qualified Substance Abuse Professional (QSAP) is defined as:~~

~~a. An individual who has completed master's level training in psychology, social work, counseling, or rehabilitation who also either:~~

~~(1) Is certified as a substance abuse counselor by the Virginia Board of Counseling;~~

~~(2) Is certified as an addictions counselor by the Substance Abuse Certification Alliance of Virginia; or~~

~~(3) Holds any certification from the National Association of Alcoholism and Drug Abuse Counselors, or the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC);~~

~~b. An individual licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, psychiatric clinical nurse specialist, psychiatric nurse practitioner, marriage and family therapist, clinical psychologist, or physician who is qualified by training and experience in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities;~~

~~c. An individual who is licensed as a substance abuse treatment practitioner by the Virginia Board of Counseling;~~

~~d. An individual who is certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a Master Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors or by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC);~~

~~e. An individual who has completed master's level training in psychology, social work, counseling, or rehabilitation and is certified as a Master Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors or by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC);~~

~~f. An individual who has completed a bachelor's degree and is certified as a Substance Abuse Counselor by the Board of Counseling;~~

~~g. An individual who has completed a bachelor's degree and is certified as an Addictions Counselor by the Substance Abuse Certification Alliance of Virginia; or~~

~~h. An individual who has completed a bachelor's degree and is certified as a Level II Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors or by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC).~~

~~If staff providing services meet only the criteria specified in subdivisions 1 f through h of this subsection, they must be supervised every two weeks by a professional who meets one of the criteria specified in subdivisions 1 a through e of this subsection. Supervision shall include documented face to face meetings between the supervisor and the professional providing the services. Documentation shall include review and approval of the plan of care for each recipient to whom services were provided but shall not require that the supervisor be onsite at the time the treatment service is provided.~~

2. ~~In order to provide substance abuse treatment services, a paraprofessional (peer support specialist) must meet the following qualifications:~~

~~a. An associate's degree in one of the following related fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, or human services counseling) and has at least one year of experience providing direct services to persons with a diagnosis of mental illness or substance abuse;~~

~~b. An associate's or higher degree, in an unrelated field and at least three years experience providing direct services to persons with a diagnosis of mental illness, substance abuse, gerontology clients, or special education clients. The experience may include supervised internships, practicums, and field experience;~~

~~c. A minimum of 90 hours classroom training in behavioral health and 12 weeks of experience under the direct personal supervision of a QSAP providing services to persons with mental illness or substance abuse and at least one year of clinical experience (including the 12 weeks of supervised experience);~~

~~d. College credits (from an accredited college) earned toward a bachelor's degree in a human service field that is equivalent to an associate's degree and one year's clinical experience; and~~

~~e. Licensure by the Commonwealth as a practical nurse with at least one year of clinical experience.~~

3. ~~Paraprofessionals must participate in clinical supervision with a QSAP at least twice a month. Supervision shall include documented face to face meetings between the supervisor and the professional providing the services. Supervision may occur individually or in a group.~~

4. ~~All providers of substance abuse treatment services must adhere to the requirements of 42 CFR Part 2,~~

~~Confidentiality of Alcohol and Drug Abuse Patient Records.~~

~~5. Day treatment providers must be licensed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) as providers of day treatment services. Intensive outpatient providers must be licensed by the DBHDS as providers of outpatient substance abuse services. The enrolled provider of opioid treatment services must be licensed as a provider of opioid treatment services by DBHDS.~~

~~C. Evaluations/assessments of the recipient shall be required for day treatment, intensive outpatient, and opioid treatment services. A structured interview shall be documented as a written report that provides recommendations substantiated by the findings of the evaluation and shall document the need for the specific service. Evaluations shall be reimbursed as part of day treatment, intensive outpatient, and opioid treatment services. The structured interview must be conducted by a qualified substance abuse professional as defined above.~~

~~D. Individual Service Plan (ISP) for day treatment, intensive outpatient, and opioid treatment services.~~

~~1. An initial ISP must be developed. A comprehensive ISP must be fully developed within 30 calendar days of admission to the service.~~

~~2. A comprehensive Individual Service Plan shall be developed with the recipient, in consultation with the individual's family, as appropriate, and must address: (i) a summary or reference to the evaluation; (ii) short term and long term goals and measurable objectives for addressing each identified individually specific need; (iii) services and supports and frequency of service to accomplish the goals and objectives; (iv) target dates for accomplishment of goals and objectives; (v) estimated duration of service; and (vi) the role of other agencies if the plan is a shared responsibility and the staff responsible for the coordination and the integration of services, including designated persons of other agencies if the plan is a shared responsibility. The ISP must be reviewed at least every 90 calendar days and must be modified as appropriate.~~

~~E. Individuals shall not receive any combination of day treatment, opioid treatment, and intensive outpatient services concurrently.~~

~~F. Crisis intervention. Admission to crisis intervention services is indicated following a marked reduction in the recipient's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress that is related to the use of alcohol or other drugs. Crisis intervention may be the initial contact with a recipient.~~

~~1. The provider of crisis intervention services shall be licensed as a provider of Substance Abuse Outpatient Services by DBHDS. Providers may bill Medicaid for substance abuse crisis intervention only when the services~~

~~are provided by either a professional or professionals who meet at least one of the criteria listed herein.~~

~~2. Only recipient related activities provided in association with a face to face contact shall be reimbursable.~~

~~3. An ISP shall not be required for newly admitted recipients to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.~~

~~4. Other than the annual service limits, there shall be no restrictions (regarding numbers of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts. An ISP must be developed within 30 days of service initiation.~~

~~5. For recipients receiving scheduled, short term counseling as part of the crisis intervention service, the ISP must reflect the short term counseling goals.~~

~~6. Crisis intervention services may be provided outside of the clinic and billed, provided the provision of out of clinic services is clinically or programmatically appropriate for the recipient's needs, and it is included on the ISP. Travel by staff to provide out of clinic services shall not be reimbursable. Crisis intervention may involve contacts with the family or significant others.~~

~~7. Documentation must include the efforts at resolving the crisis to prevent institutional admissions.~~

**12VAC30-60-181. Utilization review of addiction, recovery, and treatment services.**

A. Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider's care. Such documentation shall fully disclose the extent of services provided in order to support provider's claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

B. Utilization reviews shall be conducted by the Department of Medical Assistance Services or its designated contractor.

C. Service authorizations shall be required for American Society of Addiction Medicine (ASAM) Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0.

D. A multidimensional assessment by a credentialed addiction treatment professional, as defined in 12VAC30-130-5020, shall be required for ASAM Levels 1.0 through 4.0. The multidimensional assessment shall be maintained in the individual's record by the provider. Medical necessity for all ASAM levels of care shall be based on the outcome of the individual's multidimensional assessment.

E. Individual service plans (ISPs) and treatment plans shall be developed upon admission to medically managed intensive inpatient services (ASAM Level 4.0), substance use



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residential and inpatient services (ASAM Levels 3.1, 3.3, 3.5, and 3.7), and substance use intensive outpatient and partial hospitalization programs (ASAM Levels 2.1 and 2.5). ISPs or treatment plans shall be developed upon initiation of opioid treatment services (OTP) and office-based opioid treatment (OBOT); and substance use outpatient services (ASAM Level 1.0).

1. The provider shall include the individual and the family or caregiver, as may be appropriate, in the development of the ISP or treatment plan. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be updated at least annually and as the individual's needs and progress change. An ISP that is not updated either annually or as the individual's needs and progress change shall be considered outdated.

2. All ISPs shall be completed and contemporaneously signed and dated by the credentialed addiction treatment professional preparing the ISP.

3. The child's or adolescent's ISP shall also be signed by the parent or legal guardian, and the adult individual shall sign his own ISP. If the individual, whether a child, adolescent, or adult, is unwilling or unable to sign the ISP, then the service provider shall document the reasons why the individual was not able or willing to sign the ISP.

F. A comprehensive ISP, as defined in 12VAC30-50-226, shall be fully developed within 30 calendar days of the initiation of services. The comprehensive ISP shall be developed with the individual, in consultation with the individual's family, as appropriate, and shall address (i) a summary or reference to the individual's identified needs; (ii) short-term and long-term goals and measurable objectives for addressing each identified individually specific need; (iii) services and supports and frequency of services to accomplish the goals and objectives; (iv) target dates for accomplishment of goals and objectives; (v) estimated duration of service; and (vi) the role or roles of other agencies if the plan is a shared responsibility and the staff designated as responsible for the coordination and integration of services. The ISP shall be reviewed at least every 90 calendar days and shall be modified as the needs and progress of the individual changes. Documentation of the ISP review shall include the dated signatures of the credentialed addiction treatment professional and the individual.

G. Progress notes, as defined in 12VAC30-50-130, shall disclose the extent of services provided and corroborate the units billed. Claims not supported by corroborating progress notes may be subject to recovery of expenditures.

## **12VAC30-60-185. Utilization review of substance use case management.**

A. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes and are part of the minimum documentation requirements that convey the individual's status, staff intervention, and as appropriate, the individual's progress or lack of progress toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed for each rendered service. Progress notes shall be documented for each service that is billed.

"Register" or "registration" means notifying the Department of Medical Assistance Services or its contractor that an individual will be receiving services that do not require service authorization such as outpatient services for substance use disorders or substance use case management.

A. B. Utilization review: ~~community substance abuse treatment~~ substance use case management services.

1. The Medicaid ~~recipient~~ enrolled individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (~~DSM-IV TR~~) (DSM-5) criteria for an ~~Axis I substance-related~~ substance use disorder. ~~Nicotine Tobacco-related disorders or caffeine abuse or dependence~~ caffeine-related disorders and nonsubstance-related disorders shall not be covered.

2. Reimbursement shall be provided only for "active" case management. An active client for substance use case management shall mean an individual for whom there is a ~~plan of care~~ current substance use individual service plan (ISP) in effect that requires ~~regular direct or client related contacts or activity or communication with the client or families, significant others, service providers, and others~~ including a minimum of two distinct substance use case management activities being performed each calendar month and at a minimum one face-to-face client contact within a 90-day at least every 90-calendar-day period.

3. ~~Except for a 30-day period following the initiation of this case management service by the recipient, in order to continue receiving case management services, the Medicaid recipient must be receiving another substance abuse treatment service.~~

4. ~~3.~~ Billing can be submitted for an active recipient only for months in which ~~direct or client related contacts, activity, or communications occur~~ a minimum of two distinct substance use case management activities are performed.

~~5. There is a maximum annual service limit of 52 hours for case management services.~~

~~6. An initial Individual Service Plan (ISP) must~~ 4. An ISP shall be completed within 30 calendar days of initiation of this service with the individual in a person-centered manner and ~~must~~ shall document the need for active substance use case management before such case management services can be billed. A ~~comprehensive~~ The ISP shall be fully developed within 30 days of initiation of this service, which requires regular direct or recipient-related contacts or activity or communication with the recipient or families, significant others, service providers, and others including require a minimum of two distinct substance use case management activities being performed each calendar month and a minimum of one face-to-face client contact at least every 90 calendar days. The substance use case manager shall review the ISP with the individual at least every 90 calendar days for the purpose of evaluating and updating it or otherwise modifying it as appropriate for the recipient's changing condition the individual's progress toward meeting the individualized service plan objectives.

~~7. The ISP shall be updated at least every 90 days or within seven days of a change in the recipient's treatment.~~

~~5. The ISP shall be reviewed with the individual present, and the outcome of the review documented in the individual's medical record.~~

~~B. C. Utilization review: substance abuse treatment use case management services.~~

~~1. Utilization review general requirements. On site utilization~~ Utilization reviews shall be conducted by DMAS or its designated contractor. Reimbursement shall be provided only for "active" case management clients. An active client for case management shall mean an individual for whom there is a plan of care in effect that requires regular direct or client related contacts or activity or communication with the client or families, significant others, service providers, and others including when there is an active ISP and a minimum of two distinct substance use case management activities are performed each calendar month and there is a minimum of one face-to-face client contact within a 90-day at least every 90-calendar-day period. Billing can be submitted only for months in which direct or client related contacts, activity or communications occur a minimum of two distinct substance use case management activities are performed within the calendar month.

~~2. The Medicaid eligible individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) criteria for an Axis I Substance Abuse Disorder with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for reimbursement of these services. In order to receive reimbursement,~~

providers shall register this service with the managed care organization or the behavioral health services administration, as required, within one business day of service initiation to avoid duplication of services and to ensure informed and seamless care coordination between substance use treatment and substance use case management providers.

3. The Medicaid eligible individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for a substance use disorder with the exception of tobacco-related disorders or caffeine-related disorders and nonsubstance-related disorders.

~~3. The maximum annual limit for substance abuse treatment case management shall be 52 hours per year.~~ Case 4. Substance use case management shall not be billed for persons individuals in institutions for mental disease, except during the month prior to discharge to allow for discharge planning, limited to two months within a 12-month period. Substance abuse treatment use case management shall not be billed concurrently with any other type of Medicaid reimbursed case management and care coordination.

~~4. 5. The ISP must, as defined in 12VAC30-50-226, shall document the need for substance use case management and be fully completed within 30 calendar days of initiation of the service and the substance use case manager shall review the ISP at least every three months~~ 90 calendar days. Such reviews must shall be documented in the client's individual's medical record. The review will be due by the last day of the third month following the month in which the last review was completed. If needed a grace period will be granted up to the last day of the fourth month following the month date of the last review. When the review was is completed in a grace period, the next subsequent review shall be scheduled three months 90 calendar days from the month date the review was initially due and not the date of actual review.

~~5. 6. The ISP shall be updated and documented in the individual's medical record at least annually and as an individual's needs change.~~

~~6. 7. The provider of substance use case management services shall be licensed by DBHDS Department of Behavioral Health and Developmental Services as a provider of substance use case management and credentialed by the behavioral health services administration or managed care organization as a provider of substance use case management services.~~

~~8. Progress notes, as defined in subsection A of this section, shall be required to disclose the extent of services provided and corroborate the units billed.~~

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Part V  
Inpatient Hospital Payment System

Article 1  
Application of Payment Methodologies

**12VAC30-70-201. Application of payment methodologies.**

A. The state agency will pay for inpatient hospital services, as set out in 12VAC30-50-100, in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12VAC30-70-221 et seq.) describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12VAC30-70-400 et seq.) describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals shall be subject to the provisions of Supplement 3 (12VAC30-70-10 through 12VAC30-70-130).

C. Inpatient hospital facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) shall be reimbursed costs. Facilities may also receive disproportionate share hospital (DSH) payments. The criteria for DSH eligibility and the payment amount shall be based on subsection F of 12VAC30-70-50. If the DSH limit is exceeded by any facility, the excess DSH payments shall be distributed to all other qualifying DBHDS facilities in proportion to the amount of DSH they otherwise receive.

D. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre-hospitalization and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

E. Reduction of payments methodology.

1. For state fiscal years 2003 and 2004, the Department of Medical Assistance Services (DMAS) shall reduce payments to hospitals participating in the Virginia Medicaid Program by \$8,935,825 total funds, and \$9,227,815 total funds respectively. For purposes of distribution, each hospital's share of the total reduction amount shall be determined as provided in this subsection.

2. Determine base for revenue forecast.

a. DMAS shall use, as a base for determining the payment reduction distribution for hospitals Type I and Type II, net Medicaid inpatient operating reimbursement and outpatient reimbursed cost, as recorded by DMAS for state fiscal year 1999 from each individual hospital settled cost reports. This figure is further reduced by 18.73%, which represents the estimated statewide HMO average percentage of Medicaid business for those hospitals engaged in HMO contracts, to arrive at net baseline proportion of non-HMO hospital Medicaid business.

b. For freestanding psychiatric hospitals, DMAS shall use estimated Medicaid revenues for the six-month period (January 1, 2001, through June 30, 2001), times two, and adjusted for inflation by 4.3% for state fiscal year 2002, 3.1% for state fiscal year 2003, and 3.7% for state fiscal year 2004, as reported by DRI-WEFA, Inc.'s, hospital input price level percentage moving average.

3. Determine forecast revenue.

a. Each Type I hospital's individual state fiscal year 2003 and 2004 forecast reimbursement is based on the proportion of non-HMO business (see subdivision 2 a of this subsection) with respect to the DMAS forecast of SFY 2003 and 2004 inpatient and outpatient operating revenue for Type I hospitals.

b. Each Type II, including freestanding psychiatric, hospital's individual state fiscal year 2003 and 2004 forecast reimbursement is based on the proportion of non-HMO business (see subdivision 2 of this subsection) with respect to the DMAS forecast of SFY 2003 and 2004 inpatient and outpatient operating revenue for Type II hospitals.

4. Each hospital's total yearly reduction amount is equal to their respective state fiscal year 2003 and 2004 forecast reimbursement as described in subdivision 3 of this subsection, times 3.235857% for state fiscal year 2003, and 3.235857%, for the first two quarters of state fiscal year 2004 and 2.88572% for the last two quarters of state fiscal year 2004, not to be reduced by more than \$500,000 per year.

5. Reductions shall occur quarterly in four amounts as offsets to remittances. Each hospital's payment reduction shall not exceed that calculated in subdivision 4 of this subsection. Payment reduction offsets not covered by

claims remittance by May 15, 2003, and 2004, will be billed by invoice to each provider with the remaining balances payable by check to the Department of Medical Assistance Services before June 30, 2003, or 2004, as applicable.

F. Consistent with 42 CFR 447.26 and effective July 1, 2012, the Commonwealth shall not reimburse inpatient hospitals for provider-preventable conditions (PPCs), which include:

1. Health care-acquired conditions (HCACs). HCACs are conditions occurring in any hospital setting, identified as a hospital-acquired condition (HAC) by Medicare other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.
2. Other provider preventable conditions (OPPCs) as follows: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; or (iii) surgical or other invasive procedure performed on the wrong patient.

**12VAC30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT.**

A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12VAC30-70-321 plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's geographic area times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12VAC30-70-271.

C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio total of capital cost to total charges of the hospital, using data available from Medicare cost report.

E. Effective July 1, 2014, services provided under arrangement, as defined in subdivisions B 6 a and B 6 b of 12VAC30-50-130, shall be reimbursed directly by DMAS, according to the reimbursement methodology prescribed for each provider in 12VAC30-80 or elsewhere in the State Plan, to a provider of services under arrangement if all of the following are met:

1. The services are included in the active treatment plan of care developed and signed as described in subdivision C 4 of 12VAC30-60-25; and

2. The services are arranged and overseen by the freestanding psychiatric hospital treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the freestanding psychiatric hospital or under contract for services provided under arrangement.

**12VAC30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT.**

A. Effective January 1, 2000, DMAS shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers under the terms and payment methodology described in this section.

B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by DMAS based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all services provided under arrangement that are reimbursed in the manner described in subsection D of this section.

C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by DMAS at such time as required by DMAS. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, DMAS shall take action in accordance with its policies to assure that an overpayment is not being made.

D. Effective July 1, 2014, services provided under arrangement, as defined in subdivisions B 6 a and B 6 b of 12VAC30-50-130, shall be reimbursed directly by DMAS to a provider of services provided under arrangement according to the reimbursement methodology prescribed for that provider type elsewhere in the State Plan if all of the following are met:

1. The services provided under arrangement are included in the active written treatment plan of care developed and signed as described in section 12VAC30-130-890; and
2. The services provided under arrangement are arranged and overseen by the residential treatment facility treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the residential treatment facility or under contract for services provided under arrangement.

**12VAC30-80-32. Reimbursement for substance abuse services.**

1. Outpatient psychotherapy services for assessment and evaluation or treatment of substance abuse furnished by physicians shall be reimbursed using the methodology in 12VAC30-80-190. For nonphysicians, they shall be reimbursed at the same levels specified in 12VAC30-50-140 and 12VAC30-50-150. A. Physician services described in 12VAC30-50-140, other licensed practitioner services

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described in 12VAC30-50-150, and clinic services described in 12VAC30-50-180 for assessment and evaluation or treatment of substance use disorders shall be reimbursed using the methodology in 12VAC30-80-30 and 12VAC30-80-190 subject to the following reductions for psychotherapy services for other licensed practitioners.

1. Psychotherapy services of licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

2. Psychotherapy services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed psychiatric nurse practitioners, licensed substance abuse treatment practitioners, or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

3. The same rates shall be paid to governmental and private providers. These services are reimbursed based on the Common Procedural Terminology codes and Healthcare Common Procedure Coding System codes. The agency's rates were set as of July 1, 2007, and are updated as described in 12VAC30-80-190. All rates are published on the Department of Medical Assistance Services (DMAS) website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov).

2. B. Rates for other substance abuse the following addiction and recovery treatment services (ARTS) physician and clinic services shall be based on the agency fee schedule for 15 minute units of service; medication assisted treatment induction with a visit unit of service; individual and group opioid treatment service with a 15-minute unit of service; and substance use care coordination with a monthly unit of service. The agency's rates shall be set as of April 1, 2017. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. For each level of professional necessary to provide services described in 12VAC30-50-228 and 12VAC30-50-491 separate rates shall be established for licensed professionals, qualified substance abuse professionals (QSAP) and paraprofessionals. The same rates shall be paid to public and private providers. All rates are published on the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov).

3. C. Community substance abuse services: Rehabilitation ARTS rehabilitation services. Rates Per diem rates for community substance abuse rehabilitation services shall be based on the agency fee schedule for 15 minute units of service. Separate rates shall be established for licensed professionals, qualified substance abuse professionals (QSAP) and paraprofessionals as described in 12VAC30-50-228 clinically managed low intensity residential services (ASAM Level 3.1), partial hospitalization (ASAM Level 2.5), and intensive outpatient (ASAM Level 2.1) for ARTS shall be based on the agency fee schedule. The Medicaid and

commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates were set as of July 1, 2007 shall be set as of April 1, 2017, and are effective for services on or after that date. All rates are published on the DMAS website at: [www.dmas.virginia.gov](http://www.dmas.virginia.gov).

4. Outpatient substance abuse services: Physician services. Outpatient psychotherapy services for assessment and evaluation or treatment of substance abuse furnished by physicians, as described in 12VAC30-50-140, shall be reimbursed using the methodology described in this section and in 12VAC30-80-190. The same rates shall be paid to governmental and private providers. These services are reimbursed based on the Common Procedural Terminology (CPT) Codes. The agency's rates were set as of July 1, 2007, and are updated as described in 12VAC30-80-190. All rates are published on the DMAS website at: [www.dmas.virginia.gov](http://www.dmas.virginia.gov).

5. Outpatient substance abuse services: Other providers, including Licensed Mental Health Professionals (LMHP). Outpatient substance abuse services furnished by other licensed practitioners, as described in 12VAC30-50-150, shall be reimbursed using the methodology described in section 12VAC30-80-30 and in 12VAC30-80-190 and based upon the percentages set forth below. The same rates shall be paid to governmental and private providers. The agency's rates were set as of July 1, 2007, and are updated as described in 12VAC30-80-190. All rates are published on the DMAS website website at: [www.dmas.virginia.gov](http://www.dmas.virginia.gov).

a. Services of a licensed clinical psychologist shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, psychiatric nurse practitioners, licensed substance abuse treatment practitioner, or licensed clinical nurse specialists psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

6. Substance abuse services: Clinic services. Outpatient psychotherapy services for assessment and evaluation or treatment of substance abuse furnished by clinics as described in 12VAC30-50-150, shall be reimbursed using the methodology described in 12VAC30-80-30 and in 12VAC30-80-190. The fee schedule in effect, as of July 1, 2007, is an aggregate that is approximately 80% of the Medicare rates for these services. The same rates shall be paid to governmental and private providers. The agency's rates were set as of July 1, 2007, and are updated as described in 12VAC30-80-190. All rates are published on the DMAS website at: [www.dmas.virginia.gov](http://www.dmas.virginia.gov).

~~7. Substance abuse services: Case management services. Substance abuse case management services furnished by professionals as described in 12VAC30-50-140, 12VAC30-50-150 and in 12VAC30-50-491, shall be reimbursed based on the agency fee schedule for 15 minute units of service. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates were set as of July 1, 2007, and are effective for services on or after that date. All rates are published on the DMAS website at: [www.dmas.virginia.gov](http://www.dmas.virginia.gov).~~

D. ARTS federally qualified health center or rural health clinic services (ASAM Level 1.0) for assessment and evaluation or treatment of substance use disorder, as described in 12VAC30-130-5000 et seq., shall be reimbursed using the methodology described in 12VAC30-80-25.

E. Substance use case management services. Substance use case management services, as described in 12VAC30-50-491, shall be reimbursed a monthly rate based on the agency fee schedule. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payment shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates shall be set as of April 1, 2017, and are effective for services on or after that date. All rates are published on the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov).

#### Part VIII

#### Community Mental Health and Mental Retardation Services

#### **12VAC30-130-540. Definitions. (Repealed.)**

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

"Board" or "BMAS" means the Board of Medical Assistance Services.

"CMS" means the Centers for Medicare and Medicaid Services as that unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Code" means the Code of Virginia.

"Consumer service plan" means that document addressing the needs of the recipient of mental retardation case management services, in all life areas. Factors to be considered when this plan is developed are, but not limited to, the recipient's age, primary disability, level of functioning and other relevant factors.

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

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"DRS" means the Department of Rehabilitative Services consistent with Chapter 3 (§ 51.5-8 et seq.) of Title 51.5 of the Code of Virginia.

"Individual Service Plan" or "ISP" means a comprehensive and regularly updated statement specific to the individual being treated containing, but not necessarily limited to, his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, and estimated timetable for achieving the goals and objectives. Such ISP shall be maintained up to date as the needs and progress of the individual changes.

"Medical or clinical necessity" means an item or service that must be consistent with the diagnosis or treatment of the individual's condition. It must be in accordance with the community standards of medical or clinical practice.

"Mental retardation" means the presence of a level of retardation (mild, moderate, severe, or profound) described in the American Association on Mental Retardation's Manual on Classification in Mental Retardation (1983) or a related condition. A person with related conditions (RC) means the individual has a severe chronic disability that meets all of the following conditions:

1. It is attributable to cerebral palsy or epilepsy or any other condition, other than mental illness, found to be closely related to mental retardation because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons;
2. It is manifested before the person reaches age 22;
3. It is likely to continue indefinitely; and
4. It results in substantial functional limitations in three or more of the following areas of major life activity: self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

"Preauthorization" means the approval by the DMHMRSAS staff of the plan of care which specifies recipient and provider. Preauthorization is required before reimbursement can be made.

"Qualified case managers for mental health case management services" means individuals possessing a combination of mental health work experience or relevant education which indicates that the individual possesses the knowledge, skills, and abilities, as established by DMHMRSAS, necessary to perform case management services.

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"Qualified case managers for mental retardation case management services" means individuals possessing a combination of mental retardation work experience and relevant education which indicates that the individual possesses the knowledge, skills, and abilities, as established by DMHMRSAS, necessary to perform case management services.

"Related conditions," as defined for persons residing in nursing facilities who have been determined through Annual Resident Review to require specialized services, means a severe, chronic disability that (i) is attributable to a mental or physical impairment (attributable to mental retardation, cerebral palsy, epilepsy, autism, or neurological impairment or related conditions) or combination of mental and physical impairments; (ii) is manifested before that person attains the age of 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major areas: self care, language, learning, mobility, self direction, capacity for independent living and economic self sufficiency; and (v) results in the person's need for special care, treatment or services that are individually planned and coordinated and that are of lifelong or extended duration.

"Serious emotional disturbance" means that mental health problem as defined by the Board of Mental Health, Mental Retardation, and Substance Abuse Services in Policy 1029, Definitions of Priority Mental Health Populations, effective June 27, 1990.

"Serious mental illness" means that mental health problem as defined by the Board of Mental Health, Mental Retardation, and Substance Abuse Services in Policy 1029, Definitions of Priority Mental Health Populations, effective June 27, 1990.

"Significant others" means persons related to or interested in the individual's health, well being, and care. Significant others may be, but are not limited to, a spouse, friend, relative, guardian, priest, minister, rabbi, physician, neighbor.

"Substance abuse" means the use, without compelling medical reason, of any substance which results in psychological or physiological dependency as a function of continued use in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior.

"State Plan for Medical Assistance" or "Plan" means the document listing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

## **12VAC30-130-565. Substance abuse treatment services. (Repealed.)**

A. Substance abuse treatment services shall be provided consistent with the criteria and requirements of 12VAC30-50-510.

B. The following criteria must be met and documented in the woman's record before Medicaid reimbursement for substance abuse residential treatment services for pregnant and postpartum women can occur:

1. The woman must agree to participate in developing her own treatment plan; to comply with the treatment plan; to participate, support, and implement the plan of care; to utilize appropriate measures to negotiate changes in her treatment plan; to fully participate in treatment; to comply with program rules and procedures; and to complete the treatment plan in full.

2. The woman must be pregnant at admission and intend to complete the pregnancy.

3. The woman must:

a. Have used alcohol or other drugs within six weeks of referral to the program. If the woman was in jail or prison prior to her referral to this program, the alcohol or drug use must have been within six weeks prior to jail or prison;

b. Be participating in less intensive treatment for substance abuse and be assessed as high risk for relapse without more intensive intervention and treatment; or

c. Within 30 days of admission, have been discharged from a more intensive level of treatment, such as hospital based inpatient or jail or prison based treatment for substance abuse.

4. The woman must be under the active care of a physician who is an approved Virginia Medicaid provider and has obstetrical privileges at a hospital which is an approved Virginia Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician, the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.

C. The following criteria must be met and documented in the woman's record before Medicaid reimbursement for substance abuse day treatment services for pregnant and postpartum women can occur:

1. The woman must agree to participate in developing her own treatment plan, to comply with the treatment plan, to utilize appropriate measures to negotiate changes in her treatment plan, to fully participate in treatment, to comply with program rules and procedures, and to complete the treatment plan in full.

2. The woman must be pregnant at admission and intend to complete the pregnancy.

3. The woman must:

a. Have used alcohol or other drugs within six weeks of referral to the program. If the woman was in jail or prison prior to her referral to this program, the alcohol or drug

~~use must have been within six weeks prior to jail or prison;~~

~~b. Be participating in less intensive treatment for substance abuse and assessed as high risk for relapse without more intensive intervention and treatment; or~~

~~c. Within 30 days of admission, have been discharged from a more intensive level of treatment for substance abuse, such as hospital based or jail or prison based inpatient treatment or residential treatment.~~

~~4. The woman must be under the active care of a physician who is an approved Virginia Medicaid provider and who has obstetrical privileges at a hospital which is an approved Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician and the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.~~

**12VAC30-130-580. ~~Free choice of providers. (Repealed.)~~**

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

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

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

**12VAC30-130-590. ~~Nonduplication of payment. (Repealed.)~~**

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

Part XX

Addiction and Recovery Treatment Services

**12VAC30-130-5000. Addiction and recovery treatment services.**

The services provided for in this part shall be known as either addiction and recovery treatment services or substance use disorder services.

**12VAC30-130-5010. Addiction and recovery treatment services; purpose.**

The purpose of this part shall be to establish coverage of treatment for substance use disorders as defined in the American Society of Addiction Medicine (ASAM) Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions, Third Edition, as published by the American Society of Addiction Medicine including outpatient physician and clinic services, residential treatment services, and inpatient withdrawal management services as defined in 12VAC30-130-5040 through 12VAC30-130-5150.

**12VAC30-130-5020. Definitions.**

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

"Abstinence" means the intentional and consistent restraint from the pathological pursuit of reward or relief, or both, that involves the use of substances.

"Addiction" means a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

"Adherence" means the individual receiving treatment has demonstrated his ability to cooperate with, follow, and take personal responsibility for the implementation of his treatment plans.

"Adolescent" means an individual from 12 years of age to 20 years of age.

"Allied health professional" means counselor aides or group living workers who meet the DBHDS licensing requirements.

"ARTS" means addiction and recovery treatment services.

"ASAM criteria" means the six different life areas used by the ASAM Patient Placement Criteria to develop a holistic biopsychosocial assessment of an individual that is used for service planning, level of care, and length of stay treatment decisions.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS. The DMAS designated BHSA shall be authorized to constitute, oversee, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. DMAS shall retain authority for and oversight of the BHSA entity or entities.

"BHA" means behavioral health authority.

"Buprenorphine-waivered practitioners" means health care providers licensed under Virginia law and registered with the Drug Enforcement Administration (DEA) to prescribe Schedule III, IV, or V medications for treatment of pain. Physicians shall have completed the buprenorphine waiver training course and obtained the waiver to prescribe or dispense buprenorphine for opioid use disorder required under the Drug Addiction Treatment Act of 2000 (DATA



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2000). They shall have been issued a DEA-X number by the DEA to prescribe buprenorphine for the treatment of opioid use disorder. Practitioners who are not physicians must meet all federal and state requirements and be supervised by or work in collaboration with a qualifying physician who is buprenorphine waived.

"Care coordination" means collaboration and sharing of information among health care providers who are involved with an individual's health care to improve the care.

"Child" means an individual from birth up to 12 years of age.

"Clinical experience" means, for the purpose of these ARTS requirements, practical experience in providing direct services to individuals with diagnoses of substance use disorder. Clinical experience shall include supervised internships, supervised practicums, or supervised field experience. Clinical experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience.

"Co-occurring disorders" means the presence of concurrent substance use disorder and mental illness without implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other. Other terms used to describe co-occurring disorders include "dual diagnosis," "dual disorders," "mentally ill chemically addicted (MICA)," "chemically addicted mentally ill (CAMI)," "mentally ill substance abusers (MISA)," "mentally ill chemically dependent (MICD)," "concurrent disorders," "coexisting disorders," "comorbid disorders," and "individuals with co-occurring psychiatric and substance symptomatology (ICOPSS)."

"Credentialed addiction treatment professionals" means (i) an addiction-credentialed physician or physician with experience in addiction medicine; (ii) a licensed psychiatrist; (iii) a licensed clinical psychologist; (iv) a licensed clinical social worker; (v) a licensed professional counselor; (vi) a licensed psychiatric clinical nurse specialist; (vii) a licensed psychiatric nurse practitioner; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) residents under supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and in a residency approved by the Virginia Board of Counseling; (xi) residents in psychology under supervision of a licensed clinical psychologist and in a residency approved by the Virginia Board of Psychology (18VAC125-20-10); (xii) supervises in social work under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work (18VAC140-20-10); or (xiii) an individual with certification as a substance abuse counselor (CSAC) (18VAC115-30-10) or certification as a substance abuse counseling-assistant (CSAC-A) (18VAC115-30-10) under supervision of licensed provider and within his scope

of practice, as described in §§ 54.1-3507.1 and 54.1-3507.2 of the Code of Virginia.

"CSB" means community services board.

"DBHDS" means the Department of Behavioral Health and Developmental Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"DHP" means the Department of Health Professions.

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

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

"FAMIS" means the Family Access to Medical Insurance Security Plan as set out in 12VAC30-141.

"FOHC" means federally qualified health center.

"Individual" means the patient, client, beneficiary, or member who receives services set out in 12VAC30-130-5000 et seq. These terms are used interchangeably.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Managed care organization" or "MCO" means an organization that offers managed care health insurance plans (MCHIP), as defined by § 38.2-5800 of the Code of Virginia, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis that (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with, or employed by the health carrier.

"Multidimensional assessment" means the individualized, person-centered biopsychosocial assessment performed face-to-face, in which the provider obtains comprehensive information from the individual (including family members and significant others as needed) including history of the present illness; family history; developmental history; alcohol, tobacco, and other drug use or addictive behavior history; personal/social history; legal history; psychiatric history; medical history; spiritual history as appropriate; review of systems; mental status exam; physical examination; formulation and diagnoses; survey of assets, vulnerabilities and supports; and treatment recommendations. The ASAM multidimensional assessment is a theoretical framework for this individualized, person-centered assessment that includes the following six dimensions: (i) acute intoxication or withdrawal potential, or both; (ii) biomedical conditions and

complications; (iii) emotional, behavioral, or cognitive conditions and complications; (iv) readiness to change; (v) relapse, continued use, or continued problem potential; and (vi) recovery or living environment. The level of care determination, ISP, and recovery strategies development may be based upon this multidimensional assessment.

"Office-based opioid treatment" or "OBOT" means addiction treatment services for individuals with moderate to severe opioid use disorder provided by buprenorphine-waivered practitioners working in collaboration with credentialed addiction treatment practitioners providing psychosocial counseling in public and private practice settings.

"Opiate" means one of a group of alkaloids derived from the opium poppy (*Papaver somniferum*) that has the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression but excludes synthetic opioids.

"Opioid" means any psychoactive chemical that resembles morphine in pharmacological effects, including opiates and synthetic/semisynthetic agents that exert their effects by binding to highly selective receptors in the brain where morphine and endogenous opioids affect their actions.

"Opioid treatment program" or "OTP" means a program certified by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) that engages in supervised assessment and treatment, using methadone, buprenorphine, L-alpha acetyl methadol, or naltrexone, of individuals who are addicted to opioids.

"Opioid treatment services" or "OTS" means office-based opioid treatment (OBOT) and opioid treatment programs that encompass a variety of pharmacological and nonpharmacological treatment modalities.

"Overdose" means the inadvertent or deliberate consumption of a dose of a chemical substance much larger than either habitually used by the individual or ordinarily used for treatment of an illness that is likely to result in a serious toxic reaction or death.

"Physician extenders" means licensed nurse practitioners as defined in 18VAC90-30-10 and licensed physician assistants as defined in § 54.1-2900 of the Code of Virginia.

"Practitioner" means a provider who is permitted to prescribe buprenorphine by the scope of his licenses under federal and state law.

"Recovery" means a process of sustained effort that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction and consistently pursues abstinence, behavior control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and more effective coping with emotional responses leading to reversal of negative, self-defeating internal processes and behaviors and allowing healing of

relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process.

"Registered nurse" or "RN" means a professional who is either licensed by the Commonwealth or who holds a multi-state licensure privilege to practice nursing.

"Relapse" means a process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward or relief through the use of substances and other behaviors often leading to disengagement from recovery activities. Relapse can be triggered by exposure to (i) rewarding substances and behaviors, (ii) environmental cues to use, and (iii) emotional stressors that trigger heightened activity in brain stress circuits. The event of using or acting out is the latter part of the process, which can be prevented by early intervention.

"RHC" means rural health clinic.

"SBIRT" means screening, brief intervention, and referral to treatment.

"Service authorization" means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by a DMAS service authorization contractor, BHSA, or MCO prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

"Substance use case management" means the same as set out in 12VAC30-50-491.

"Substance use disorder" or "SUD" means a disorder, as defined in the DSM-5, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, tobacco, or other drugs despite significant related problems.

"Telemedicine" means the practice of the medical arts via electronic means rather than face-to-face.

"Withdrawal management" means services to assist an individual's withdrawal from the use of substances.

### **12VAC30-130-5030. Eligible individuals.**

Children and adults who participate in Medicaid managed care plans and Medicaid fee for service and meet ASAM medical necessity criteria shall be eligible for ARTS. Notwithstanding the coverage limitations set forth in the Governor's Access Plan for the Seriously Mental Ill (GAP SMI) who meet ASAM medical necessity criteria shall be eligible for ARTS with the exception of inpatient detoxification services (ASAM Level 4.0), substance use residential treatment (ASAM Levels 3.1 through 3.7), and substance use partial hospitalization (ASAM Level 2.5).

### **12VAC30-130-5040. Covered services: requirements; limits; standards.**

A. Addiction recovery and treatment services.

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1. In order to be covered, ARTS shall (i) meet medical necessity criteria based upon the multidimensional assessment completed by a credentialed addiction treatment professional within the scope of their practice and (ii) be accurately reflected in provider medical record documentation and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

2. These ARTS services, with their service definitions, shall be covered: (i) medically managed intensive inpatient services (ASAM Level 4); (ii) substance use residential/inpatient services (ASAM Levels 3.1, 3.3, 3.5, and 3.7); (iii) substance use intensive outpatient and partial hospitalization programs (ASAM Levels 2.1 and 2.5); (iv) opioid treatment services, (opioid treatment programs and office-based opioid treatment); (v) substance use outpatient services (ASAM Level 1.0); (vi) early intervention services (ASAM Level 0.5); (vii) substance use care coordination, (viii) substance use case management services; and (ix) withdrawal management services, which shall be provided when medically necessary, as a component of the medically managed inpatient services (ASAM Level 4.0), substance use residential/inpatient services (ASAM Levels 3.3, 3.5, and 3.7), substance use intensive outpatient and partial hospitalization programs (ASAM Levels 2.1 and 2.5), opioid treatment services, opioid treatment programs and office-based opioid treatment, and substance use outpatient services (ASAM Level 1.0).

B. ARTS services shall be fully integrated with all physical health and behavioral health services for a complete continuum of care for all Medicaid individuals meeting the medical necessity criteria. In order to receive reimbursement for ARTS services, the individual shall be enrolled in Virginia Medicaid and shall meet the following medical necessity criteria:

1. The individual shall demonstrate at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Substance-Related and Addictive Disorders with the exception of tobacco-related disorders or caffeine-related disorders or dependence and nonsubstance-related disorders or be assessed to be at risk for developing substance use disorder, for youth younger than 21 years of age using the ASAM multidimensional assessment.

2. The individual shall be assessed by a certified addiction treatment professional who will determine if he meets the severity and intensity of treatment requirements for each service level defined by the most current version of the American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions (Third Edition, 2013). Medical necessity for ASAM levels of care shall be based on the outcome of the individual's documented multidimensional assessment. The following outpatient ASAM levels of care

do not require a complete multidimensional assessment using the ASAM theoretical framework to determine medical necessity but do require an assessment by a certified addiction treatment professional: opioid treatment programs, office-based opioid treatment, and substance use outpatient services (ASAM Level 1.0).

3. For individuals younger than 21 years of age who do not meet the ASAM medical necessity criteria upon initial review, a second individualized review shall be conducted to determine if the individual needs medically necessary treatment under the early periodic screening diagnosis and treatment (EPSDT) benefit described in § 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening.

C. Determination of medical necessity based on ASAM criteria for addiction and recovery treatment services.

1. DMAS contracted managed care organizations and the BHSA shall employ or contract with licensed treatment professionals to apply the ASAM criteria to review and coordinate service needs when administering ARTS benefits.

2. The ARTS care coordinator or a licensed physician or medical director employed by the MCO or BHSA shall perform an independent assessment of requests for all ARTS residential treatment services (ASAM Levels 3.1, 3.3, 3.5, and 3.7) and ARTS inpatient treatment services (ASAM Level 4.0).

3. Length of treatment and service limits shall be determined by the ARTS care coordinator employed by the BHSA or MCO who is applying the ASAM criteria.

4. "ARTS care coordinator" means a licensed practitioner of the healing arts, including a physician or medical director, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, or nurse practitioner or registered nurse with clinical experience in substance use disorders, who is employed by the BHSA or MCO to perform an independent assessment of requests for all ARTS residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7, and 4.0).

**12VAC30-130-5050. Covered services: clinic services - opioid treatment services.**

A. Settings for opioid treatment program services. The agency-based OTP provider shall be licensed by DBHDS and contracted by the BHSA or MCO. Opioid treatment services are allowable in ASAM Levels 1.0 through 3.7 (excluding inpatient services). OTP's shall meet the service components, staff requirements, and risk management requirements.

B. OTP service components.

1. Linking the individual to psychological, medical, and psychiatric consultation as necessary to meet the individual's needs.

2. Access to emergency medical and psychiatric care through connections with more intensive levels of care.
3. Access to evaluation and ongoing primary care.
4. Ability to conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.
5. Licensed physicians are available to evaluate and monitor (i) use of methadone, buprenorphine products, or naltrexone products and (ii) pharmacists and nurses to dispense and administer these medications.
6. Individualized, patient-centered assessment and treatment.
7. Ability to assess, order, administer, reassess, and regulate medication and dose levels appropriate to the individual; supervise withdrawal management from opioid analgesics, including methadone, buprenorphine products, or naltrexone products; and oversee and facilitate access to appropriate treatment for opioid use disorder.
8. Medication for other physical and mental health illness is provided as needed either on site or through collaboration with other providers.
9. Cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, or family basis.
10. Optional substance use care coordination that includes integrating behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring individual progress and tracking individual outcomes; supporting conversations between buprenorphine-waivered practitioners and behavioral health professionals to develop and monitor individualized treatment plans; linking individuals with community resources to facilitate referrals and respond to social service needs; and tracking and supporting individuals when they obtain medical, behavioral health, or social services outside the practice.
11. Ability to refer for screening for infectious diseases such as human immunodeficiency virus, hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.

C. OTP staff requirements.

1. Staff requirements shall meet the licensing requirements of 12VAC35-105-925. The interdisciplinary team shall include credentialed addiction professionals trained in the treatment of opioid use disorder including an addiction credentialed physician and credentialed addiction treatment professionals as defined in 12VAC30-130-5020. "Addiction-credentialed physician" means a physician who holds a board certification in addiction medicine from the American Board of Addiction Medicine, a subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology, or subspecialty board certification in addiction medicine from

the American Osteopathic Association. In situations where a certified addiction physician is not available, physicians treating addiction should have some specialty training or experience in addiction medicine or addiction psychiatry. If treating adolescents, they should have experience with adolescent medicine.

2. Staff shall be knowledgeable in the assessment, interpretation, and treatment of the biopsychosocial dimensions of alcohol or other substance use disorders.
3. A physician or physician extender as defined in 12VAC30-130-5020, shall be available during medication dispensing and clinical operating hours, in person or by telephone.

D. OTP risk management shall be clearly and adequately documented in each individual's record and shall include:

1. Random urine drug screening for all individuals, conducted at least eight times during a 12-month period as described in 12VAC35-105-980.
2. A check of the Virginia Prescription Monitoring Program at least quarterly for all individuals.
3. Opioid overdose prevention education including the prescribing of naloxone.

**12VAC30-130-5060. Covered services: clinic services - office-based opioid treatment.**

A. Office-based opioid treatment (OBOT) shall be provided by a buprenorphine-waivered practitioner and may be provided in a variety of practice settings including primary care clinics, outpatient health system clinics, psychiatry clinics, federally qualified health centers, CSBs/BHAs, local health department clinics, and physician offices. The practitioner shall be contracted by the BHSA or MCO to perform OBOT services. OBOT services shall meet the following criteria:

1. OBOT service components.

- a. Access to emergency medical and psychiatric care.
- b. Affiliations with more intensive levels of care such as intensive outpatient programs and partial hospitalization programs that unstable individuals can be referred to when clinically indicated.
- c. Individualized, patient-centered assessment and treatment.
- d. Assessing, ordering, administering, reassessing, and regulating medication and dose levels appropriate to the individual; supervising withdrawal management from opioid analgesics; and overseeing and facilitating access to appropriate treatment for opioid use disorder and alcohol use disorder.
- e. Medication for other physical and mental illnesses shall be provided as needed either on site or through collaboration with other providers.
- f. Cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of

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treatment approaches, shall be provided to the individual on an individual, group, or family basis and shall be provided by credentialed addiction treatment professionals working in collaboration with the buprenorphine-waivered practitioner who is prescribing buprenorphine products or naltrexone products to individuals with moderate to severe opioid use disorder. These therapies can be provided via telemedicine as long as they meet the department's requirements for an OBOT and for the use of telemedicine. (See the Medicaid Memo entitled "Updates to Telemedicine Coverage" dated May 13, 2014.)

g. Substance use care coordination provided including interdisciplinary care planning between buprenorphine-waivered physician and the licensed behavioral health provider to develop and monitor individualized and personalized treatment plans focused on the best outcomes for the individual. This care coordination includes monitoring individual progress, tracking individual outcomes, linking individual with community resources to facilitate referrals and respond to social service needs, and tracking and supporting the individual's medical, behavioral health, or social services received outside the practice.

h. Referral for screening for infectious diseases such as human immunodeficiency virus, hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.

### B. OBOT staff requirements.

1. Buprenorphine-waivered practitioner licensed under Virginia law who has completed one of the continuing medical education courses approved by the federal Center for Substance Abuse Treatment and obtained the waiver to prescribe or dispense buprenorphine for opioid use disorder required under the Drug Addiction Treatment Act of 2000 (21 USC § 800 et seq.). The practitioner must have a DEA-X number issued by the U.S. Drug Enforcement Agency that is included on all buprenorphine prescriptions for treatment of opioid use disorder.

2. Credentialed addiction treatment professionals shall work in collaboration with the buprenorphine-waivered practitioner who is prescribing buprenorphine products or naltrexone products to individuals with moderate to severe opioid use disorder. This collaboration can be in person or via telemedicine as long as it meets the department's requirements for the OBOT setting and for telemedicine.

C. OBOT risk management shall be documented in each individual's record and shall include:

1. Random urine drug screening for all individuals, conducted at a minimum of eight times per year.

2. A check of the Virginia Prescription Monitoring Program at least quarterly for all individuals.

3. Opioid overdose prevention education including the prescribing of naloxone.

### **12VAC30-130-5070. Covered services: practitioner services – early intervention/screening brief intervention and referral to treatment (ASAM Level 0.5).**

A. Early intervention (ASAM Level 0.5) settings for screening, brief intervention, and referral to treatment (SBIRT) services shall include health care settings including local health departments, federally qualified health centers, rural health clinics, CSBs/BHAs, health systems, emergency departments, pharmacies, physician offices, and outpatient clinics. These providers shall be licensed by DHP and either directly contracted by the BHSA or MCO to perform this level of care, or employed by organizations that are contracted by the BHSA or MCO.

B. Early intervention/SBIRT (ASAM Level 0.5) service components shall include:

1. Identifying individuals who may have alcohol or other substance use problems using an evidence-based screening tool.

2. Following administration of the evidence-based screening tool, a brief intervention by a licensed clinician shall be provided to educate individuals about substance use, alert these individuals to possible consequences and, if needed, begin to motivate individuals to take steps to change their behaviors.

C. Early intervention/SBIRT (ASAM Level 0.5) staff requirements. Physicians, pharmacists, and other credentialed addiction treatment professionals shall administer the evidence-based screening tool with the individual and provide the counseling and intervention. Licensed providers may delegate administration of the evidence-based screening tool to other clinical staff as allowed by their scope of practice, such as physicians delegating administration of the tool to a licensed registered nurse or licensed practical nurse, but the licensed provider shall review the tool with the individual and provide the counseling and intervention.

### **12VAC30-130-5080. Covered services: outpatient services – physician services (ASAM Level 1.0).**

A. Outpatient services (ASAM Level 1.0) shall be provided by a credentialed addiction treatment professional, psychiatrist, or physician contracted by the BHSA or MCO to perform the services in the following community based settings: primary care clinics, outpatient health system clinics, psychiatry clinics, federally qualified health centers (FOHCs), community service boards/BHAs, local health departments, and physician and provider offices. Reimbursement for substance use outpatient services shall be made for medically necessary services provided in accordance with an ISP or the treatment plan and include withdrawal management as necessary. Services can be provided face-to-face or by telemedicine. Outpatient services shall meet the ASAM Level 1.0 service components and staff requirements as follows:

1. Outpatient services (ASAM Level 1.0) service components.

a. Substance use outpatient services shall be provided fewer than nine hours per week and may be delivered in the following health care settings: local health departments, FQHCs, rural health clinics, CSBs/BHAs, health systems, emergency departments, physician and provider offices, and outpatient clinics. Provision of services in a setting other than the office or a clinic, as defined in this subsection shall be documented. Services shall include professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services.

b. A multidimensional assessment shall (i) be used, (ii) be documented to determine that an individual meets the medical necessity criteria, and (iii) include the evaluation or analysis of substance use disorders, the diagnosis of substance use disorder, and the assessment of treatment needs to provide medically necessary services. The multidimensional assessment shall include a physical examination and laboratory testing necessary for substance use disorder treatment as necessary.

c. Individual counseling between the individual and a credentialed addiction treatment professional shall be provided. Services provided face to face or by telemedicine shall qualify as reimbursable.

d. Group counseling by a credentialed addiction treatment professional, with a maximum of 10 individuals in the group shall be provided. Such counseling shall focus on the needs of the individuals served.

e. Family therapy shall be provided to facilitate the individual's recovery and support for the family's recovery.

f. Evidenced-based patient education on addiction, treatment, recovery, and associated health risks shall be provided.

g. Medication services shall be provided including the prescription of or administration of medication related to substance use treatment, or the assessment of the side effects or results of that medication. Medication services shall be provided by staff lawfully authorized to provide such services who shall order laboratory testing within their scope of practice or licensure.

h. Collateral services shall be provided. "Collateral services" means services provided by therapists or counselors for the purpose of engaging persons who are significant to the individual receiving SUD services. The services are focused on the individual's treatment needs and support achievement of his recovery goals.

2. Outpatient services (ASAM Level 1.0) staff requirements shall include:

a. Credentialed addiction treatment professional; or

b. A registered nurse or a practical nurse who is licensed by the Commonwealth with at least one year of clinical experience involving medication management.

B. Outpatient services (ASAM Level 1.0) co-occurring enhanced programs shall include:

1. Ongoing substance use case management for highly crisis prone individuals with co-occurring disorders.

2. Credentialed addiction treatment professionals who are trained in severe and chronic mental health and psychiatric disorders and are able to assess, monitor, and manage individuals who have a co-occurring mental health disorder.

**12VAC30-130-5090. Covered services: community based services - intensive outpatient services (ASAM Level 2.1).**

A. Intensive outpatient services (ASAM Level 2.1) shall be a structured program of skilled treatment services for adults, children, and adolescents delivering a minimum of three service hours per service day to achieve nine to 19 hours of services per week for adults and six to 19 hours of services per week for children and adolescents. Withdrawal management services may be provided as necessary. The following service components shall be provided weekly as directed by the ISP for reimbursement:

1. Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral.

2. Psychiatric and other individualized treatment planning.

3. Individual and group counseling, medication management, family therapy, and psychoeducation. "Psychoeducation" means (i) a specific form of education aimed at helping individuals who have a substance use disorder or mental illness and their family members or caregivers to access clear and concise information about substance use disorders or mental illness and (ii) a way of accessing and learning strategies to deal with substance use disorders or mental illness and its effects in order to design effective treatment plans and strategies.

4. Occupational and recreational therapies, motivational interviewing, enhancement, and engagement strategies to inspire an individual's motivation to change behaviors.

5. Psychiatric and medical consultation, which shall be available within 24 hours of the requested consult by telephone and preferably within 72 hours of the requested consult in person or via telemedicine.

6. Psychopharmacological consultation.

7. Addiction medication management and 24-hour crisis services.

8. Medical, psychological, psychiatric, laboratory, and toxicology services.

B. Intensive outpatient services (ASAM Level 2.1) shall be provided by agency-based providers that shall be licensed by DBHDS as a substance abuse intensive outpatient service for

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adults, children, and adolescents and contracted with the BHSA or MCO to provide this service. Intensive outpatient service providers shall meet the ASAM Level 2.1 service components and staff requirements as follows:

1. Interdisciplinary team of credentialed addiction treatment professionals shall be required.
2. Generalist physicians or physicians with experience in addiction medicine are permitted to provide general medical evaluations and concurrent/integrated general medical care.
3. Staff shall be cross-trained to understand signs and symptoms of psychiatric disorders and be able to understand and explain the uses of psychotropic medications and understand interactions with substance use and other addictive disorders.
4. Emergency services, which shall be available, when necessary, by telephone 24 hours per day and seven days per week when the treatment program is not in session.
5. Direct affiliation with, or close coordination through referrals to, higher and lower levels of care and supportive housing services.

C. Intensive outpatient services (ASAM Level 2.1) co-occurring enhanced programs.

1. Co-occurring capable programs offer these therapies and support systems in intensive outpatient services described in this section to individuals with co-occurring addictive and psychiatric disorders who are able to tolerate and benefit from a planned program of therapies.
2. Individuals who are not able to benefit from a full program of therapies will be offered enhanced program services to match the intensity of hours in ASAM Level 2.1, including substance use case management, program of assertive community treatment (PACT), medication management, and psychotherapy. "Program of assertive community treatment" or "PACT" means the same as defined in 12VAC30-105-20.

## **12VAC30-130-5100. Covered services: community based care - partial hospitalization services (ASAM Level 2.5).**

A. Partial hospitalization services (ASAM Level 2.5) components. Partial hospitalization services components shall include the following, as defined in the ISP and provided on a weekly basis:

1. Individualized treatment planning;
2. A minimum of 20 hours per week and at least five service hours per service day of skilled treatment services with a planned format including individual and group counseling, medication management, family therapy, education groups, occupational and recreational therapy, and other therapies. Withdrawal management services may be provided as necessary. Time not spent in skilled, clinically intensive treatment is not billable.

3. Family therapies involving family members, guardians, or significant other in the assessment, treatment, and continuing care of the individual.

4. A planned format of therapies, delivered in individual or group settings.

5. Motivational interviewing, enhancement, and engagement strategies.

B. Partial hospitalization services (ASAM Level 2.5). The substance use partial hospitalization service provider shall be licensed by DBHDS as a substance abuse partial hospitalization program or substance abuse/mental health partial hospitalization program and contracted with the BHSA or MCO. Partial hospitalization service providers shall meet the ASAM Level 2.5 support systems and staff requirements as follows:

1. Interdisciplinary team comprised of credentialed addiction treatment professionals and an addiction-credentialed physician, or physician with experience in addiction medicine, or physician extenders as defined in 12VAC30-130-5020, shall be required.

2. Physicians shall have specialty training or experience, or both, in addiction medicine or addiction psychiatry. Physicians who treat adolescents shall have experience with adolescent medicine.

3. Program staff shall be cross-trained to understand signs and symptoms of mental illness and be able to understand and explain the uses of psychotropic medications and understand interactions with substance use and other addictive disorders.

4. Medical, psychological, psychiatric, laboratory, and toxicology services that are available by consult or referral.

5. Psychiatric and medical formal agreements to provide medical consult within eight hours of the requested consult by telephone or within 48 hours in person or via telemedicine.

6. Emergency services are available 24-hours a day and seven days a week.

7. Direct affiliation with or close coordination through referrals to higher and lower levels of care and supportive housing services.

C. Partial hospitalization services (ASAM Level 2.5) co-occurring enhanced programs shall offer:

1. Therapies and support systems as described in this section to individuals with co-occurring addictive and psychiatric disorders who are able to tolerate and benefit from a full program of therapies. Other individuals who are not able to benefit from a full program of therapies (who are severely or chronically mentally ill) will be offered enhanced program services to constitute intensity of hours in Level 2.5, including substance use case management, assertive community treatment, medication management, and psychotherapy.

2. Psychiatric services as appropriate to meet the individual's mental health condition. Services may be available by telephone and on site, or closely coordinated off site, or via telemedicine within a shorter time than in a co-occurring capable program.

3. Clinical leadership and oversight and, at a minimum, capacity to consult with an addiction psychiatrist via telephone, telemedicine, or in person.

4. Credentialed addiction treatment professionals with experience assessing and treating co-occurring mental illness.

**12VAC30-130-5110. Covered services: clinically managed low intensity residential services (ASAM Level 3.1).**

A. Clinically managed low intensity residential services (ASAM Level 3.1). The agency-based residential group home services (ASAM Level 3.1) shall be licensed by DBHDS as a mental health and substance abuse group home service for adults or children or licensed by DBHDS as a substance abuse halfway house for adults and contracted by the BHSA or MCO. Clinically directed program activities constituting at least five hours per week of professionally directed treatment shall be designed to stabilize and maintain substance use disorder symptoms and to develop and apply recovery skills. Activities shall include relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery. This service shall not include settings where clinical treatment services are not provided. ASAM Level 3.1 clinically managed low intensity residential service providers shall meet the service components and staff requirements of this section.

B. Clinically managed low intensity residential services (ASAM Level 3.1) service components.

1. Physician consultation and emergency services, which shall be available 24 hours a day and seven days per week.

2. Arrangements for medically necessary procedures including laboratory and toxicology tests that are appropriate to the severity and urgency of an individual's condition.

3. Arrangements for pharmacotherapy for psychiatric or anti-addiction medications.

4. Arrangements for higher and lower levels of care and other services.

C. The following services shall be provided as directed by the ISP:

1. Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life;

2. Addiction pharmacotherapy and drug screening;

3. Motivational enhancement and engagement strategies;

4. Counseling and clinical monitoring;

5. Regular monitoring of the individual's medication adherence;

6. Recovery support services;

7. Services for the individual's family and significant others, as appropriate to advance the individual's treatment goals and objectives identified in the ISP; and

8. Education on benefits of medication assisted treatment and referral to treatment as necessary.

D. Clinically managed low intensity residential services (ASAM Level 3.1) staff requirements.

1. Staff shall provide awake 24-hour onsite supervision. The provider's staffing plan must be in compliance with DBHDS licensing regulations for staffing plans set forth in 12VAC35-46-870 and 12VAC35-105-590.

2. Clinical staff who are experienced and knowledgeable about the biopsychosocial and psychosocial dimensions and treatment of substance use disorders. Clinical staff shall be able to identify the signs and symptoms of acute psychiatric conditions and decompensation.

3. An addiction-credentialed physician or physician with experience in addiction medicine shall review the residential group home admission to confirm medical necessity for services, and a team of credentialed addiction treatment professionals shall develop and shall ensure delivery of the ISP.

4. Coordination with community physicians to review treatment as needed.

5. Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and to monitor the individual's administration of prescribed medications.

E. Clinically managed low intensity residential services (ASAM Level 3.1) co-occurring enhanced programs as required by ASAM.

1. In addition to the ASAM Level 3.1 service components listed in this section, programs for individuals with both unstable substance use and psychiatric disorders shall offer appropriate psychiatric services, including medication evaluation and laboratory services. Such services are provided either on site, via telemedicine, or closely coordinated with an off-site provider, as appropriate to the severity and urgency of the individual's mental health condition.

2. Certified addiction treatment professionals shall be cross-trained in addiction and mental health to (i) understand the signs and symptoms of mental illness and (ii) understand and be able to explain to the individual the purpose of psychotropic medications and interactions with substance use.

3. The therapies described in this section shall be offered as well as planned clinical activities (either on site or with an off-site provider) that are designed to stabilize and



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maintain the individual's mental health program and psychiatric symptoms.

4. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental illness.

5. Medication education and management shall be provided.

**12VAC30-130-5120. Covered services: clinically managed population - specific high intensity residential service (ASAM Level 3.3).**

A. Clinically managed population-specific high intensity residential service (ASAM Level 3.3). The facility-based provider shall be licensed by DBHDS to provide supervised residential treatment services for adults or licensed by DBHDS to provide substance abuse residential treatment for adults, supervised residential treatment services for adults, or substance abuse and mental health residential treatment services for adults, and contracted by the BHSA or MCO. ASAM Level 3.3 settings do not include sober houses, boarding houses, or group homes where treatment services are not provided. Residential treatment service providers for clinically managed population-specific high intensity residential service (ASAM Level 3.3) shall meet the service components and staff requirements in this section.

B. Clinically managed population-specific high intensity residential service (ASAM Level 3.3) service components.

1. Clinically managed population-specific high intensity residential service components shall include:

a. Access to consulting physician or physician extender and emergency services 24 hours a day and seven days a week;

b. Arrangements for higher and lower levels of care;

c. Arrangements for laboratory and toxicology services appropriate to the severity of need; and

d. Arrangements for addiction pharmacotherapy.

2. The following therapies shall be provided as directed by the ISP for reimbursement:

a. Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life;

b. Addiction pharmacotherapy and drug screening;

c. Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the individual in initial involvement or re-engagement in regular productive daily activity;

d. Recreational therapy, art, music, physical therapy, and vocational rehabilitation;

e. Motivational enhancement and engagement strategies;

f. Regular monitoring of the individual's medication adherence;

g. Recovery support services;

h. Services for the individual's family and significant others, as appropriate to advance the individual's treatment goals and objectives identified in the ISP;

i. Education on benefits of medication assisted treatment and referral to treatment as necessary; and

j. Withdrawal management services may be provided as necessary.

C. Clinically managed population-specific high intensity residential service (ASAM Level 3.3) staff requirements.

1. The interdisciplinary team shall include credentialed addiction treatment professionals, physicians, or physician extenders and allied health professionals in an interdisciplinary team.

2. Staff shall provide awake 24-hour onsite supervision. The provider's staffing plan must be in compliance with DBHDS licensing regulations for staffing plans set forth in 12VAC35-46-870 and 12VAC35-105-590.

3. Clinical staff who are experienced and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders and who are available on site or by telephone 24 hours per day. Clinical staff shall be able to identify acute psychiatric conditions and decompensation.

4. Substance use case management is included in this level of care.

5. Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and to monitor the individual's administration of prescribed medications.

D. Clinically managed population-specific high intensity residential service co-occurring enhanced programs, as required by ASAM.

1. Appropriate psychiatric services, including medication evaluation and laboratory services, shall be provided on site or through a closely coordinated off-site provider, as appropriate to the severity and urgency of the individual's mental condition.

2. Psychiatrists and credentialed addiction treatment professionals shall be available to assess and treat co-occurring substance use and mental illness using specialized training in behavior management techniques.

3. Credentialed addiction treatment professionals shall be cross-trained in addiction and mental health to understand the signs and symptoms of mental illness and be able to provide education to the individual on the interactions with substance use and psychotropic medications.

**12VAC30-130-5130. Covered services: clinically managed high intensity residential services (adult) and clinically managed medium intensity residential services (adolescent) (ASAM Level 3.5).**

A. Clinically managed high intensity residential services (adult) and clinically managed medium intensity residential

services (adolescent) (ASAM Level 3.5) settings for services. The facility based residential treatment service provider (ASAM Level 3.5) shall be licensed by DBHDS as a substance abuse residential treatment services for adults or children, a psychiatric unit, or a substance abuse and mental health residential treatment services for adults and children and shall be contracted by the BHSA or MCO. Residential treatment providers (ASAM Level 3.5) shall meet the service components and staff requirements in this section.

B. Clinically managed high intensity residential services (adult) and clinically managed medium intensity residential services (adolescent) (ASAM Level 3.5) service components.

1. These residential treatment services, as required by ASAM, include:

- a. Telephone or in-person consultation with a physician or physician extender who shall be available to perform required physician services. Emergency services shall be available 24 hours per day and seven days per week;
- b. Arrangements for more and less intensive levels of care and other services such as sheltered workshops, literacy training, and adult education;
- c. Arrangements for needed procedures including medical, psychiatric, psychological, laboratory, and toxicology services appropriate to the severity of need; and
- d. Arrangements for addiction pharmacotherapy.

2. The following therapies shall be provided as directed by the ISP for reimbursement:

- a. Clinically directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life. Activities shall be designed to stabilize and maintain substance use disorder symptoms and apply recovery skills and may include relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery.
- b. Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the individual in initial involvement or re-engagement in regular productive daily activities including education on medication management, addiction pharmacotherapy, and education skill building groups to enhance the individual's understanding of substance use and mental illness.
- c. Addiction pharmacotherapy and drug screening.
- d. Recreational therapy, art, music, physical therapy, and vocational rehabilitation.
- e. Motivational enhancements and engagement strategies.
- f. Monitoring the adherence to prescribed medications and over-the-counter medications and supplements.

g. Daily scheduled professional services and interdisciplinary assessments and treatment designed to develop and apply recovery skills.

h. Services for family and significant others, as appropriate, to advance the individual's treatment goals and objectives identified in the ISP.

i. Education on benefits of medication assisted treatment and referral to treatment as necessary.

j. Withdrawal management services may be provided as necessary.

C. Clinically managed high intensity residential services (adult) and clinically managed medium intensity residential services (adolescent) (ASAM Level 3.5) staff requirements.

1. The interdisciplinary team shall include credentialed addiction treatment professionals, physicians, or physician extenders and allied health professionals.

2. Staff shall provide awake 24-hour onsite supervision. The provider's staffing plan must be in compliance with DBHDS licensing regulations for staffing plans set forth in 12VAC35-46-870 and 12VAC35-105-590.

3. Clinical staff who are experienced in and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders. Clinical staff shall be able to identify acute psychiatric conditions and decompensations.

4. Substance use case management shall be provided in this level of care.

5. Appropriately credentialed medical staff shall be available on site or by telephone 24 hours per day, seven days per week to assess and treat co-occurring biological and physiological disorders and to monitor the individual's administration of medications in accordance with a physician's prescription.

D. Clinically managed high intensity residential services (adult) and clinically managed medium intensity residential services (adolescent) (ASAM Level 3.5) co-occurring enhanced programs as required by ASAM.

1. Psychiatric services, medication evaluation, and laboratory services shall be provided. Such services shall be available by telephone within eight hours of requested service and on site or via telemedicine, or closely coordinated with an off-site provider within 24 hours of requested service, as appropriate to the severity and urgency of the individual's mental and physical condition.

2. Staff shall be credentialed addiction treatment professionals who are able to assess and treat co-occurring substance use and psychiatric disorders.

3. Planned clinical activities shall be required and shall be designed to stabilize and maintain the individual's mental health problems and psychiatric symptoms.

4. Medication education and management shall be provided.

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## 12VAC30-130-5140. Covered services: medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7).

A. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) settings for services. The facility-based providers of ASAM Level 3.7 services shall be licensed by DBHDS as an inpatient psychiatric unit with a DBHDS medical detoxification license, a substance abuse residential treatment services (RTS) for adults/children with a DBHDS medical detoxification license or a residential crisis stabilization unit with DBHDS medical detoxification license and shall be contracted by the BHSA or the MCO. ASAM Level 3.7 providers shall meet the service components and staff requirements in this section.

B. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) service components. The following therapies shall be provided as directed by the ISP for reimbursement:

1. Daily clinical services provided by an interdisciplinary team to involve appropriate medical and nursing services, as well as individual, group, and family activity services. Activities may include pharmacological, withdrawal management, cognitive-behavioral, and other therapies administered on an individual or group basis and modified to meet the individual's level of understanding and assist in the individual's recovery.
2. Counseling and clinical monitoring to facilitate re-involvement in regular productive daily activities and successful re-integration into family living if applicable.
3. Random drug screens to monitor use and strengthen recovery and treatment gains.
4. Regular medication monitoring.
5. Planned clinical activities to enhance understanding of substance use disorders.
6. Health education associated with the course of addiction and other potential health related risk factors including tuberculosis, human immunodeficiency virus, hepatitis B and C, and other sexually transmitted infections.
7. Evidence based practices, such as motivational interviewing to address the individuals readiness to change, designed to facilitate understanding of the relationship of the substance use disorder and life impacts.
8. Daily treatments to manage acute symptoms of biomedical substance use or mental illness.
9. Services to family and significant others as appropriate to advance the individual's treatment goals and objectives identified in the ISP.
10. Physician monitoring, nursing care, and observation shall be available. A physician shall be available to assess

the individual in person within 24 hours of admission and thereafter as medically necessary.

11. A registered nurse shall conduct an alcohol or other drug-focused nursing assessment upon admission. A licensed registered nurse or licensed practical nurse shall be responsible for monitoring the individual's progress and for medication administration duties.

12. Additional medical specialty consultation, psychological, laboratory, and toxicology services shall be available on site, either through consultation or referral.

13. Coordination of necessary services shall be available on site or through referral to a closely coordinated off-site provider to transition the individual to lower levels of care.

14. Psychiatric services shall be available on site or through consultation or referral to a closely coordinated off-site provider when a presenting problem could be attended to at a later time. Such services shall be available within eight hours of requested service by telephone or within 24 hours of requested service in person or via telemedicine.

C. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) staff requirements.

1. The interdisciplinary team shall include credentialed addiction treatment professionals and addiction-credentialed physicians or physicians with experience in addiction medicine to assess, treat, and obtain and interpret information regarding the individual's psychiatric and substance use disorders.

2. Clinical staff shall be knowledgeable about the biological and psychosocial dimensions of substance use disorders and mental illnesses and their treatment. Clinical staff shall be able to identify acute psychiatric conditions, symptom increase or escalation, and decompensation.

3. Clinical staff shall be able to provide a planned regimen of 24-hour professionally directed evaluation, care, and treatment including the administration of prescribed medications.

4. Addiction-credentialed physician or physician with experience in addiction medicine shall oversee the treatment process and assure quality of care. Licensed physicians shall perform physical examinations for all individuals who are admitted. Staff shall supervise addiction pharmacotherapy integrated with psychosocial therapies. The professional may be a physician or psychiatrist, or physician extender as defined in 12VAC30-130-5020 if knowledgeable about addiction treatment.

D. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) co-occurring enhanced programs as required by ASAM.

1. Appropriate psychiatric services, medication evaluation, and laboratory services shall be available.

2. A psychiatrist assessment of the individual shall occur within four hours of admission by telephone and within 24 hours following admission in person or via telemedicine, or sooner, as appropriate to the individual's behavioral health condition, and thereafter as medically necessary.

3. A behavioral health-focused assessment at the time of admission shall be performed by a registered nurse or licensed mental health clinician. A licensed registered nurse or licensed practical nurse supervised by a registered nurse shall be responsible for monitoring the individual's progress and administering or monitoring the individual's self-administration of medications.

4. Psychiatrists and credentialed addiction treatment professionals who are able to assess and treat co-occurring psychiatric disorders and who have specialized training in the behavior management techniques and evidenced-based practices shall be available.

5. Access to an addiction-credentialed physician shall be available along with access to either a psychiatrist, a certified addiction psychiatrist, or a psychiatrist with experience in addiction medicine.

6. Credentialed addiction treatment professionals shall have experience and training in addiction and mental health to understand the signs and symptoms of mental illness and be able to provide education to the individual on the interaction of substance use and psychotropic medications.

7. Planned clinical activities shall be offered and designed to promote stabilization and maintenance of the individual's behavioral health needs, recovery, and psychiatric symptoms.

8. Medication education and management shall be offered.

**12VAC30-130-5150. Covered services: medically managed intensive inpatient services (ASAM Level 4.0).**

A. Medically managed intensive inpatient services (ASAM Level 4.0) settings for services. Acute care hospitals licensed by the Virginia Department of Health shall be the designated setting for medically managed intensive inpatient treatment and shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs. Such service settings shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress, or all of these, resulting from, or co-occurring with, an individual's use of alcohol or other drugs with the exception of tobacco-related disorders, caffeine-related disorders or dependence or nonsubstance-related disorders.

B. Medically managed intensive inpatient services (ASAM Level 4.0) service components.

1. The service components of medically managed intensive inpatient services shall be:

a. An evaluation or analysis of substance use disorders shall be provided, including the diagnosis of substance use disorders and the assessment of treatment needs for medically necessary services.

b. Observation and monitoring the individual's course of withdrawal shall be provided. This shall be conducted as frequently as deemed appropriate for the individual and the level of care the individual is receiving. This may include, for example, observation of the individual's health status.

c. Medication services, including the prescription or administration related to substance use disorder treatment services or the assessment of the side effects or results of that medication, conducted by appropriate licensed staff who provide such services within their scope of practice or license.

2. The following therapies shall be provided for reimbursement:

a. Daily clinical services provided by an interdisciplinary team to stabilize acute addictive or psychiatric symptoms. Activities shall include pharmacological, cognitive-behavioral, and other therapies administered on an individual or group basis and modified to meet the individual's level of understanding. For individuals with a severe biomedical disorder, physical health interventions are available to supplement addiction treatment. For the individual who has less stable psychiatric symptoms, ASAM Level 4.0 co-occurring capable programs offer individualized treatment activities designed to monitor the individual's mental health and to address the interaction of the mental health programs and substance use disorders.

b. Health education services.

c. Planned clinical interventions that are designed to enhance the individual's understanding and acceptance of illness of addiction and the recovery process.

d. Services for the individual's family, guardian, or significant other, as appropriate, to advance the individual's treatment and recovery goals and objectives identified in the ISP.

e. This level of care offers 24-hour nursing care and daily physician care for severe, unstable problems in any of the following ASAM dimensions: (i) acute intoxication or withdrawal potential; (ii) biomedical conditions and complications; and (iii) emotional, behavioral, or cognitive conditions and complications.

f. Discharge services shall be the process to prepare the individual for referral into another level of care, post treatment return or reentry into the community, or the linkage of the individual to essential community treatment, housing, recovery, and human services.

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# Regulations

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C. Medically managed intensive inpatient services (ASAM Level 4.0) staff requirements.

1. An interdisciplinary staff of appropriately credentialed clinical staff including, for example, addiction-credentialed physicians or physicians with experience in addiction medicine, licensed nurse practitioners, licensed physician assistants, registered nurses, licensed professional counselors, licensed clinical psychologists, or licensed clinical social workers who assess and treat individuals with severe substance use disorders or addicted individuals with concomitant acute biomedical, emotional, or behavioral disorders.

2. Medical management by physicians and primary nursing care shall be available 24 hours per day and counseling services shall be available 16 hours per day.

D. Medically managed intensive inpatient services (ASAM Level 4.0) co-occurring enhanced programs. These programs shall be provided by appropriately credentialed mental health professionals who assess and treat the individual's co-occurring mental illness and are knowledgeable about the biological and psychosocial dimensions of psychiatric disorders and his treatment.

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-130)

Virginia Medicaid Nursing Home Manual, Department of Medical Assistance Services.

Virginia Medicaid Rehabilitation Manual, Department of Medical Assistance Services.

Virginia Medicaid Hospice Manual, Department of Medical Assistance Services.

Virginia Medicaid School Division Manual, Department of Medical Assistance Services.

~~ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, ASAM PPC 2R, Second Edition, revised 2001, American Society of Addiction Medicine.~~

~~Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM IV, October 1996, American Psychiatric Association.~~

[The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, American Society of Addiction Medicine, Inc., 4601 North Park Avenue, Upper Arcade, Suite 101 Chevy Chase, Maryland 20815, www.asam.org](#)

[Diagnostic and Statistical Manual of Mental Disorders: DSM-5, Fifth Edition, 2013, American Psychiatric Association, 1000 Wilson Boulevard, Arlington, Virginia 22209, www.psych.org](#)

[Medicaid Memo: Updates to Telemedicine Coverage, May 13, 2014, Department of Medical Assistance Services](#)

VA.R. Doc. No. R17-4887; Filed January 17, 2017, 3:53 p.m.

## TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

### BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

#### Fast-Track Regulation

Title of Regulation: **18VAC30-21. Regulations Governing Audiology and Speech-Language Pathology (amending 18VAC30-21-110, 18VAC30-21-120; repealing 18VAC30-21-130).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: March 8, 2017.

Effective Date: March 23, 2017.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Audiology and Speech-Language Pathology, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4630, FAX (804) 527-4471, or email [audbd@dhp.virginia.gov](mailto:audbd@dhp.virginia.gov).

Basis: Section 54.1-2400 of the Code of Virginia authorizes the Board of Audiology and Speech-Language Pathology to promulgate regulations to administer the regulatory system.

Purpose: The purpose of the amendments is to remove outdated language and clarify the reinstatement and reactivation requirements for school speech-language pathologists. The Code of Virginia currently requires all school speech-language pathologists to hold a license issued by the board but no longer requires endorsement by the Department of Education; 18VAC30-21-130 retained the reference in previous regulations to such endorsement when someone is applying for reinstatement or reactivation.

Additionally, requirements for reinstatement do not include a certification issued by the American Board of Audiology, which is the credential some audiologists maintain rather than American Speech-Language-Hearing Association certification. Clarity in regulatory language avoids confusion and promotes compliance with license laws and regulations for the health and safety of clients who utilize speech-language services.

Rationale for Using Fast-Track Rulemaking Process: The amendments remove outdated and confusing information, clarify requirements for reactivation or reinstatement, and include an additional credential that may be submitted for reinstatement. All changes are noncontroversial and less restrictive.

Substance: Proposed amendments clarify that school speech-language pathologists are included in provisions for inactive licensure and reactivation or reinstatement of licensure, and they repeal the related, outdated section. The proposal also makes documentation of current certification by the American Board of Audiology acceptable as the credential that may be

used to demonstrate competency for reinstatement of a lapsed licensed by an audiologist.

Issues: There are no real advantages or disadvantages to the public; the amended regulations are clarifying rather than substantive. There are no advantages or disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Audiology and Speech-Language Pathology (Board) proposes to amend its regulation to clarify that school speech-language pathologists are included in general provisions for inactive licensure of Board licensees and to remove an obsolete section that dealt separately with inactive licensure for school speech-language pathologists. The Board also proposes to add an additional professional organization whose certification will be accepted by the Board as proof of demonstrated competency for the purposes of reinstatement of audiologists' lapsed licenses.

Result of Analysis. Benefits outweigh costs for all proposed changes.

Estimated Economic Impact. Current regulation contains a section on inactive licensure for school speech-language pathologists who were dually licensed by the Board and the Department of Education. This section became obsolete in 2014 when the General Assembly mandated that school speech-language pathologists be solely licensed by the Board. In response to this General Assembly action, the Board now proposes to add speech-language pathologists to the section governing inactive licensure for all Board licensees and remove the obsolete language that dealt solely with school speech language pathologists. These changes will not change any substantive requirements for inactive licensure. Accordingly, no entity is likely to incur costs on account of these proposed changes. All interested parties will benefit from the additional clarity these proposed changes bring to the regulation.

Currently, the Board allows a licensee who has allowed his license to lapse for longer than one year to reinstate that license with proof of either current American Speech-Language-Hearing Association (ASHA) certification or documentation of having completed at least 10 continuing education (CE) hours for each year his license was lapsed in Virginia (not to exceed 30 CE hours). The Board now proposes to add current certification by the American Board of Audiology or any other accrediting body recognized by the Board to the list of documentation that would demonstrate continuing competency for the purposes of reinstating lapsed licenses. This change will benefit licensees as it gives them a greater number of options to prove continuing competency to the Board's satisfaction. This may allow them to decrease their time or dollar costs to reinstate lapsed licenses. Because the Board will still be ensuring acceptable competency and licensees are not required to use the additional options

allowed by the Board, no entity is likely to incur costs on account of this proposed change.

Businesses and Entities Affected. These proposed regulatory changes will affect the 507 audiologists and 484 school speech-language pathologists licensed by the Board.

Localities Particularly Affected. No locality is likely to be particularly affected by these proposed regulatory changes.

Projected Impact on Employment. These proposed regulatory changes are unlikely to affect employment in the Commonwealth.

Effects on the Use and Value of Private Property. These proposed regulatory changes are unlikely to affect the use or value of private property in the Commonwealth.

Real Estate Development Costs. These proposed regulatory changes are unlikely to affect real estate development costs in the Commonwealth.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million."

Costs and Other Effects. No small businesses will be adversely affected by these proposed regulatory changes.

Alternative Method that Minimizes Adverse Impact. No small businesses will be adversely affected by these proposed regulatory changes.

Adverse Impacts:

Businesses. No businesses will be adversely affected by these proposed regulatory changes.

Localities. Localities in the Commonwealth are unlikely to see any adverse impacts on account of these proposed regulatory changes.

Other Entities. No other entities are likely to be adversely affected by these proposed changes.

Agency's Response to Economic Impact Analysis: The Board of Audiology and Speech-Language Pathology concurs with the analysis of the Department of Planning and Budget.

Summary:

*The amendments (i) clarify that school speech-language pathologists are included in provisions regarding an inactive license, (ii) repeal an obsolete provision regarding school speech-language pathologists, and (iii) add the American Board of Audiology as an organization whose certification may be used to demonstrate competency for the reinstatement of a lapsed audiologist license.*

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# Regulations

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## Part IV Reactivation and Reinstatement

### **18VAC30-21-110. Inactive licensure; reactivation for audiologists, ~~or~~ speech-language pathologists, or school speech-language pathologists.**

A. An audiologist ~~or~~, speech-language pathologist, ~~or school speech-language pathologist~~ who holds a current, unrestricted license in Virginia may, upon a request on the renewal application and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be required to maintain continuing education requirements and shall not be entitled to perform any act requiring a license to practice audiology or speech-language pathology in Virginia.

B. A licensee whose license has been inactive and who requests reactivation of an active license shall file an application, pay the difference between the inactive and active renewal fees for the current year, and provide documentation of current ASHA certification or of having completed 10 continuing education hours equal to the requirement for the number of years in which the license has been inactive, not to exceed 30 contact hours.

C. A licensee who does not reactivate within five years shall meet the requirements of subsection B of this section and shall either:

1. Meet the requirements for initial licensure as prescribed by 18VAC30-21-60; or
2. Provide documentation of a current license in another jurisdiction in the United States and evidence of active practice for at least one of the past three years or practice in accordance with 18VAC30-21-70 with a provisional license for six months and submit a recommendation for licensure from his supervisor.

D. If the licensee holds licensure in any other state or jurisdiction, he shall provide evidence that no disciplinary action is pending or unresolved. The board may deny a request for reactivation to any licensee who has been determined to have committed an act in violation of 18VAC30-21-160.

### **18VAC30-21-120. Reinstatement of a lapsed license for audiologists ~~or~~, speech-language pathologists, or school speech-language pathologists.**

A. When a license has not been renewed within one year of the expiration date, a person may apply to reinstate his license by submission of a reinstatement application, payment of the reinstatement fee, and submission of documentation of ~~current ASHA certification~~ a current Certificate of Clinical Competence issued by ASHA or certification issued by the American Board of Audiology or any other accrediting body recognized by the board or at least 10 continuing education hours for each year the license has been lapsed, not to exceed 30 contact hours, obtained during the time the license in Virginia was lapsed.

B. A licensee who does not reinstate within five years shall meet the requirements of subsection A of this section and shall either:

1. Reinstate by meeting the requirements for initial licensure as prescribed by 18VAC30-21-60; or
2. Provide documentation of a current license in another United States jurisdiction and evidence of active practice for at least one of the past three years or practice in accordance with 18VAC30-21-70 with a provisional license for six months and submit a recommendation for licensure from his supervisor.

C. If the licensee holds licensure in any other state or jurisdiction, he shall provide evidence that no disciplinary action is pending or unresolved. The board may deny a request for reinstatement to any licensee who has been determined to have committed an act in violation of 18VAC30-21-160.

### **18VAC30-21-130. ~~Reactivation or reinstatement of a school speech-language pathologist. (Repealed.)~~**

~~A. A school speech language pathologist whose license has been inactive and who requests reactivation of an active license shall file an application and pay the difference between the inactive and active renewal fees for the current year. A school speech language pathologist whose license has lapsed and who requests reinstatement shall file an application and pay the reinstatement fee as set forth in 18VAC30-21-40.~~

~~B. The board may reactivate or reinstate licensure as a school speech language pathologist to an applicant who:~~

- ~~1. Holds a master's degree in speech language pathology; and~~
- ~~2. Holds a current endorsement in speech language pathology from the Virginia Department of Education.~~

~~C. The board may deny a request for reactivation or reinstatement to any licensee who has been determined to have committed an act in violation of 18VAC30-21-160.~~

VA.R. Doc. No. R17-4877; Filed January 14, 2017, 3:10 p.m.

## **BOARD FOR BRANCH PILOTS**

### **Fast-Track Regulation**

Title of Regulation: **18VAC45-11. Public Participation Guidelines (amending 18VAC45-11-50).**

Statutory Authority: §§ 2.2-4007.02 and 54.1-201 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: March 8, 2017.

Effective Date: April 1, 2017.

Agency Contact: Kathleen R. Nosbisch, Executive Director, Board for Branch Pilots, 9960 Mayland Drive, Suite 400,

Richmond, VA 23233, telephone (804) 367-8514, FAX (866) 465-6206, or email [branchpilots@dpor.virginia.gov](mailto:branchpilots@dpor.virginia.gov).

**Basis:** The Board for Branch Pilots is authorized under § 54.1-201 of the Code of Virginia to promulgate regulations necessary to assure continued competency, to prevent deceptive or misleading practices by practitioners, and to effectively administer the regulatory system administered by the regulatory board. The amendments conform to Chapter 795 of the 2012 Acts of Assembly, which provides that in formulating any regulation or in evidentiary hearings on regulations, an interested party shall be entitled to be accompanied by and represented by counsel or other qualified representative.

**Purpose:** The purpose of this action is clarity and conformity to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia). Participation by the public in the regulatory process is essential to assist the board in the promulgation of regulations that will protect the public health and safety.

**Rationale for Using Fast-Track Rulemaking Process:** As the proposed amendment merely conforms the regulation to the underlying statute (subsection B of § 2.2-4007.02 of the Code of Virginia), the rulemaking is not expected to be controversial and therefore appropriate for the fast-track process.

**Substance:** The amendment provides that interested persons may be accompanied by and represented by counsel or other representative when presenting their views in the promulgation of any regulatory action.

**Issues:** Other than conformity and consistency between law and regulation, there are no primary advantages or disadvantages to the public in implementing the amended provisions, since the provisions are already in the Code of Virginia. There are no primary advantages and disadvantages to the agency or the Commonwealth.

**Department of Planning and Budget's Economic Impact Analysis:**

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 795 of the 2012 Acts of Assembly,<sup>1</sup> the Board for Branch Pilots (Board) proposes to specify in this regulation that interested persons shall be afforded an opportunity to be accompanied by and represented by counsel or other representative when submitting data, views, and arguments, either orally or in writing, to the agency.

Result of Analysis. The benefits likely exceed the costs for all proposed changes.

Estimated Economic Impact. The current Public Participation Guidelines state that: "In considering any nonemergency, nonexempt regulatory action, the agency shall afford interested persons an opportunity to submit data, views, and arguments, either orally or in writing, to the agency." The Board proposes to append "and (ii) be accompanied by and represented by counsel or other representative."

Chapter 795 of the 2012 Acts of Assembly added to § 2.2-4007.02. "Public participation guidelines" of the Code of Virginia that interested persons also be afforded an opportunity to be accompanied by and represented by counsel or other representative. Since the Code of Virginia already specifies that interested persons shall be afforded an opportunity to be accompanied by and represented by counsel or other representative, the Board's proposal to add this language to the regulation will not change the law in effect, but will be beneficial in that it will inform interested parties who read this regulation but not the statute of their legal rights concerning representation.

**Businesses and Entities Affected.** The proposed amendment potentially affects all individuals who comment on pending regulatory changes.

**Localities Particularly Affected.** The proposed amendment does not disproportionately affect particular localities.

**Projected Impact on Employment.** The proposed amendment does not significantly affect employment.

**Effects on the Use and Value of Private Property.** The proposed amendment does not affect the use and value of private property.

**Real Estate Development Costs.** The proposed amendment does not affect real estate development costs.

**Small Businesses:**

**Definition.** Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million."

**Costs and Other Effects.** The proposed amendment does not affect costs for small businesses.

**Alternative Method that Minimizes Adverse Impact.** The proposed amendment does not adversely affect small businesses.

**Adverse Impacts:**

**Businesses.** The proposed amendment does not adversely affect businesses.

**Localities.** The proposed amendment does not adversely affect localities.

**Other Entities.** The proposed amendment does not adversely affect other entities.

<sup>1</sup> See <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0795+hil>

**Agency's Response to Economic Impact Analysis:** The agency concurs with the economic impact analysis prepared by the Department of Planning and Budget.

**Summary:**

*Pursuant to § 2.2-4007.02 of the Code of Virginia, the amendment provides that interested persons submitting data, views, and arguments on a regulatory action may be accompanied by and represented by counsel or another representative.*



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# Regulations

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Part III  
Public Participation Procedures

**18VAC45-11-50. Public comment.**

A. In considering any nonemergency, nonexempt regulatory action, the agency shall afford interested persons an opportunity to (i) submit data, views, and arguments, either orally or in writing, to the agency; and (ii) be accompanied by and represented by counsel or other representative. Such opportunity to comment shall include an online public comment forum on the Town Hall.

1. To any requesting person, the agency shall provide copies of the statement of basis, purpose, substance, and issues; the economic impact analysis of the proposed or fast-track regulatory action; and the agency's response to public comments received.

2. The agency may begin crafting a regulatory action prior to or during any opportunities it provides to the public to submit comments.

B. The agency shall accept public comments in writing after the publication of a regulatory action in the Virginia Register as follows:

1. For a minimum of 30 calendar days following the publication of the notice of intended regulatory action (NOIRA).

2. For a minimum of 60 calendar days following the publication of a proposed regulation.

3. For a minimum of 30 calendar days following the publication of a repropoed regulation.

4. For a minimum of 30 calendar days following the publication of a final adopted regulation.

5. For a minimum of 30 calendar days following the publication of a fast-track regulation.

6. For a minimum of 21 calendar days following the publication of a notice of periodic review.

7. Not later than 21 calendar days following the publication of a petition for rulemaking.

C. The agency may determine if any of the comment periods listed in subsection B of this section shall be extended.

D. If the Governor finds that one or more changes with substantial impact have been made to a proposed regulation, he may require the agency to provide an additional 30 calendar days to solicit additional public comment on the changes in accordance with § 2.2-4013 C of the Code of Virginia.

E. The agency shall send a draft of the agency's summary description of public comment to all public commenters on the proposed regulation at least five days before final adoption of the regulation pursuant to § 2.2-4012 E of the Code of Virginia.

VA.R. Doc. No. R17-5015; Filed January 11, 2017, 6:02 p.m.

**BOARD OF MEDICINE**

**Final Regulation**

Title of Regulation: **18VAC85-150. Regulations Governing the Practice of Behavior Analysis (amending 18VAC85-150-90, 18VAC85-150-100).**

Statutory Authority: §§ 54.1-2400 and 54.1-2957.16 of the Code of Virginia.

Effective Date: March 8, 2017.

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4558, FAX (804) 527-4429, or email william.harp@dhp.virginia.gov.

Summary:

*The amendments (i) increase the required number of continuing education hours for biennial license renewal from 24 to 32 for behavior analysts and from 16 to 20 for assistant behavior analysts and require that four of the required hours be related to the practice of ethics in behavior analysis, (ii) modify the number of continuing education hours required to reactivate an inactive license or reinstate a license that has lapsed more than two years, and (iii) pursuant to Chapter 82 of the 2016 Acts of Assembly, allow behavior analysts and assistant behavior analysts to substitute six hours of volunteer work for two hours of continuing education biennially.*

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

**18VAC85-150-90. Reactivation or reinstatement.**

A. To reactivate an inactive license or to reinstate a license that has been lapsed for more than two years, a behavior analyst or assistant behavior analyst shall submit evidence of competency to return to active practice to include one of the following:

1. Information on continued practice in another jurisdiction as a licensed behavior analyst or a licensed assistant behavior analyst or with certification as a BCBA<sup>®</sup> or BCaBA<sup>®</sup> during the period in which the license has been inactive or lapsed;

2. ~~Twelve~~ Sixteen hours of continuing education for each year in which the license as a behavior analyst or 10 hours for each year in which the license as an assistant behavior analyst has been inactive or lapsed, not to exceed three years; or

3. Recertification by passage of the BCBA<sup>®</sup> or the BCaBA<sup>®</sup> certification examination from the BACB.

B. To reactivate an inactive license, a behavior analyst or assistant behavior analyst shall pay a fee equal to the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure.

C. To reinstate a license that has been lapsed for more than two years, a behavior analyst or assistant behavior analyst shall file an application for reinstatement and pay the fee for reinstatement of his license as prescribed in 18VAC85-150-40. The board may specify additional requirements for reinstatement of a license so lapsed to include education, experience, or reexamination.

D. A behavior analyst or assistant behavior analyst whose licensure has been revoked by the board and who wishes to be reinstated shall make a new application to the board, fulfill additional requirements as specified in the order from the board, and make payment of the fee for reinstatement of his licensure as prescribed in 18VAC85-150-40 pursuant to § 54.1-2408.2 of the Code of Virginia.

E. The board reserves the right to deny a request for reactivation or reinstatement to any licensee who has been determined to have committed an act in violation of § 54.1-2915 of the Code of Virginia or any provisions of this chapter.

**18VAC85-150-100. Continuing education requirements.**

A. In order to renew an active license, a behavior analyst shall attest to having completed ~~24~~ 32 hours of continuing education and an assistant behavior analyst shall attest to having completed ~~16~~ 20 hours of continuing education as approved and documented by a sponsor recognized by the BACB within the last biennium. Four of the required hours shall be related to ethics in the practice of behavior analysis. [ Up to two continuing education hours may be satisfied through delivery of behavioral analysis services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for three hours of providing such volunteer services. For the purpose of continuing education credit for voluntary service, the hours shall be approved and documented by the health department or free clinic. ]

B. A practitioner shall be exempt from the continuing education requirements for the first biennial renewal following the date of initial licensure in Virginia.

C. The practitioner shall retain in his records the completed form with all supporting documentation for a period of four years following the renewal of an active license.

D. The board shall periodically conduct a random audit of its active licensees to determine compliance. The practitioners selected for the audit shall provide all supporting documentation within 30 days of receiving notification of the audit.

E. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

F. The board may grant an extension of the deadline for continuing education requirements, for up to one year, for

good cause shown upon a written request from the licensee prior to the renewal date.

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

VA.R. Doc. No. R16-4296; Filed January 13, 2017, 3:21 p.m.

**BOARD OF PHYSICAL THERAPY**

**Fast-Track Regulation**

**Title of Regulation:** 18VAC112-11. Public Participation Guidelines (amending 18VAC112-11-50).

**Statutory Authority:** §§ 2.2-4007.02 and 54.1-2400 of the Code of Virginia.

**Public Hearing Information:** No public hearings are scheduled.

**Public Comment Deadline:** March 8, 2017.

**Effective Date:** March 23, 2017.

**Agency Contact:** Corie Tillman Wolf, Executive Director, Board of Physical Therapy, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4674, FAX (804) 527-4413, or email ptboard@dhp.virginia.gov.

**Basis:** The Board of Physical Therapy is authorized under § 54.1-2400 of the Code of Virginia to promulgate regulations that are reasonable and necessary to administer effectively the regulatory system. The action conforms the board's regulation to Chapter 795 of the 2012 Acts of Assembly, which provides that in formulating any regulation or in evidentiary hearings on regulations, an interested party shall be entitled to be accompanied by and represented by counsel or other qualified representative.

**Purpose:** The purpose is clarity and conformity to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia). Participation by the public in the regulatory process is essential to assist the board in the promulgation of regulations that will protect the public health and safety.

**Rationale for Using Fast-Track Rulemaking Process:** The amendment was recommended by the Department of Planning and Budget and is intended to merely conform the regulation to the statute. Therefore, there is no controversy in its promulgation.

**Substance:** The board has amended subsection A of 18VAC112-11-50 to provide that interested persons may be accompanied by and represented by counsel or other representative when presenting their views in the promulgation of any regulatory action.

**Issues:** Other than conformity and consistency between law and regulation, there are no primary advantages or disadvantages to the public in implementing the amended provisions, since the provisions are already in the Code of Virginia. There are no primary advantages and disadvantages to the agency or the Commonwealth.

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## Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 795 of the 2012 Acts of the Assembly,<sup>1</sup> the Board of Physical Therapy (Board) proposes to specify in this regulation that interested persons shall be afforded an opportunity to be accompanied by and represented by counsel or other representative when submitting data, views, and arguments, either orally or in writing, to the agency.

Result of Analysis. The benefits likely exceed the costs for all proposed changes.

Estimated Economic Impact. The current Public Participation Guidelines state that: "In considering any nonemergency, nonexempt regulatory action, the agency shall afford interested persons an opportunity to submit data, views, and arguments, either orally or in writing, to the agency." The Board proposes to append "and (ii) be accompanied by and represented by counsel or other representative."

Chapter 795 of the 2012 Acts of Assembly added to § 2.2-4007.02. "Public participation guidelines" of the Code of Virginia that interested persons also be afforded an opportunity to be accompanied by and represented by counsel or other representative. Since the Code of Virginia already specifies that interested persons shall be afforded an opportunity to be accompanied by and represented by counsel or other representative, the Board's proposal to add this language to the regulation will not change the law in effect, but will be beneficial in that it will inform interested parties who read this regulation but not the statute of their legal rights concerning representation.

Businesses and Entities Affected. The proposed amendment potentially affects all individuals who comment on pending regulatory changes.

Localities Particularly Affected. The proposed amendment does not disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendment does not significantly affect employment.

Effects on the Use and Value of Private Property. The proposed amendment does not affect the use and value of private property.

Real Estate Development Costs. The proposed amendment does not affect real estate development costs.

### Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million."

Costs and Other Effects. The proposed amendment does not affect costs for small businesses.

Alternative Method that Minimizes Adverse Impact. The proposed amendment does not adversely affect small businesses.

### Adverse Impacts:

Businesses. The proposed amendment does not adversely affect businesses.

Localities. The proposed amendment does not adversely affect localities.

Other Entities. The proposed amendment does not adversely affect other entities.

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<sup>1</sup> See <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0795+hil>

Agency's Response to Economic Impact Analysis: The Board of Physical Therapy concurs with the analysis of the Department of Planning and Budget.

### Summary:

*Pursuant to § 2.2-4007.02 of the Code of Virginia, the amendment provides that interested persons submitting data, views, and arguments on a regulatory action may be accompanied by and represented by counsel or another representative.*

### Part III

#### Public Participation Procedures

#### **18VAC112-11-50. Public comment.**

A. In considering any nonemergency, nonexempt regulatory action, the agency shall afford interested persons an opportunity to (i) submit data, views, and arguments, either orally or in writing, to the agency; and (ii) be accompanied by and represented by counsel or other representative. Such opportunity to comment shall include an online public comment forum on the Town Hall.

1. To any requesting person, the agency shall provide copies of the statement of basis, purpose, substance, and issues; the economic impact analysis of the proposed or fast-track regulatory action; and the agency's response to public comments received.

2. The agency may begin crafting a regulatory action prior to or during any opportunities it provides to the public to submit comments.

B. The agency shall accept public comments in writing after the publication of a regulatory action in the Virginia Register as follows:

1. For a minimum of 30 calendar days following the publication of the notice of intended regulatory action (NOIRA).

2. For a minimum of 60 calendar days following the publication of a proposed regulation.

3. For a minimum of 30 calendar days following the publication of a repropounded regulation.

4. For a minimum of 30 calendar days following the publication of a final adopted regulation.

5. For a minimum of 30 calendar days following the publication of a fast-track regulation.

6. For a minimum of 21 calendar days following the publication of a notice of periodic review.

7. Not later than 21 calendar days following the publication of a petition for rulemaking.

C. The agency may determine if any of the comment periods listed in subsection B of this section shall be extended.

D. If the Governor finds that one or more changes with substantial impact have been made to a proposed regulation, he may require the agency to provide an additional 30 calendar days to solicit additional public comment on the changes in accordance with § 2.2-4013 C of the Code of Virginia.

E. The agency shall send a draft of the agency's summary description of public comment to all public commenters on the proposed regulation at least five days before final adoption of the regulation pursuant to § 2.2-4012 E of the Code of Virginia.

VA.R. Doc. No. R17-4961; Filed January 12, 2017, 4:21 p.m.

**TITLE 21. SECURITIES AND RETAIL FRANCHISING**

**STATE CORPORATION COMMISSION**

**Final Regulation**

**REGISTRAR'S NOTICE:** The State Corporation Commission is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4002 A 2 of the Code of Virginia, which exempts courts, any agency of the Supreme Court, and any agency that by the Constitution is expressly granted any of the powers of a court of record.

**Titles of Regulations:** 21VAC5-20. **Broker-Dealers, Broker-Dealer Agents and Agents of the Issuer (amending 21VAC5-20-280).**

**21VAC5-45. Federal Covered Securities (adding 21VAC5-45-30).**

**Statutory Authority:** §§ 12.1-13 and 13.1-523 of the Code of Virginia.

**Effective Date:** February 1, 2017.

**Agency Contact:** Timothy O'Brien, Manager, Securities Division, State Corporation Commission, Tyler Building, 9th Floor, P.O. Box 1197, Richmond, VA 23218, telephone (804) 371-9415, FAX (804) 371-9911, or email timothy.o'brien@scc.virginia.gov.

**Summary:**

*The amendments (i) provide for a notice filing for a securities issuer that is using federal Regulation A for*

*offerings up to \$50 million in a 12-month period, which allows monitoring of the offerings; (ii) require the filing of a short form with basic information about the issuer and the offering; and (iii) establish a filing fee of \$500 and a renewal fee of \$250. The amendments also clarify that high quality foreign issuers are not subject to the prohibited business conduct rule in subdivision D 6 of 21VAC5-20-280.*

AT RICHMOND, JANUARY 5, 2017

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. SEC-2016-00051

Ex Parte: In the matter of

Adopting a Revision to the Rules

Governing the Virginia Securities Act

**ORDER ADOPTING AMENDED RULES**

By Order to Take Notice ("Order") entered on October 14, 2016,<sup>1</sup> all interested persons were ordered to take notice that the State Corporation Commission ("Commission") would consider the adoption of revisions to Chapters 45 and 20 of Title 21 of the Virginia Administrative Code. On October 25, 2016,<sup>2</sup> the Division of Securities and Retail Franchising ("Division") mailed and emailed the Order of the proposed rules to all interested persons pursuant to the Virginia Securities Act, § 13.1-501 et seq. of the Code of Virginia. The Order described the proposed revisions and afforded interested persons an opportunity to file comments and request a hearing on or before December 1, 2016, with the Clerk of the Commission. The Order provided that requests for hearing shall state why a hearing is necessary and why the issues cannot be adequately addressed in written comments.

The Commission received no comments with regard to the proposed revision to Chapter 45, regarding the notice filing requirements for those companies that wished to take advantage of an exemption under federal law for Regulation A, Tier 2 offerings.

The Commission received one comment from the Securities Industry and Financial Markets Association ("SIFMA")<sup>3</sup> requesting that the Division consider a couple of minor changes to the proposed revision of Commission Rule 21 VAC 5-20-280 D (6) in order to further clarify the rule's application. The Division did not object to the proposed revisions and recommends that the regulations be adopted, as revised.

No one requested a hearing on either of the proposed regulations.

NOW THE COMMISSION, upon consideration of the proposed amendments to the proposed rules, the recommendation of the Division, and the record in this case, finds that the proposed amendments should be adopted.

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Accordingly, IT IS ORDERED THAT:

(1) The proposed rules are attached hereto, made a part hereof, and are hereby ADOPTED effective February 1, 2017.

(2) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, together with the adopted rules, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the Virginia Register of Regulations.

(3) This case is dismissed from the Commission's docket, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof, together with a copy of the adopted rules, shall be sent by the Clerk of the Commission in care of Ronald W. Thomas, Director of the Division, who forthwith shall give further notice of the adopted rules by mailing or emailing a copy of this Order Adopting Amended Rules, to all interested persons.

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<sup>1</sup> Doc. Con. Cen. No 161020197.

<sup>2</sup> The notice was published by the Virginia Registrar of Regulations on November 14, 2016. Doc. Con. Cen. No. 161210137.

<sup>3</sup> Although the comment was filed on December 2, 2016, the Division received the comment by the December 1, 2016, deadline as required by the Order. Doc. Con. Cen. No. 161210095.

## **21VAC5-20-280. Prohibited business conduct.**

A. Every broker-dealer is required to observe high standards of commercial honor and just and equitable principles of trade in the conduct of its business. The acts and practices described ~~below~~ in this subsection are considered contrary to such standards and may constitute grounds for denial, suspension, or revocation of registration or such other action authorized by the Act. No broker-dealer who is registered or required to be registered shall:

1. Engage in a pattern of unreasonable and unjustifiable delays in the delivery of securities purchased by any of its customers or in the payment upon request of free credit balances reflecting completed transactions of any of its customers, or take any action that directly or indirectly interferes with a customer's ability to transfer his account; provided that the account is not subject to any lien for moneys owed by the customer or other bona fide claim, including, but not limited to, seeking a judicial order or decree that would bar or restrict the submission, delivery or acceptance of a written request from a customer to transfer his account;

2. Induce trading in a customer's account which is excessive in size or frequency in view of the financial resources and character of the account;

3. Recommend to a customer the purchase, sale or exchange of any security without reasonable grounds to believe that the recommendation is suitable for the customer. The reasonable basis to recommend any such

transaction to a customer shall be based upon the risks associated with a particular security, and the information obtained through the diligence and inquiry of the broker-dealer to ascertain the customer's investment profile. A customer's investment profile includes, but is not limited to, the customer's investment objectives, financial situation, risk tolerance and needs, tax status, age, other investments, investment experience, investment time horizon, liquidity needs, and any other relevant information known by the broker-dealer or of which the broker-dealer is otherwise made aware in connection with such recommendation;

4. Execute a transaction on behalf of a customer without authority to do so or, when securities are held in a customer's account, fail to execute a sell transaction involving those securities as instructed by a customer, without reasonable cause;

5. Exercise any discretionary power in effecting a transaction for a customer's account without first obtaining written discretionary authority from the customer, unless the discretionary power relates solely to the time or price for the execution of orders;

6. Execute any transaction in a margin account without securing from the customer a properly executed written margin agreement promptly after the initial transaction in the account, or fail, prior to or at the opening of a margin account, to disclose to a noninstitutional customer the operation of a margin account and the risks associated with trading on margin at least as comprehensively as required by FINRA Rule 2264;

7. Fail to segregate customers' free securities or securities held in safekeeping;

8. Hypothecate a customer's securities without having a lien thereon unless the broker-dealer secures from the customer a properly executed written consent promptly after the initial transaction, except as permitted by Rules of the SEC;

9. Enter into a transaction with or for a customer at a price not reasonably related to the current market price of a security or receiving an unreasonable commission or profit;

10. Fail to furnish to a customer purchasing securities in an offering, no later than the date of confirmation of the transaction, either a final prospectus or a preliminary prospectus and an additional document, which together include all information set forth in the final prospectus, either by (i) hard copy prospectus delivery or (ii) electronic prospectus delivery;

11. Introduce customer transactions on a "fully disclosed" basis to another broker-dealer that is not exempt under § 13.1-514 B 6 of the Act;

12. a. Charge unreasonable and inequitable fees for services performed, including miscellaneous services such

as collection of moneys due for principal, dividends or interest, exchange or transfer of securities, appraisals, safekeeping, or custody of securities and other services related to its securities business;

b. Charge a fee based on the activity, value or contents (or lack thereof) of a customer account unless written disclosure pertaining to the fee, which shall include information about the amount of the fee, how imposition of the fee can be avoided and any consequence of late payment or nonpayment of the fee, was provided no later than the date the account was established or, with respect to an existing account, at least 60 days prior to the effective date of the fee;

13. Offer to buy from or sell to any person any security at a stated price unless the broker-dealer is prepared to purchase or sell at the price and under such conditions as are stated at the time of the offer to buy or sell;

14. Represent that a security is being offered to a customer "at a market" or a price relevant to the market price unless the broker-dealer knows or has reasonable grounds to believe that a market for the security exists other than that made, created or controlled by the broker-dealer, or by any person for whom he is acting or with whom he is associated in the distribution, or any person controlled by, controlling or under common control with the broker-dealer;

15. Effect any transaction in, or induce the purchase or sale of, any security by means of any manipulative, deceptive or fraudulent device, practice, plan, program, design or contrivance, which may include but not be limited to:

a. Effecting any transaction in a security which involves no change in the beneficial ownership thereof;

b. Entering an order or orders for the purchase or sale of any security with the knowledge that an order or orders of substantially the same size, at substantially the same time and substantially the same price, for the sale of any security, has been or will be entered by or for the same or different parties for the purpose of creating a false or misleading appearance of active trading in the security or a false or misleading appearance with respect to the market for the security; however, nothing in this subdivision shall prohibit a broker-dealer from entering bona fide agency cross transactions for its customers; or

c. Effecting, alone or with one or more other persons, a series of transactions in any security creating actual or apparent active trading in the security or raising or depressing the price of the security, for the purpose of inducing the purchase or sale of the security by others;

16. Guarantee a customer against loss in any securities account of the customer carried by the broker-dealer or in any securities transaction effected by the broker-dealer with or for the customer;

17. Publish or circulate, or cause to be published or circulated, any notice, circular, advertisement, newspaper article, investment service, or communication of any kind which purports to report any transaction as a purchase or sale of any security unless the broker-dealer believes that the transaction was a bona fide purchase or sale of the security; or which purports to quote the bid price or asked price for any security, unless the broker-dealer believes that the quotation represents a bona fide bid for, or offer of, the security;

18. Use any advertising or sales presentation in such a fashion as to be deceptive or misleading. An example of such practice would be a distribution of any nonfactual data, material or presentation based on conjecture, unfounded or unrealistic claims or assertions in any brochure, flyer, or display by words, pictures, graphs or otherwise designed to supplement, detract from, supersede or defeat the purpose or effect of any prospectus or disclosure;

19. Fail to make reasonably available upon request to any person expressing an interest in a solicited transaction in a security, not listed on a registered securities exchange or quoted on an automated quotation system operated by a national securities association approved by regulation of the commission, a balance sheet of the issuer as of a date within 18 months of the offer or sale of the issuer's securities and a profit and loss statement for either the fiscal year preceding that date or the most recent year of operations, the names of the issuer's proprietor, partners or officers, the nature of the enterprises of the issuer and any available information reasonably necessary for evaluating the desirability or lack of desirability of investing in the securities of an issuer. All transactions in securities described in this subdivision shall comply with the provisions of § 13.1-507 of the Act;

20. Fail to disclose that the broker-dealer is controlled by, controlling, affiliated with or under common control with the issuer of any security before entering into any contract with or for a customer for the purchase or sale of the security, the existence of control to the customer, and if disclosure is not made in writing, it shall be supplemented by the giving or sending of written disclosure at or before the completion of the transaction;

21. Fail to make a bona fide public offering of all of the securities allotted to a broker-dealer for distribution, whether acquired as an underwriter, a selling group member, or from a member participating in the distribution as an underwriter or selling group member;

22. Fail or refuse to furnish a customer, upon reasonable request, information to which the customer is entitled, or to respond to a formal written request or complaint;

23. Fail to clearly and separately disclose to its customer, prior to any security transaction, providing investment advice for compensation or any materially related

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transaction that the customer's funds or securities will be in the custody of an investment advisor or contracted custodian, in a manner that does not provide Securities Investor Protection Corporation protection, or equivalent third-party coverage over the customer's assets;

24. Market broker-dealer services that are associated with financial institutions in a manner that is misleading or confusing to customers as to the nature of securities products or risks;

25. In transactions subject to breakpoints, fail to:

a. Utilize advantageous breakpoints without reasonable basis for their exclusion;

b. Determine information that should be recorded on the books and records of a member or its clearing firm, which is necessary to determine the availability and appropriateness of breakpoint opportunities; or

c. Inquire whether the customer has positions or transactions away from the member that should be considered in connection with the pending transaction and apprise the customer of the breakpoint opportunities;

26. Use a certification or professional designation in connection with the offer, sale, or purchase of securities that indicates or implies that the user has special certification or training in advising or servicing senior citizens or retirees in such a way as to mislead any person.

a. The use of such certification or professional designation includes, but is not limited to, the following:

(1) Use of a certification or designation by a person who has not actually earned or is otherwise ineligible to use such certification or designation;

(2) Use of a nonexistent or self-conferred certification or professional designation;

(3) Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the person using the certification or professional designation does not have; or

(4) Use of a certification or professional designation that was obtained from a designating or certifying organization that:

(a) Is primarily engaged in the business of instruction in sales or marketing;

(b) Does not have reasonable standards or procedures for assuring the competency of its designees or certificants;

(c) Does not have reasonable standards or procedures for monitoring and disciplining its designees or certificants for improper or unethical conduct; or

(d) Does not have reasonable continuing education requirements for its designees or certificants in order to maintain the designation or certificate.

b. There is a rebuttable presumption that a designating or certifying organization is not disqualified solely for purposes of subdivision 26 a (4) of this subsection, when the organization has been accredited by:

(1) The American National Standards Institute;

(2) The Institute for Credentialing Excellence (formerly the National Commission for Certifying Agencies); or

(3) An organization that is on the ~~United States~~ U.S. Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes" and the designation or credential issued therefrom does not primarily apply to sales or marketing.

c. In determining whether a combination of words (or an acronym standing for a combination of words) constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing senior citizens or retirees, factors to be considered shall include:

(1) Use of one or more words such as "senior," "retirement," "elder," or like words, combined with one or more words such as "certified," "chartered," "adviser," "specialist," "consultant," "planner," or like words, in the name of the certification or professional designation; and

(2) The manner in which those words are combined.

d. For purposes of this section, a certification or professional designation does not include a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency when that job title:

(1) Indicates seniority within the organization; or

(2) Specifies an individual's area of specialization within the organization.

For purposes of this subdivision d, "financial services regulatory agency" includes, but is not limited to, an agency that regulates broker-dealers, investment advisers, or investment companies as defined under § 3 (a)(1) of the Investment Company Act of 1940 (15 USC § 80a-3(a)(1)).

e. Nothing in this regulation shall limit the commission's authority to enforce existing provisions of law;

27. Represent that securities will be listed or that application for listing will be made on a securities exchange or the National Association of Securities Dealers Automated Quotations (NASDAQ) system or other quotation system without reasonable basis in fact for the representation;

28. Falsify or alter so as to make false or misleading any record or document or any information provided to the commission;

29. Negotiate, facilitate, or otherwise execute a transaction on behalf of an investor involving securities issued by a third party pursuant to a claim for exemption under

subsection B of § 13.1-514 of the Act unless the broker-dealer intends to report the securities owned and the value of such securities on at least a quarterly basis to the investor;

30. Offer or sell securities pursuant to a claim for exemption under subsection B of § 13.1-514 of the Act without having first verified the information relating to the securities offered or sold, which shall include, but not be limited to, ascertaining the risks associated with investing in the respective security;

31. Allow any person to represent or utilize its name as a trading platform without conspicuously disclosing the name of the registered broker-dealer in effecting or attempting to effect purchases and sales of securities; or

32. Engage in any conduct that constitutes a dishonest or unethical practice including, but not limited to, forgery, embezzlement, nondisclosure, incomplete disclosure or material omissions or untrue statements of material facts, manipulative or deceptive practices, or fraudulent course of business.

B. Every agent is required to observe high standards of commercial honor and just and equitable principles of trade in the conduct of his business. The acts and practices described below in this subsection are considered contrary to such standards and may constitute grounds for denial, suspension, or revocation of registration or such other action authorized by the Act. No agent who is registered or required to be registered shall:

1. Engage in the practice of lending or borrowing money or securities from a customer, or acting as a custodian for money, securities or an executed stock power of a customer;

2. Effect any securities transaction not recorded on the regular books or records of the broker-dealer which the agent represents, unless the transaction is authorized in writing by the broker-dealer prior to execution of the transaction;

3. Establish or maintain an account containing fictitious information in order to execute a transaction which would otherwise be unlawful or prohibited;

4. Share directly or indirectly in profits or losses in the account of any customer without the written authorization of the customer and the broker-dealer which the agent represents;

5. Divide or otherwise split the agent's commissions, profits or other compensation from the purchase or sale of securities in this ~~state~~ Commonwealth with any person not also registered as an agent for the same broker-dealer, or for a broker-dealer under direct or indirect common control;

6. Engage in conduct specified in subdivision A 2, 3, 4, 5, 6, 10, 15, 16, 17, 18, 23, 24, 25, 26, 28, 30, 31, or 32 of this section;

7. Fail to comply with the continuing education requirements under 21VAC5-20-150 C; or

8. Hold oneself out as representing any person other than the broker-dealer with whom the agent is registered and, in the case of an agent whose normal place of business is not on the premises of the broker-dealer, failing to conspicuously disclose the name of the broker-dealer for whom the agent is registered when representing the dealer in effecting or attempting to effect the purchases or sales of securities.

C. No person shall publish, give publicity to, or circulate any notice, circular, advertisement, newspaper article, letter, investment service or communication which, though not purporting to offer a security for sale, describes the security, for a consideration received or to be received, directly or indirectly, from an issuer, underwriter, or dealer, without fully disclosing the receipt, whether past or prospective, of such consideration and the amount thereof.

D. The purpose of this subsection is to identify practices in the securities business that are generally associated with schemes to manipulate and to identify prohibited business conduct of broker-dealers or sales agents who are registered or required to be registered.

1. Entering into a transaction with a customer in any security at an unreasonable price or at a price not reasonably related to the current market price of the security or receiving an unreasonable commission or profit.

2. Contradicting or negating the importance of any information contained in a prospectus or other offering materials with intent to deceive or mislead or using any advertising or sales presentation in a deceptive or misleading manner.

3. In connection with the offer, sale, or purchase of a security, falsely leading a customer to believe that the broker-dealer or agent is in possession of material, nonpublic information that would affect the value of the security.

4. In connection with the solicitation of a sale or purchase of a security, engaging in a pattern or practice of making contradictory recommendations to different investors of similar investment objective for some to sell and others to purchase the same security, at or about the same time, when not justified by the particular circumstances of each investor.

5. Failing to make a bona fide public offering of all the securities allotted to a broker-dealer for distribution by, among other things, (i) transferring securities to a customer, another broker-dealer, or a fictitious account with the understanding that those securities will be returned to the broker-dealer or its nominees or (ii) parking or withholding securities.

6. ~~Although nothing in this subsection precludes a. In addition to the~~ application of the general anti-fraud



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provisions against anyone [~~for~~ in connection with] practices similar in nature to the practices discussed ~~below~~ in this subdivision 6, the following subdivisions ~~a~~ (1) through ~~f~~ (6) specifically apply only in connection with the solicitation of a purchase or sale of over the counter (OTC) unlisted non-NASDAQ equity securities except those exempt from registration under 21VAC5-40-50:

~~a.~~ (1) Failing to advise the customer, both at the time of solicitation and on the confirmation, of any and all compensation related to a specific securities transaction to be paid to the agent including commissions, sales charges, or concessions.

~~b.~~ (2) In connection with a principal transaction, failing to disclose, both at the time of solicitation and on the confirmation, a short inventory position in the firm's account of more than 3.0% of the issued and outstanding shares of that class of securities of the issuer; however, [this] subdivision 6 of this subsection shall apply only if the firm is a market maker at the time of the solicitation.

~~c.~~ (3) Conducting sales contests in a particular security.

~~d.~~ (4) After a solicited purchase by a customer, failing or refusing, in connection with a principal transaction, to promptly execute sell orders.

~~e.~~ (5) Soliciting a secondary market transaction when there has not been a bona fide distribution in the primary market.

~~f.~~ (6) Engaging in a pattern of compensating an agent in different amounts for effecting sales and purchases in the same security.

b. Although subdivisions D 6 a (1) through (6) of this section do not apply to OTC unlisted non-NASDAQ equity securities exempt from registration under 21VAC5-40-50, nothing in this subsection precludes application of the general anti-fraud provisions against anyone [~~for~~ in connection with] practices similar in nature to the practices discussed in subdivisions D 6 a (1) through (6) of this section [~~in connection with such securities~~].

7. Effecting any transaction in, or inducing the purchase or sale of, any security by means of any manipulative, deceptive, or other fraudulent device or contrivance including but not limited to the use of boiler room tactics or use of fictitious or nominee accounts.

8. Failing to comply with any prospectus delivery requirements promulgated under federal law or the Act.

9. In connection with the solicitation of a sale or purchase of an OTC unlisted non-NASDAQ security, failing to promptly provide the most current prospectus or the most recently filed periodic report filed under § 13 of the Securities Exchange Act when requested to do so by a customer.

10. Marking any order tickets or confirmations as unsolicited when in fact the transaction was solicited.

11. For any month in which activity has occurred in a customer's account, but in no event less than every three months, failing to provide each customer with a statement of account with respect to all OTC non-NASDAQ equity securities in the account, containing a value for each such security based on the closing market bid on a date certain; however, this subdivision shall apply only if the firm has been a market maker in the security at any time during the month in which the monthly or quarterly statement is issued.

12. Failing to comply with any applicable provision of the FINRA Rules or any applicable fair practice, privacy, or ethical standard promulgated by the SEC or by a self-regulatory organization approved by the SEC.

13. In connection with the solicitation of a purchase or sale of a designated security:

a. Failing to disclose to the customer the bid and ask price, at which the broker-dealer effects transactions with individual, retail customers, of the designated security as well as its spread in both percentage and dollar amounts at the time of solicitation and on the trade confirmation documents; or

b. Failing to include with the confirmation, the notice disclosure contained under 21VAC5-20-285, except the following shall be exempt from this requirement:

(1) Transactions in which the price of the designated security is \$5.00 or more, exclusive of costs or charges; however, if the designated security is a unit composed of one or more securities, the unit price divided by the number of components of the unit other than warrants, options, rights, or similar securities must be \$5.00 or more, and any component of the unit that is a warrant, option, right, or similar securities, or a convertible security must have an exercise price or conversion price of \$5.00 or more.

(2) Transactions that are not recommended by the broker-dealer or agent.

(3) Transactions by a broker-dealer (i) whose commissions, commission equivalents, and mark-ups from transactions in designated securities during each of the preceding three months, and during 11 or more of the preceding 12 months, did not exceed 5.0% of its total commissions, commission-equivalents, and mark-ups from transactions in securities during those months; and (ii) who has not executed principal transactions in connection with the solicitation to purchase the designated security that is the subject of the transaction in the preceding 12 months.

(4) Any transaction or transactions that, upon prior written request or upon its own motion, the commission conditionally or unconditionally exempts as not encompassed within the purposes of this section.

c. For purposes of this section, the term "designated security" means any equity security other than a security:

(1) Registered, or approved for registration upon notice of issuance, on a national securities exchange and makes transaction reports available pursuant to 17 CFR 11Aa3-1 under the Securities Exchange Act of 1934;

(2) Authorized, or approved for authorization upon notice of issuance, for quotation in the NASDAQ system;

(3) Issued by an investment company registered under the Investment Company Act of 1940;

(4) That is a put option or call option issued by The Options Clearing Corporation; or

(5) Whose issuer has net tangible assets in excess of \$4 million as demonstrated by financial statements dated within no less than 15 months that the broker-dealer has reviewed and has a reasonable basis to believe are true and complete in relation to the date of the transaction with the person, and

(a) In the event the issuer is other than a foreign private issuer, are the most recent financial statements for the issuer that have been audited and reported on by an independent public accountant in accordance with the provisions of 17 CFR 210.2-02 under the Securities Exchange Act of 1934; or

(b) In the event the issuer is a foreign private issuer, are the most recent financial statements for the issuer that have been filed with the SEC; furnished to the SEC pursuant to 17 CFR 240.12g3-2(b) under the Securities Exchange Act of 1934; or prepared in accordance with generally accepted accounting principles in the country of incorporation, audited in compliance with the requirements of that jurisdiction, and reported on by an accountant duly registered and in good standing in accordance with the regulations of that jurisdiction.

**21VAC5-45-30. Federal Regulation A Tier 2 offerings.**

A. An issuer planning to offer and sell securities in this Commonwealth in an offering exempt under Tier 2 of federal Regulation A (17 CFR 230.251 through 17 CFR 230.263) and § 18(b)(3) or 18(b)(4) of the Securities Act of 1933 (15 USC § 77a) shall submit the following at least 21 calendar days prior to the initial sale in this Commonwealth:

1. A completed Regulation A – Tier 2 notice filing form or copies of all documents filed with the U.S. Securities and Exchange Commission;

2. A consent to service of process on Form U-2 if not filing on the Regulation A – Tier 2 notice filing form; and

3. A filing fee of \$500 payable the Treasurer of Virginia.

B. The initial notice filing is effective for 12 months from the date of the filing with this Commonwealth. For each additional 12-month period in which the same offering is continued, an issuer conducting a Tier 2 offering under

federal Regulation A may renew its notice filing by filing the following on or before the expiration of the notice filing:

1. The Regulation A – Tier 2 notice filing form marked "renewal" or a cover letter or other document requesting renewal; and

2. A renewal fee in the amount of \$250 payable to the Treasurer of Virginia.

C. An issuer may increase the amount of securities offered in this Commonwealth by submitting a Regulation A – Tier 2 notice filing form marked "amendment" or other document describing the transaction.

**NOTICE:** The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (21VAC5-45)

[Form D, Notice of Exempt Offering of Securities, U.S. Securities and Exchange Commission, SEC1972 \(rev. 2/12\);](#)

[Uniform Consent to Service of Process, Form U-2 \(7/1981\)](#)

[Uniform Notice of Regulation A - Tier 2 Offering \(undated, filed 10/2016\)](#)

VA.R. Doc. No. R17-4869; Filed January 5, 2017, 6:02 p.m.

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# GOVERNOR

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## EXECUTIVE ORDER NUMBER 62 (2017)

### **DECLARATION OF A STATE OF EMERGENCY FOR THE COMMONWEALTH OF VIRGINIA DUE TO A SEVERE WINTER WEATHER EVENT**

#### Importance of the Issue

On January 6, 2017, I declare a state of emergency to exist for the Commonwealth of Virginia due to approaching severe winter weather expected to affect portions of the Commonwealth. Early estimates predict that severe weather will begin impacting the Commonwealth on or about January 6, 2017, potentially resulting in significant snow accumulation, hazardous road conditions, and high winds. The storm may create transportation issues and significant power outages.

The health and general welfare of the citizens require that state action be taken to help alleviate the conditions caused by this situation. The effects of this incident constitute a disaster wherein human life and public and private property are imperiled, as described in § 44-146.16 of the Code of Virginia.

Therefore, by virtue of the authority vested in me by § 44-146.17 of the Code of Virginia, as Governor and as Director of Emergency Management, and by virtue of the authority vested in me by Article V, Section 7 of the Constitution of Virginia and by § 44-75.1 of the Code of Virginia, as Governor and Commander-in-Chief of the armed forces of the Commonwealth, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby confirm, ratify, and memorialize in writing my verbal orders issued on January 6, 2017, whereby I proclaimed that a state of emergency exists, and directed that appropriate assistance be rendered by agencies of both state and local governments to prepare for potential impacts of the winter storm, alleviate any conditions resulting from the incident, and to implement recovery and mitigation operations and activities so as to return impacted areas to pre-event conditions in so far as possible. Pursuant to § 44-75.1(A)(3) and (A)(4) of the Code of Virginia, I am also directing that the Virginia National Guard and the Virginia Defense Force be called forth to state active duty to be prepared to assist in providing such aid. This shall include Virginia National Guard assistance to the Virginia Department of State Police to direct traffic, prevent looting, and perform such other law enforcement functions as the Superintendent of State Police, in consultation with the State Coordinator of Emergency Management, the Adjutant General, and the Secretary of Public Safety and Homeland Security, may find necessary.

In order to marshal all public resources and appropriate preparedness, response, and recovery measures to meet this threat and recover from its effects, and in accordance with my authority contained in § 44-146.17 of the Code of Virginia, I hereby order the following protective and restoration measures:

A. Implementation by state agencies of the Commonwealth of Virginia Emergency Operations Plan (COVEOP), as amended, along with other appropriate state agency plans.

B. Activation of the Virginia Emergency Operations Center (VEOC) and the Virginia Emergency Support Team (VEST) to coordinate the provision of assistance to local governments. I am directing that the VEOC and VEST coordinate state actions in support of affected localities, other mission assignments to agencies designated in the COVEOP, and others that may be identified by the State Coordinator of Emergency Management, in consultation with the Secretary of Public Safety and Homeland Security, which are needed to provide for the preservation of life, protection of property, and implementation of recovery activities.

C. The authorization to assume control over the Commonwealth's state-operated telecommunications systems, as required by the State Coordinator of Emergency Management, in coordination with the Virginia Information Technologies Agency, and with the consultation of the Secretary of Public Safety and Homeland Security, making all systems assets available for use in providing adequate communications, intelligence, and warning capabilities for the incident, pursuant to § 44-146.18 of the Code of Virginia.

D. The evacuation of areas threatened or stricken by effects of the winter storm, as appropriate. Following a declaration of a local emergency pursuant to § 44-146.21 of the Code of Virginia, if a local governing body determines that evacuation is deemed necessary for the preservation of life or other emergency mitigation, response, or recovery effort, pursuant to § 44-146.17(1) of the Code of Virginia, I direct the evacuation of all or part of the populace therein from such areas and upon such timetable as the local governing body, in coordination with the VEOC, acting on behalf of the State Coordinator of Emergency Management, shall determine. Notwithstanding the foregoing, I reserve the right to direct and compel evacuation from the same and different areas and determine a different timetable both where local governing bodies have made such a determination and where local governing bodies have not made such a determination. Also, in those localities that have declared a local emergency pursuant to § 44-146.21 of the Code of Virginia, if the local governing body determines that controlling movement of persons is deemed necessary for the preservation of life, public safety, or other emergency mitigation, response, or recovery effort, pursuant to § 44-146.17(1) of the Code of Virginia, I authorize the control of ingress and egress at an emergency area, including the movement of persons within the area and the occupancy of premises therein upon such timetable as the local governing body, in coordination with the State Coordinator of Emergency Management and the VEOC, shall determine. Violations of any order to citizens to evacuate shall constitute a violation of this Executive Order and are punishable as a Class 1 misdemeanor.

E. The activation, implementation, and coordination of appropriate mutual aid agreements and compacts, including the Emergency Management Assistance Compact (EMAC), and the authorization of the State Coordinator of Emergency Management to enter into any other supplemental agreements, pursuant to § 44-146.17(5) and § 44-146.28:1 of the Code of Virginia, to provide for the evacuation and reception of injured and other persons and the exchange of medical, fire, police, National Guard personnel and equipment, public utility, reconnaissance, welfare, transportation, and communications personnel, equipment, and supplies. The State Coordinator of Emergency Management is hereby designated as Virginia's authorized representative within the meaning of the Emergency Management Assistance Compact, § 44-146.28:1 of the Code of Virginia.

F. The authorization of the Departments of State Police, Transportation, and Motor Vehicles to grant temporary overweight, over width, registration, or license exemptions to all carriers transporting essential emergency relief supplies, livestock or poultry, feed or other critical supplies for livestock or poultry, heating oil, motor fuels, or propane, or providing restoration of utilities (electricity, gas, phone, water, wastewater, and cable) in and through any area of the Commonwealth in order to support the disaster response and recovery, regardless of their point of origin or destination. Weight exemptions are not valid on interstate highways or on posted structures for restricted weight unless there is an associated Federal emergency declaration.

All over width loads, up to a maximum of 12 feet, and over height loads up to a maximum of 14 feet must follow Virginia Department of Motor Vehicles (DMV) hauling permit and safety guidelines.

In addition to described overweight/over width transportation privileges, carriers are also exempt from vehicle registration with the Department of Motor Vehicles. This includes vehicles en route and returning to their home base. The above-cited agencies shall communicate this information to all staff responsible for permit issuance and truck legalization enforcement.

This Emergency Declaration implements limited relief from the provisions of 49 CFR 390-399. Accordingly, the State Coordinator of Emergency Management recognizes the exemption for hours of service by any carrier when transporting essential emergency relief supplies, passengers, property, livestock, poultry, equipment, food, feed for livestock or poultry, fuel, construction materials, and other critical supplies to or from any portion of the Commonwealth for purpose of providing direct relief or assistance as a result of this disaster, pursuant to § 52-8.4 of the Code of Virginia and Title 49 Code of Federal Regulations, Section 390.23 and Section 395.3.

The foregoing overweight/over width transportation privileges as well as the regulatory exemption provided by

§ 52-8.4(A) of the Code of Virginia, and implemented in 19VAC30-20-40(B) of the "Motor Carrier Safety Regulations," shall remain in effect for 30 days from the onset of the disaster, or until emergency relief is no longer necessary, as determined by the Secretary of Public Safety and Homeland Security in consultation with the Secretary of Transportation, whichever is earlier. The discontinuance of provisions authorized in paragraph F above may be implemented and disseminated by the publication of administrative notice to all affected and interested parties. I hereby delegate to the Secretary of Public Safety and Homeland Security, after consultation with other affected Cabinet Secretaries, the authority to implement this order as set forth in § 2.2-104 of the Code of Virginia.

G. The authorization of a maximum of \$550,000 in state sum sufficient funds for state and local governments' mission assignments authorized and coordinated through the Virginia Department of Emergency Management that are allowable as defined by The Stafford Act. This funding is also available for state response and recovery operations and incident documentation. Out of this state disaster sum sufficient, \$250,000, or more if available, is authorized for the Department of Military Affairs for the state's portion of the eligible disaster-related costs incurred for salaries, travel, and meals during mission assignments authorized and coordinated through the Virginia Department of Emergency Management.

H. The authorization of a maximum of \$450,000 for matching funds for the Individuals and Household Program, authorized by The Stafford Act (when presidentially authorized), to be paid from state funds.

I. The implementation by public agencies under my supervision and control of their emergency assignments as directed in the COVEOP without regard to normal procedures pertaining to performance of public work, entering into contracts, incurring of obligations or other logistical and support measures of the Emergency Services and Disaster Laws, as provided in § 44-146.28(b) of the Code of Virginia. § 44-146.24 of the Code of Virginia also applies to the disaster activities of state agencies.

J. Designation of members and personnel of volunteer, auxiliary, and reserve groups including search and rescue (SAR), Virginia Associations of Volunteer Rescue Squads (VAVRS), Civil Air Patrol (CAP), member organizations of the Voluntary Organizations Active in Disaster (VOAD), Radio Amateur Civil Emergency Services (RACES), volunteer fire fighters, Citizen Corps Programs such as Medical Reserve Corps (MRCs), Community Emergency Response Teams (CERTs), and others identified and tasked by the State Coordinator of Emergency Management for specific disaster-related mission assignments as representatives of the Commonwealth engaged in emergency services activities within the meaning of the immunity provisions of § 44-146.23(a) and (f) of the Code of Virginia,

in the performance of their specific disaster-related mission assignments.

K. The authorization of appropriate oversight boards, commissions, and agencies to ease building code restrictions and to permit emergency demolition, hazardous waste disposal, debris removal, emergency landfill siting, and operations and other activities necessary to address immediate health and safety needs without regard to time-consuming procedures or formalities and without regard to application or permit fees or royalties.

L. The activation of the statutory provisions in § 59.1-525 et seq. of the Code of Virginia related to price gouging. Price gouging at any time is unacceptable. Price gouging is even more reprehensible during a time of disaster after issuance of a state of emergency. I have directed all applicable executive branch agencies to take immediate action to address any verified reports of price gouging of necessary goods or services. I make the same request of the Office of the Attorney General and appropriate local officials. I further request that all appropriate executive branch agencies exercise their discretion to the extent allowed by law to address any pending deadlines or expirations affected by or attributable to this disaster event.

M. The following conditions apply to the deployment of the Virginia National Guard and the Virginia Defense Force:

1. The Adjutant General of Virginia, after consultation with the State Coordinator of Emergency Management, shall make available on state active duty such units and members of the Virginia National Guard and Virginia Defense Force and such equipment as may be necessary or desirable to assist in preparations for this incident and in alleviating the human suffering and damage to property.

2. Pursuant to § 52-6 of the Code of Virginia, I authorize the Superintendent of the Department of State Police to appoint any and all such Virginia Army and Air National Guard personnel called to state active duty as additional police officers as deemed necessary. These police officers shall have the same powers and perform the same duties as the State Police officers appointed by the Superintendent. However, they shall nevertheless remain members of the Virginia National Guard, subject to military command as members of the State Militia. Any bonds and/or insurance required by § 52-7 of the Code of Virginia shall be provided for them at the expense of the Commonwealth.

3. In all instances, members of the Virginia National Guard and Virginia Defense Force shall remain subject to military command as prescribed by § 44-78.1 of the Code of Virginia and are not subject to the civilian authorities of county or municipal governments. This shall not be deemed to prohibit working in close cooperation with members of the Virginia Departments of State Police or Emergency Management or local law enforcement or emergency

management authorities or receiving guidance from them in the performance of their duties.

4. Should service under this Executive Order result in the injury or death of any member of the Virginia National Guard, the following will be provided to the member and the member's dependents or survivors:

a. Workers' Compensation benefits provided to members of the National Guard by the Virginia Workers' Compensation Act, subject to the requirements and limitations thereof; and, in addition,

b. The same benefits, or their equivalent, for injury, disability, and/or death, as would be provided by the federal government if the member were serving on federal active duty at the time of the injury or death. Any such federal-type benefits due to a member and his or her dependents or survivors during any calendar month shall be reduced by any payments due under the Virginia Workers' Compensation Act during the same month. If and when the time period for payment of Workers' Compensation benefits has elapsed, the member and his or her dependents or survivors shall thereafter receive full federal-type benefits for as long as they would have received such benefits if the member had been serving on federal active duty at the time of injury or death. Any federal-type benefits due shall be computed on the basis of military pay grade E-5 or the member's military grade at the time of injury or death, whichever produces the greater benefit amount. Pursuant to § 44-14 of the Code of Virginia, and subject to the availability of future appropriations which may be lawfully applied to this purpose, I now approve of future expenditures out of appropriations to the Department of Military Affairs for such federal-type benefits as being manifestly for the benefit of the military service.

5. The following conditions apply to service by the Virginia Defense Force:

a. Virginia Defense Force personnel shall receive pay at a rate equivalent to a National Guard soldier of like rank, not to exceed 25 years of service.

b. Lodging and meals shall be provided by the Adjutant General or reimbursed at standard state per diem rates;

c. All privately owned equipment, including, but not limited to, vehicles, boats, and aircraft, will be reimbursed for the expense of fuel. Damage or loss of said equipment will be reimbursed, minus reimbursement from personal insurance, if said equipment was authorized for use by the Adjutant General in accordance with § 44 54.12 of the Code of Virginia;

d. In the event of death or injury, benefits shall be provided in accordance with the Virginia Workers' Compensation Act, subject to the requirements and limitations thereof.

Upon my approval, the costs incurred by state agencies and other agents in performing mission assignments through the VEOC of the Commonwealth as defined herein and in § 44-146.28 of the Code of Virginia, other than costs defined in the paragraphs above pertaining to the Virginia National Guard and pertaining to the Virginia Defense Force, in performing these missions shall be paid from state funds.

Effective Date of this Executive Order

This Executive Order shall be effective January 6, 2017, and shall remain in full force and effect until March 3, 2017, unless sooner amended or rescinded by further executive order. Termination of the Executive Order is not intended to terminate any federal-type benefits granted or to be granted due to injury or death as a result of service under this Executive Order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 6th day of January, 2017.

/s/ Terence R. McAuliffe  
Governor

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# GENERAL NOTICES/ERRATA

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## DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

### Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board of Agriculture and Consumer Services is currently reviewing each of the regulations listed below to determine whether it should be repealed, amended, or retained in its current form. The review of each regulation will be guided by the principles in Executive Order 17 (2014) and § 2.2-4007.1 of the Code of Virginia. Each regulation will be reviewed to determine whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

#### 2VAC5-195, Prevention and Control of Avian Influenza in the Live-Bird Marketing System

Agency Contact: Dr.Carolynn Bissett, Program Manager, Office of Veterinary Services, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-4560, FAX (804) 371-2380, or email [carolynn.bissett@vdacs.virginia.gov](mailto:carolynn.bissett@vdacs.virginia.gov).

#### 2VAC5-220, Virginia Horse Breeder Incentive Program

Agency Contact: Heather Wheeler, Business and Marketing Specialist, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 371-8993, FAX (804) 371-7786, or email [heather.wheeler@vdacs.virginia.gov](mailto:heather.wheeler@vdacs.virginia.gov).

#### 2VAC5-318, Rules and Regulations for Enforcement of the Virginia Pest Law – Thousand Cankers Disease

#### 2VAC5-325, Regulations Governing Pine Shoot Beetle

#### 2VAC5-390, Rules and Regulations for the Enforcement of the Virginia Seed Law

#### 2VAC5-450, Rules and Regulations Relating to the Virginia Plants and Plant Products Inspection Law

Agency Contact: Debra Martin, Program Manager, Office of Plant Industry Services, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 786-3515, FAX (804) 371-7793, or email [debra.martin@vdacs.virginia.gov](mailto:debra.martin@vdacs.virginia.gov).

#### 2VAC5-600, Regulations Pertaining to Food for Human Consumption

Agency Contact: Ryan Davis, Program Manager, Office of Dairy and Foods, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone

(804) 786-8910, FAX (804) 371-7792, or email [ryan.davis@vdacs.virginia.gov](mailto:ryan.davis@vdacs.virginia.gov).

The comment period begins February 6, 2017, and ends February 27, 2017.

Comments may be submitted online to the Virginia Regulatory Town Hall at <http://www.townhall.virginia.gov/L/Forums.cfm>. Comments may also be sent to the agency contacts listed above.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

## DEPARTMENT OF ENVIRONMENTAL QUALITY

### Colonial Trail W Solar, LLC Notice of Intent Small Renewable Energy (Solar) Project Permit by Rule - Surry County

Colonial Trail W Solar, LLC, has provided the Department of Environmental Quality a notice of intent to submit the necessary documentation for a permit by rule for a small renewable energy project (solar) in Surry County pursuant to 9VAC15-60. The proposed project will be located to the northwest of the intersection of Colonial Trail (Route 10) and Hollybush Road (Route 618) in Surry County. The project will have a maximum generating capacity of 100 megawatts alternating current (AC) across roughly 1250 acres on multiple parcels. There is an existing transmission line bisecting the property and a new substation is proposed to be built to connect to the grid.

Contact Information: Mary E. Major, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4423, FAX (804) 698-4510, or email [mary.major@deq.virginia.gov](mailto:mary.major@deq.virginia.gov).

### Citizen Nomination of State Surface Waters - Annual Water Quality Monitoring Plan

Purpose of guidance document: This document provides detailed guidance on implementation of § 62.1-44.19:5 F of the Code of Virginia that provides for requests from the public regarding specific segments that should be included in the Virginia Department of Environmental Quality's (DEQ) annual Water Quality Monitoring Plan.

Virginia Department of Environmental Quality contact: Questions concerning this document should be addressed to the contact person listed at the end of this notice.

Background on the guidance document: Section 62.1-44.19:5 F of the State Water Control Law directs DEQ to provide a procedure for citizens of the Commonwealth to nominate

portions of lakes, streams, and rivers of Virginia for water quality monitoring by DEQ. Citizens can send nominations to DEQ via the procedures described in this notice. Nominations received by April 30, 2017, will be considered for inclusion in DEQ's annual monitoring plan for the 2018 calendar year. The monitoring plan will be finalized after considering the citizen's nominations for inclusion. DEQ will respond to each request in writing, stating the reasons for accepting or denying each nomination. DEQ's response is due by August 31 for nominations received between January 1 and April 30.

Process to request additional monitoring: Any person may request that a specific body of water be included in DEQ's annual water quality monitoring plan. Each request received between January 1 and April 30 shall be reviewed when DEQ develops or updates the annual water quality monitoring plan. Such requests shall include, at a minimum (i) a geographical description of the water body recommended for monitoring, (ii) the reason the monitoring is requested, and (iii) any water quality data that the petitioner may have collected or compiled. Please see the nominating form (Attachment 1).

Please note that the monitoring program covered by this process is directed at the surface waters of the state. Private ponds, privately owned lakes, and any other body of water not deemed to be "state waters" are ineligible.

Nominations can be submitted by mail, fax, email, or hand delivered to the receptionist's desk at DEQ's Central Office, 629 East Main Street, Richmond, Virginia.

Use of the nomination form shown in Attachment 1 is preferred. All nominations with the minimum information outlined above will be accepted for review.

Timeline: Nominations received between January 1, 2017, and April 30, 2017, will be considered for inclusion in DEQ's water quality monitoring plan for the following calendar year (2018). DEQ will respond in writing on its approval or denial of each nomination by August 31, 2017. The DEQ 2018 monitoring plan will be made available for public inspection. A notice of availability of the annual monitoring plan will be placed in the Virginia Register and posted on DEQ's website at <http://www.deq.virginia.gov/Programs/Water.aspx>.

ATTACHMENT 1

REQUEST TO INCLUDE A WATER SEGMENT IN DEQ'S ANNUAL MONITORING PLAN

<b>Name:</b>		<b>Date:</b>	
<b>Mailing Address:</b>			
<b>Street</b>			
<b>City:</b>		<b>State:</b>	<b>Zip:</b>
<b>E-mail address:</b>			
<b>Telephone: Home:</b>		<b>Business:</b>	<b>Fax:</b>

Geographic description of the water body:

(1) Name of the water body or segment proposed for monitoring:

(2) Description of the upstream and downstream boundaries of the water body proposed for monitoring. Attach a map (preferably a photocopy of a 7.5 minute quad USGS topographic map) which delineates the boundaries:

(3) Reason for requesting that this water body be monitored:

(4) Attach any water quality data that you have collected or compiled. Include the name of the organization/entity that generated the data.

**Contact Information:** Stuart Torbeck, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4461, FAX (804) 698-4032, or email [charges.torbeck@deq.virginia.gov](mailto:charges.torbeck@deq.virginia.gov).



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# General Notices/Errata

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## STATE BOARD OF HEALTH

### Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Health is conducting a periodic review and small business impact review of **12VAC5-545, Regulations for the Nurse Educator Scholarship**. The review of this regulation will be guided by the principles in Executive Order 17 (2014).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins February 6, 2017, and ends February 27, 2017.

Comments may be submitted online to the Virginia Regulatory Town Hall at <http://www.townhall.virginia.gov/L/Forums.cfm>. Comments may also be sent to Adrienne McFadden, MD, JD, Director, Office of Health Equity, Virginia Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7435, FAX (804) 864-7440, or email [adrienne.mcfadden@vdh.virginia.gov](mailto:adrienne.mcfadden@vdh.virginia.gov).

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

## VIRGINIA LOTTERY

### Director's Orders

#### Director's Order Number Thirteen (17)

Certain Virginia Lottery Scratch Games; End of Games.

In accordance with the authority granted by §§ 2.2-4002 B 15 and 58.1-4006 A of the Code of Virginia, I hereby give notice that the following Virginia Lottery instant games will officially end at midnight on January 20, 2017:

Game 1726	Season's Winnings
Game 1725	Holiday Riches
Game 1724	Tacky Sweater

Game 1723	Sneak a Peak
Game 1722	Festive \$50s
Game 1712	Turkey Payout
Game 1701	Thrills, Chills & \$50 Bills
Game 1682	Give Me \$100s
Game 1663	\$500 Frenzy
Game 1658	Cash In A Flash
Game 1655	5X The Money (TOP)
Game 1638	Cash Multiplier (TOP)
Game 1631	Mustache Cash
Game 1582	Queen of Hearts (TOP)
Game 1550	Jewels 7's
Game 1497	All About The Benjamins (TOP)
Game 1428	Wild Number Bingo
Game 1343	Lucky Cherry Slots

The last day for lottery retailers to return for credit unsold tickets from any of these games will be March 6, 2017. The last day to redeem winning tickets for any of these games will be July 19, 2017, 180 days from the declared official end of the game. Claims for winning tickets from any of these games will not be accepted after that date. Claims that are mailed and received in an envelope bearing a postmark of the United States Postal Service or another sovereign nation of July 19, 2017, or earlier, will be deemed to have been received on time. This notice amplifies and conforms to the duly adopted State Lottery Board regulations for the conduct of lottery games.

This order is available for inspection and copying during normal business hours at the Virginia Lottery headquarters, 900 East Main Street, Richmond, Virginia, and at any Virginia Lottery regional office. A copy may be requested by mail by writing to Director's Office, Virginia Lottery, 900 East Main Street, Richmond, Virginia 23219.

This Director's Order becomes effective on the date of its signing and shall remain in full force and effect unless amended or rescinded by further Director's Order.

## STATE MILK COMMISSION

### Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the State Milk Commission is conducting a periodic review and small business impact review of **2VAC15-20, Regulations for the Control and Supervision of Virginia's Milk Industry**. The review of this

regulation will be guided by the principles in Executive Order 17 (2014).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins February 6, 2017, and ends February 27, 2017.

Comments may be submitted online to the Virginia Regulatory Town Hall at <http://www.townhall.virginia.gov/L/Forums.cfm>. Comments may also be sent to Crafton Wilkes, Administrator, Oliver Hill Building, Department of Agriculture and Consumer Services, 102 Governor Street, Room 206, Richmond, VA 23218, telephone (804) 786-2013, FAX (804) 371-8700, or email [crafton.wilkes@vdacs.virginia.gov](mailto:crafton.wilkes@vdacs.virginia.gov).

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

## STATE WATER CONTROL BOARD

### Proposed Consent Order for Fauquier County Public Schools

An enforcement action has been proposed for the Fauquier County Public Schools in Fauquier County. The consent order describes a settlement to resolve violations of State Water Control Law and the applicable regulations associated with the Mary Walter Elementary School Sewage Treatment Plant. A description of the proposed action is available at the Department of Environmental Quality office named below or online at [www.deq.virginia.gov](http://www.deq.virginia.gov). Daniel Burstein will accept comments by email at [daniel.burstein@deq.virginia.gov](mailto:daniel.burstein@deq.virginia.gov), FAX at (703) 583-3821, or postal mail at Department of Environmental Quality, Northern Regional Office, 13901 Crown Court, Woodbridge, VA 22193, from February 7, 2017, through March 13, 2017.

### Proposed Consent Special Order for W. Henry Hardy Inc.

An enforcement action has been proposed with W. Henry Hardy Inc. for violations in Danville, Virginia. The special order by consent will address and resolve violations of

environmental law and regulations. A description of the proposed action is available at the Department of Environmental Quality office named below or online at [www.deq.virginia.gov](http://www.deq.virginia.gov). Jerry Ford, Jr. will accept comments by email at [jerry.ford@deq.virginia.gov](mailto:jerry.ford@deq.virginia.gov) or postal mail at Department of Environmental Quality, Blue Ridge Regional Office, 3019 Peters Creek Road, Roanoke, VA 24019, from February 6, 2017, to March 8, 2017.

### Proposed Consent Special Order for Larry Himelright

An enforcement action has been proposed for Larry Himelright for violations in Warren County, Virginia. The State Water Control Board proposes to issue a special order by consent to Larry Himelright to address noncompliance with the State Water Control Law and Regulations. A description of the proposed action is available at the Department of Environmental Quality office named below or online at [www.deq.virginia.gov](http://www.deq.virginia.gov). Kristen Sadtler will accept comments by email at [kristen.sadtler@deq.virginia.gov](mailto:kristen.sadtler@deq.virginia.gov), FAX (804) 698-4277, or postal mail at Department of Environmental Quality, Central Office, P.O. Box 1105, Richmond, VA 23218, from February 6, 2017, to March 7, 2017.

### Proposed Consent Order for the Town of Saltville

An enforcement action has been proposed for the Town of Saltville for violations in Smyth County, Virginia. The proposed consent order contains a schedule to address inflow and infiltration problems within the town's sewage collection system. A description of the proposed action is available at the Department of Environmental Quality office named below or online at [www.deq.virginia.gov](http://www.deq.virginia.gov). Ralph T. Hilt will accept comments by email at [ralph.hilt@deq.virginia.gov](mailto:ralph.hilt@deq.virginia.gov), FAX at (276) 676-4899, or postal mail at Department of Environmental Quality, Southwest Regional Office, 355-A Deadmore Street, Abingdon, VA 24210, from February 7, 2017, to March 8, 2017.

## VIRGINIA CODE COMMISSION

### Notice to State Agencies

**Contact Information:** *Mailing Address:* Virginia Code Commission, General Assembly Building, 201 North 9th Street, 2nd Floor, Richmond, VA 23219; *Telephone:* Voice (804) 786-3591; *Email:* [varegs@dls.virginia.gov](mailto:varegs@dls.virginia.gov).

**Meeting Notices:** Section 2.2-3707 C of the Code of Virginia requires state agencies to post meeting notices on their websites and on the Commonwealth Calendar at <http://www.virginia.gov/connect/commonwealth-calendar>.

**Cumulative Table of Virginia Administrative Code Sections Adopted, Amended, or Repealed:** A table listing regulation sections that have been amended, added, or repealed in the *Virginia Register of Regulations* since the

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## General Notices/Errata

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regulations were originally published or last supplemented in the print version of the Virginia Administrative Code is available at <http://register.dls.virginia.gov/documents/cumultab.pdf>.

**Filing Material for Publication in the *Virginia Register of Regulations*:** Agencies use the Regulation Information System (RIS) to file regulations and related items for publication in the *Virginia Register of Regulations*. The Registrar's office works closely with the Department of Planning and Budget (DPB) to coordinate the system with the Virginia Regulatory Town Hall. RIS and Town Hall complement and enhance one another by sharing pertinent regulatory information.