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**State Name:** Virginia

**State Plan Amendment (SPA) #**: 16-001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

**Region III/Division of Medicaid and Children's Health Operations**

SWIFT #032320164070

November 30, 2017

Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Jones:

The Centers for Medicare & Medicaid Services (CMS) has reviewed Virginia's State Plan Amendment (SPA) 16-001, Inpatient/Outpatient Rehabilitation Update. SPA 16-001 revises the therapies section and the rehabilitative services section of the state plan to reflect updates in the provision of inpatient and outpatient rehabilitation services and provider documentation requirements.

This SPA is acceptable. Therefore, we are approving SPA 16-001 with an effective date of January 1, 2016. Enclosed are the approved SPA pages and signed CMS-179 form.

If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 16-001

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~March 31, 2016~~ SMM (8/28/16) January 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 440

7. FEDERAL BUDGET IMPACT
a. FFY 2016 $ -0-
b. FFY 2017 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supp. 1 to Attachment 3.1-A&B,
Pages 4.5, 17, 18, 19

New Pages, 4.5.1, 19.1, 19.2. 19.3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same Pages

10. SUBJECT OF AMENDMENT
Inpatient/Outpatient Rehabilitation Update

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2016
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED
Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL
/S/ [redacted]

13. TYPED NAME
Cynthia B. Jones

14. TITLE
Director

15. DATE SUBMITTED
3/14/16

16. RETURN TO
Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
March 23, 2016

18. DATE APPROVED
November 30, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
**January 1, 2016**

20. SIGNATURE OF REGIONAL OFFICIAL
/S/

21. TYPED NAME
**Francis McCullough**

22. TITLE
**Associate Regional Administrator**

23. REMARKS
**Pen and ink change to Section 4 to reflect the proposed effective date of January 1, 2016.**

FORM CMS-179 (07/92)

*Instructions on Back*

Saved

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY
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11. Physical therapy, occupational therapy, services for individuals with speech, hearing, and language disorders.

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

"Actively participate" means the individual regularly, as may be ordered by the physician, attends planned therapeutic activities and demonstrates progress towards goals established in the plan of care.

"Acute conditions" means conditions that are expected to be of brief duration (less than 12 months) and in which progress toward established goals is likely to occur frequently.

"Admission certification statement" means that the physician signs and dates an initial written statement in the individual's medical record of the need for intensive rehabilitation services. This statement shall be documented at the time of the rehabilitation admission.

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

"Evaluation" means a thorough assessment completed by a licensed therapist that is signed and fully dated and includes the following components: a medical diagnosis, clinical signs and symptoms, medical history, current functional status, summary of previous rehabilitative treatment and the result, and the therapist's recommendation for treatment.

"Nonacute conditions" means conditions that are of long duration (greater than 12 months) and in which progress toward established goals is likely to occur slowly.

"Plan of care" means a treatment plan developed by a licensed therapist, which shall include medical diagnosis; current functional status; individualized, measurable, participant-oriented goals (long-term and short-term goals) that describe the anticipated level of functional improvement; achievement timeframes for all goals; therapeutic interventions or treatments to be utilized by the therapist; frequency and duration of the therapies; and a discharge plan and anticipated discharge date.

"Recertification" means that the physician shall sign and date at least every 60 days a written statement in the individual's medical record of the continuing need for intensive rehabilitation services.

"Reevaluation" means an assessment that contains all of the same components as an evaluation and that shall be completed when an individual has a significant change in his condition or when an individual is readmitted to a rehabilitative service.

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"SLP" means speech-language pathology.

"Therapist plan of care" means a written treatment plan, developed by each licensed therapist involved with the individual's care, to include measurable long-term and short-term goals, interventions or modalities, frequency and duration, and a discharge disposition. These therapist plans of care shall be written, signed, and dated by either a licensed physical or occupational therapist, speech-language pathologist, cognitive rehabilitative therapist, psychologist, social worker, or certified therapeutic recreational specialist

11.a Physical Therapy Services are provided in accordance with 42 CFR 440.110 and shall meet medical necessity requirements.

A. The provision of physical therapy services shall meet all of the following conditions:

1. The services that the individual needs shall be directly and specifically related to a written plan of care developed, signed, and dated by a licensed physical therapist.
2. The services shall be of a level of complexity and sophistication or the condition of the individual shall be of a nature that the services can only be performed by a physical therapist licensed by the Virginia Board of Physical Therapy or a physical therapy assistant licensed by the Virginia Board of Physical Therapy and who is under the direct supervision of a licensed physical therapist.
3. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days and documents the findings of the visit in the medical record. The supervisory visit shall not be reimbursable.

B. Service Limitations. The following general conditions shall apply to reimbursable physical therapy:

1. The individual must be under the care of a physician or other licensed practitioner who is legally authorized to practice and who is acting within the scope of his license.
2. The orders for elevauation of the need for therapy services identify the specific therapy discipline and must be personally signed and dated prior to the initiation of rehabilitative services.
3. The plan of care shall include the specific procedures and modalities to be used and indicate the frequency and duration for services. A written plan of care shall be reviewed by the physician or licensed practitioner every 60 days for acute conditions or annually for nonacute conditions. The requested services shall be necessary to carry out the plan of care and shall be related to the individual's condition. The plan of care shall be signed and dated, as specified in this section, by the physician or other licensed practitioner who reviews the plan of care.

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4. Quality management reviews, in accordance with VA regulations, shall be performed by DMAS or its contractor.
5. Physical therapy services are to be considered for termination regardless of the service authorized visits or services when any of the following conditions are met:

a. No further potential for improvement is demonstrated and the individual has reached his maximum progress
b. Lack of participation on the part of the individual is evident.
c. The individual has an unstable condition that affects his ability to actively participate in a rehabilitative plan of care.
d. Progress toward an established goal or goals cannot be achieved within a reasonable period of time as determined by the licensed therapist.
e. The established goal serves no purpose to increase meaningful functional or cognitive capabilities.
f. The service no longer requires the skills of a qualified therapist.
g. A home maintenance program has been established to maintain the individual's function at the level to which it has been restored.

11.b Occupational Therapy Services are provided in accordance with 42 CFR 440.110 and shall meet medical necessity requirements.

A. The provision of occupational therapy services shall meet all of the following conditions:

1. The services that the individual needs shall be directly and specifically related to a written plan of care developed, signed, and dated by a licensed occupational therapist.
2. The services shall be of a level of complexity and sophistication or the condition of the individual shall be of a nature that the services can only be performed by an occupational therapist certified by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine or an occupational therapy assistant certified by the National Board for Certification in Occupational Therapy who is under the direct supervision of a licensed occupational therapist.
3. When occupational therapy services are provided by a qualified occupational therapy assistant, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days and documents the visit findings in the medical record. The supervisory visit shall not be reimbursable.

B. Service Limitations. The following general conditions shall apply to reimbursable occupational therapy:

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1. The individual must be under the care of a physician or other licensed practitioner who is legally authorized to practice and who is acting within the scope of his license.
2. The orders for elevauation of the need for therapy services identify the specific therapy discipline and must be personally signed and dated prior to the initiation of rehabilitative services.
3. The plan of care shall include the specific procedures and modalities to be used and indicate the frequency and duration for services. A written plan of care shall be reviewed by the physician or licensed practitioner every 60 days for acute conditions or annually for nonacute conditions. The requested services shall be necessary to carry out the plan of care and shall be related to the individual's condition. The plan of care shall be signed and dated, as specified in this section, by the physician or other licensed practitioner who reviews the plan of care.
4. Quality management reviews, in accordance with VA regulations, shall be performed by DMAS or its contractor.
5. Occupational therapy services are to be considered for termination regardless of the service authorized visits or services when any of the following conditions are met:

a. No further potential for improvement is demonstrated and the individual has reached his maximum progress.
b. Lack of participation on the part of the individual is evident.
c. The individual has an unstable condition that affects his ability to actively participate in a rehabilitative plan of care.
d. Progress toward an established goal or goals cannot be achieved within a reasonable period of time as determined by the licensed therapist.
e. The established goal serves no purpose to increase meaningful functional or cognitive capabilities.
f. The service no longer requires the skills of a qualified therapist.
g. A home maintenance program has been established to maintain the individual's function at the level to which it has been restored.

11.c Speech-Language Pathology Services are provided in accordance with 42 CFR 440.110 and shall meet medical necessity requirements.

A. The provision of speech-language pathology services shall meet all of the following conditions:

1. The services that the individual needs shall be directly and specifically related to a written plan of care developed, signed, and dated by a licensed speech-language pathologist.
2. The services shall be of a level of complexity and sophistication or the condition of the individual shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Virginia Board of Audiology and Speech-Language Pathology or who, if exempted from licensure by statute, meets the requirements in 42 CFR 440.110(c).

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3. DMAS shall reimburse for the provision of speech-language pathology services when provided by a person considered by DMAS as a speech-language assistant (i.e., has a bachelor's level or a master's level degree without licensure by the Virginia Board of Audiology and Speech-Language Pathology and who does not meet the qualifications required for billing as a speech-language therapist). Speech-language assistants shall work under the direct supervision of a licensed professional therapist holding a Certificate of Clinical Competence (CCC) in SLP or a speech-language pathologist who meets the licensing requirements of the Virginia Board of Audiology and Speech-Language Pathology.

4. When services are provided by a therapist who is in his Clinical Fellowship Year (CFY) of an SLP Program or a speech-language assistant, a licensed professional therapist holding a CCC in SLP or a speech-language pathologist who shall make a supervisory visit at least every 30 days while therapy is being conducted and document the findings in the medical record. The supervisory visit shall not be reimbursable.

B. Service Limitations. The following general conditions shall apply to reimbursable speech-language pathology therapy:

1. The individual must be under the care of a physician or other licensed practitioner who is legally authorized to practice and who is acting within the scope of his license.

2. The orders for elevauation of the need for therapy services identify the specific therapy discipline and must be personally signed and dated prior to the initiation of rehabilitative services.

3. The plan of care shall include the specific procedures and modalities to be used and indicate the frequency and duration for services. A written plan of care shall be reviewed by the physician or licensed practitioner every 60 days for acute conditions or annually for nonacute conditions. The requested services shall be necessary to carry out the plan of care and shall be related to the individual's condition. The plan of care shall be signed and dated, as specified in this section, by the physician or other licensed practitioner who reviews the plan of care.

4. Quality management reviews, in accordance with VA regulations, shall be performed by DMAS or its contractor.

5. Speech-language pathology therapy services are to be considered for termination regardless of the service authorized visits or services when any of the following conditions are met:

a. No further potential for improvement is demonstrated and the individual has reached his maximum progress.

b. Lack of participation on the part of the individual is evident.

c. The individual has an unstable condition that affects his ability to actively participate in a rehabilitative plan of care.

d. Progress toward an established goal or goals cannot be achieved within a reasonable period of time as determined by the licensed therapist.

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e. The established goal serves no purpose to increase meaningful functional or cognitive capabilities.
f. The service no longer requires the skills of a qualified therapist.
g. A home maintenance program has been established to maintain the individual's function at the level to which it has been restored.

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

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

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

2. Non-routine 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. **Non-covered routine use shall be**:

   (a) Routine preparatory services and routine recovery time for outpatient surgical or diagnostic testing services, (e.g., services for routine postoperative monitoring during a normal recovery period (four to six hours)).

   (b) 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.

   (c) Any substitution of an outpatient observation service for a medically appropriate inpatient admission.

3. 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 pre-certification where applicable.

4. 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.

D. Comprehensive Outpatient Rehabilitation Facilities (CORF) Services are provided in accordance with 42 CFR, Subpart B., 485.50 – 485.74 and shall meet medical necessity requirements.

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1. All providers of CORFs shall be enrolled as a Medicaid provider. CORFs shall enroll via the Comprehensive Outpatient Rehabilitation Facility Participation Agreement.

2. Service Limitations: CORF services shall be considered for termination based on medical necessity.

2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
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A. The same service limitations apply to rural health clinics as to all other services.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with §4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

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