Limitations on Services Provided

1. Inpatient Hospital Services

A. Private Hospitals

1. Those items and services furnished are defined as those included as covered under Inpatient Hospital Services in 42 CFR 440.10. Inappropriate level of care services are not covered.

2. Services provided in connection with dental or oral surgery services will be limited to those required for emergency repair of accidental injury to the jaw or related structures.

3. Services provided in connection with surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be included only by prior authorization issued by the State Agency.

4. Organ transplant services require prior authorization, and are limited to the guidelines set forth in the District of Columbia Standards for the Coverage of Organ Transplant Services under the D.C. Medicaid Program.

5. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional post-operative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

6. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Reviewed hospital claims with admission dates on Friday

or Saturday will be pended for review of these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

B. Public Hospitals

1. Those items and services furnished are those included as covered under Inpatient Hospital services in 42 CFR 440.10 by a hospital providing such services that is owned and operated by the District of Columbia. Unless specifically stated within the State Plan, public hospitals should refer to the Health Insurance Manual 10.

2. The program may exempt portions or all of the utilization review requirements of subsections (b), (c), (h) and (i) as it relates to recipients under age twenty-one (21). In accordance with the requirements of 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to medical documentation requirements.

3. Services provided in connection with dental or oral surgery services will be limited to those required for emergency repair of accidental injury to the jaw or related structures.

4. Services provided in connection with surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be included only by prior authorization issued by the State Agency.

5. Organ transplant services require prior authorization, and are limited to the guidelines set forth in the District of Columbia Standards for the Coverage of Organ Transplant Services under the D.C. Medicaid Program.

6. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional post-operative days.

Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

7. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Reviewed hospital claims with admission dates on Friday or Saturday will be pended for review of these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

2. Outpatient Hospital Services

A. Surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be provided only by prior authorization issued by the State Agency.

B. Dental or oral surgery services will be limited to the emergency repair. Emergency repair is defined as an accident which caused injury to the jaw and related structures.

C. Surgical procedures meeting the standards specified in 42 CFR 416.65(a) and (b), and included in the list published in accordance with 42 CFR 416.65(c) shall be reimbursed only if provided in facilities meeting the requirements of 42 CFR 416, Subpart C.

D. Surgical procedures meeting the standards specified in 42 CFR 416.65(a) and (b), and included in the list published in accordance with 42 CFR 416.65(c) shall not be reimbursed on an inpatient basis.

E. Surgical procedures meeting the standards as specified in the 42 CFR 416. 65(c) shall not be reimbursed unless certified by the District of Columbia's Certification Program.

3. Other Laboratory and X-Ray Services

A. Other Laboratory and X-ray Services shall refer to professional and technical laboratory and radiological services that are:

(1) Medically Necessary;

(2) Ordered, in writing, by a physician or advanced practice registered nurse (APRN) who is screened and enrolled as a District Medicaid program provider pursuant to 29 DCMR §§ 9400 *et seq.*; and

(3) Provided in an office or similar facility other than a hospital outpatient department or clinic.

B. All ordering clinicians shall be licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985,

effective March 25, 1986 (D.C. Law 6-99); D.C. Official Code §§ 3-1201 *et seq.*).

C. Coverage of and Medicaid reimbursement for other laboratory and x-ray services shall be limited as follows:

(1) Other laboratory and x-ray services performed in connection with a routine physical examination shall not be billed separately;

(2) Services primarily for, or in connection with, cosmetic purposes shall require prior approval by the Department of Health Care Finance or its designee;

(3) Services primarily for, or in connection with, dental or oral surgery services, shall be limited to those required as a result of the emergency repair or accidental injury to the jaw or related structure; and

(4) Other laboratory and x-ray services provided to an individual who is in an outpatient setting, including services referred to an outside office or facility shall be included in a hospital outpatient claim.

D. To receive Medicaid reimbursement, a provider of other laboratory services shall meet the following requirements:

(1) Be certified under Title XVIII of the Social Security Act and the Clinical Laboratories Improvement Amendments of 1988;

(2) Be licensed or registered in accordance with D.C. Official Code § 44-202;

(3) Hold an approved District Medicaid program Provider Agreement as an independent laboratory provider; and

(4) Be screened and enrolled as a District Medicaid provider pursuant to 29 DCMR § 9400.

4. **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** services performed for individuals under 22 years of age are provided without limitation. Services provided in school settings are described below.

A. **School-Based Health (SBH)** services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions; recommended by qualified health care professionals; and listed in a recipient's Individualized Education Program (IEP) or Individual Family Service Plan (IFSP). SBH services include the initial evaluation for disability in accordance with 20 U.S.C. § 1414.

Eligibility. Children with disabilities are eligible to receive SBH services necessary to ensure a Free Appropriate Public Education (FAPE). Services shall be indicated on the IEP/IFSP and described as to their amount, scope, and duration.

Providers. Providers of SBH services shall be duly licensed professionals employed by or under contract with District of Columbia Public Schools (DCPS) Office of the State Superintendent of Education (OSSE), the District of Columbia Public Charter Schools, and/or non-public schools. D.C. Code § 3-1205.01.

Services. SBH services are subject to utilization control as provided in 42 C.F.R. §§ 456.1 - 456.23. Covered services include:

Audiology Services. Special education related services and screenings necessary for identifying and treating a child with hearing loss. 34 C.F.R. § 300.34(c)(1). Providers shall meet the qualification requirements of 42 C.F.R. § 440.110; D.C. Mun. Regs. tit. 5, § 1663; and any amendments thereto.

Behavioral Supports (Counseling Services). Screenings and services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel in accordance with 42 C.F.R. § 440.60(a); D.C. Mun. Regs. tit. 5, §§ 1657, 1659-1660; and any amendments thereto.

Nutrition Services. Services and screenings relative to a medical condition shall be provided by a qualified dietician under applicable District of

**School-Based Health (SBH)** (Continued)

Nutrition Services (continued).

Columbia laws. Provider qualifications shall meet the requirements of 42 C.F.R. § 440.60(a) and any amendments thereto.

Occupational Therapy. Services include special education related services and screenings intended to improve and prevent initial or further loss of function and are provided by qualified occupational therapists or occupational therapy aides under the supervision of qualified occupational therapists. 34 C.F.R. § 300.34(c)(6); D.C. Code §§ 3-1201.02(9)(B), (9)(C). Provider qualifications shall meet the requirements of 42 C.F.R. § 440.110 and any amendments thereto.

Orientation and Mobility. Services and screenings that enable blind or visually impaired children to gain systematic orientation to and safe movement within their school environment. Providers must be certified as Orientation and Mobility Specialists and qualified under 42 C.F.R. § 440.130(d) and any amendments thereto.

Personal Care. Services and screenings provided in accordance with 42 C.F.R. § 440.167. These services may be provided by a Personal Care Aide under the supervision of a Registered Nurse as provided in D.C. Mun. Regs, tit. 29, § 4221 and any amendments thereto.

Physical Therapy. Special education related services and screenings provided by a qualified physical therapist or by a physical therapy assistant under the supervision of a qualified physical therapists in accordance with 34 C.F.R. § 300.34(c)(9); D.C. Code §§ 3-1201.02(9)(B), (9)(C). Provider qualifications shall meet the requirements of 42 C.F.R. § 440.110 and any amendments thereto.

Psychological Evaluation. Services and screenings provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel in accordance with 42 C.F.R. § 440.60(a); D.C. Mun. Regs. tit. 5, §§ 1657, 1659-1660; and any amendments thereto.

School-Based Health (SBH) (Continued)

Skilled Nursing. Services and screenings rendered by practitioners as defined in 42 C.F.R. § 440.60 and any amendments thereto. These services include the administration of physician ordered medications or treatments to qualified children who require such action during the school day in accordance with the IEP/IFSP.

Specialized Transportation. Transportation services that require a specially equipped vehicle, or the use of specialized equipment to ensure a recipient is taken to and from the recipient's residence for school-based health services. Approved transportation services will only be claimed when a beneficiary has a specific school-based health service on the date the transportation is provided. Transportation services are described in Attachment 3.1-D of the D.C. State Plan for Medical Assistance.

Speech-Language Pathology. Services and screenings provided to eligible children by a qualified speech pathologist in accordance with 34 C.F.R. § 300.34(c)(15). Providers shall meet the qualification requirements of 42 C.F.R. § 440.110; D.C. Mun. Regs. tit. 5, § 1658; and any amendments thereto.

B. **Family Planning Services and Supplies** for individuals of childbearing age are provided with no limitations.

5. **Physicians' Services Whether Furnished in the Office, the Patient's Home, a Hospital, a Skilled Nursing Facility or Elsewhere**

A. Elective procedures requiring general anesthesia will be provided only when performed in a facility accredited for such procedures.

B. Surgical procedures for cosmetic purpose (except for emergency repair of accidental injury) will be provided only by prior authorization issued by the State Agency.

C. Medicaid payment is prohibited for services connected with providing methadone treatment to patients addicted to narcotics unless such treatment is rendered by providers specifically authorized to do so by the Addiction Prevention and Recovery Administration in the Department of Health.

5. **Physicians' Services Whether Furnished in the Office, the Patient's Home, a Hospital, a Skilled Nursing Facility or Elsewhere (continued)**

D. Gastric bypass surgery requires written justification and prior authorization.

E. Assistant surgeon services require prior authorization by the State Agency.

F. Reimbursement for inpatient consultations or inpatient hospital visits by a physician to a patient whose level of care has been reclassified by the Peer Review Organization from acute to a lower level are not covered. Only those visits determined medically necessary will be reimbursed.

G. Sterilizations are not covered if the patient is under age twenty-one (21).

H. Organ transplantation requires prior authorization in accordance with the District of Columbia Standards for the Coverage of Organ Transplant Services as indicated in Attachment 3.1E of this state plan.

I. Certain surgical procedures (examples: reduction mammoplasty, intestinal bypass for morbid obesity, and insertion of penile prosthesis) require prior authorization.

J. Reimbursement for induced abortions is provided only in cases where the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition, caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or the pregnancy occurred as a result of rape or incest.

Reimbursement shall be made according to the fee schedule amount and shall cover all services related to the procedure including physician fee(s), laboratory fee(s) and counseling fee(s).

6. Medical Care and any other type of Remedial Care Recognized Under State Law, Furnished by Licensed Practitioners Within The Scope of Their Practice as Defined by State Law

A. Podiatrists' Services

The limitations on routine foot care are the same as the limitations under Medicare and delineated in the Medicare Carriers Manuel (HIM-14) and the Medicare Intermediary Manual (HIM-13). Special treatment should be prior authorized by the State Agency.

B. Optometrists' Services

Limited to specific services except where prior authorization is made by the State Agency. Services are further limited as follows:

1. Contact lenses must be prior authorized by the State Agency.

2. Eyeglasses are limited to one complete pair in a twenty-four (24) month period. Exceptions to this policy are:

a. Recipients under twenty-one (21) years of age;

b. Whenever there is a change in the prescription of more than plus or minus .5 (one half) diopter; and

c. Broken or lost eyeglasses.

3. Special glasses such as sunglasses and tints must be prior authorized by the State Agency and justified in writing by the optometrist. Special tints and sunglasses are not allowed in addition to untinted eyewear.

In addition, the optometrist must adhere to the dispensing procedures in the providers Medical Assistance Manual.

7. Home Health Services

A. A "Home Health Agency" is defined as a public or private agency or organization which meets the requirements of Medicare.

B. Services of a home health aide must not exceed four (4) hours per visit per day, unless prior authorization is given by the State Agency.

C. Medical Supplies, Equipment, and Appliances for use of the patients in their own homes are limited to those items on the Durable Medical Equipment/Medical Supplies Procedures Codes and Price list, except where prior authorization is given by the State Agency.

D. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services.

1. Physical therapy is provided as long as it is a part of a plan of treatment and provided in a hospital, skilled care facility, intermediate care facility or through a home health agency.

2. Occupational therapy is provided as long as it is a part of a plan of treatment and provided in a hospital, skilled care facility, intermediate care facility or through a home health agency.

3. Services for individuals with speech, hearing and language disorders are limited to eligible EPSDT recipients.

E. Services provided by Home Health Agencies which are covered under the State Plan and authorized in the patient treatment plan may not exceed in total 36 visits per year per recipient, unless prior authorization is given by the State Agency.

The 36 visit limitation includes services performed by all disciplines included in the Medicare certification of a home health agency which are certified by a physician as medically necessary in the patient's treatment plan.

8. Private Duty Nursing Services

All requests for private duty nursing must be prior authorized by the State Agency. Private duty nursing is available only for recipients who require more individual and continuous care than is routinely provided by a Visiting Nurse Association or routinely provided by a skilled nursing facility or hospital.

9. Clinic Services

A. Surgical procedures for medically necessary cosmetic purposes (except for emergency repair of accidental injury) will be provided only by prior authorization issued by the State Agency.

B. Dental or oral surgery will be limited to the emergency repair of accidental injury to the jaw and related structures.

C. Clinic services include day treatment services. These services:

1. are designed to serve all Medicaid beneficiaries;

2. are provided by or under the supervision of a physician;

3. include nutrition services; individual and group counseling; mental health counseling; physical therapy; occupational therapy; speech therapy; and activities of daily living (i.e., personal care, self-awareness, and level of function); and

4. are provided within the four walls of the clinic facility.

Reimbursement shall be made according to the fee schedule amount and shall cover all services related to the procedure including physician fee(s), laboratory fee(s) and counseling fee(s).

10. Dental services.

All dental services must be provided consistent with scope of practice authorized pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 *et seq.*) or consistent with the applicable professional practices within the jurisdiction where services are provided.

A. Dental services for individuals under the age of 21 are covered under EPSDT services. The service descriptions and reimbursement rates are set forth in a fee schedule published in the District of Columbia Municipal Regulations.

B. Dental services are covered for individuals residing in intermediate care facilitates for persons with mental retardation (ICF/MR). The service descriptions and reimbursement rates are set forth in a fee schedule published in the District of Columbia Municipal Regulations.

C. Dental services for individuals age 21 and over who are not enrolled in the Waiver or residing in an ICFMR are limited to the services set forth below:

1. General dental examinations and routine maintenance cleaning with oral hygiene instruction limited to once every six (6) months.

2. Surgical services and extractions.

3. Emergency care.

4. Fillings.

10. Dental Services.

All dental services must be provided by licensed practitioners acting within the scope of practice authorized pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 *et seq.*) or consistent with the applicable professional practices within the jurisdiction where services are provided.

Dental services requiring inpatient hospitalization, including elective procedures that require general anesthesia, must be prior authorized by DHCF. Subject to the service descriptions and reimbursement rates as set forth in the DHCF fee schedule, dental services are covered as follows:

A. Individuals under the age of 21
Dental services are comprehensive and covered under EPSDT. Service limitations established under EPSDT may be exceeded based on medical necessity. To be eligible for orthodontia services, the individual's dental or orthodontia provider must demonstrate that the child meets one of the following criteria:

1. Has an adjusted score ≥ 15 on the Handicapping Labio-Lingual Deviations Index (HLD); or

2. Exhibits one or more of the following Automatic Qualifying Condition(s) that cause dysfunction due to a handicapping malocclusion listed below:

   i. left palate deformity;
   ii. Cranio-facial anomaly;
   iii. Deep impinging overbite;
   iv. Crossbite of individual anterior teeth;
   v. Severe traumatic Deviation; or
   vi. Overjet> 9mm or mandibular protrusion > 3.5mm; or

3. Has otherwise established a medical need for orthodontic treatment by meeting two or more "Other Factors for Consideration" as indicated on the Orthodontia Prior Authorization Form and justified the need in an accompanying narrative prepared by the recommending dentist or orthodontist.

B. Individuals residing in intermediate care facilities for persons with mental retardation (ICF/MR).

C. Adults, age 21 and over, who are not enrolled in the 1915(c) Home and Community Based Services (HCBS) Waiver for the ID/DD population and do not reside in an ICF/MR.

11. Physical Therapy And Related Services. Physical therapy and related services shall be defined as physical therapy, occupational therapy and speech-language pathology services. These services shall be prescribed by a physician and be part of a written plan of care. All practitioners of these services shall be required to meet District and federal licensing and/or certification requirements.

A. Physical therapy is provided only as an element of hospital inpatient or outpatient care, nursing facility care provided in an intermediate care facility, services provided to children by the District's school system by qualified therapists, or through a home health agency by qualified therapists.

Only physical therapy services meeting all the following requirements shall be reimbursed by the program:

1. Physical therapy services shall be directly and specifically related to a plan of care written by a physician after consultation with a licensed physical therapist;

2. The condition of the patient shall be such, or the services shall be of a level of complexity and sophistication that the services can be performed only by a licensed physical therapist or a physical therapy assistant or aide under the supervision of a licensed therapist. Services provided by a physical therapy assistant or aide shall be limited to those allowed under District legislation and shall be provided under the supervision of a licensed therapist who makes an on-site supervisory visit at least once each week. This visit shall not be reimbursable; and

3. The services shall be of reasonable amount, duration and frequency and shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice.

B. Occupational therapy is provided only as an element of hospital inpatient or outpatient care, nursing facility care provided in an intermediate care facility, services provided to children by the District's school system by qualified therapists, or through a home health agency by qualified therapists.

Only occupational therapy services meeting all the following requirements shall be reimbursed by the program:

1. Occupational therapy services shall be directly and specifically related to a plan of care written by a physician after consultation with an occupational therapist licensed by the District and registered and certified by the American Occupational Therapy Certification Board;

2. The condition of the patient shall be such, or the services shall be of a level of complexity and sophistication that the services can be performed only by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed therapist. Services provided by a licensed occupational therapy assistant shall be provided under the supervision of a licensed therapist who makes an on-site supervisory visit at least once every two weeks. This visit shall not be reimbursable; and

3. The services shall be of reasonable amount, duration and frequency and shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice.

C. Services for individuals with speech, hearing and language disorders are services provided by a speech pathologist or audiologist provided as an element of services provided to children by the District's school system by qualified therapists and to eligible EPSDT recipients only.

Only therapy for speech, hearing and language services meeting all the following requirements shall be reimbursed by the program:

1. The services shall be directly and specifically related to a plan of care written by a physician after any needed consultation with a speech-language pathologist meeting the requirements of 42 CFR 440.110(c);

2. The condition of the patient shall be such, or the services shall be of a level of complexity and sophistication such that the services can be performed only by a speech-language pathologist who meets the qualifications in number 1. The program shall meet the requirements of 42 CFR 405.1719(c). At least one speech-language pathologist must be present at the time speech-language pathology services are being provided; and

3. The services shall be of reasonable amount, duration and frequency and shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice.

D. Documentation Requirements

Documentation of physical and occupational therapy and speech-language pathology services provided by a hospital-based outpatient setting, home health agency, the District's school system or a rehabilitation agency shall, at a minimum:

1. describe the clinical signs and symptoms of the patient's condition;

2. include a complete and accurate description of the patient's clinical course and treatments;

3. document that a plan of care based specifically on a comprehensive assessment of the patient's needs has been developed for the patient;

4. include a copy of the plan of care and the physician's orders;

5. include all treatment rendered to the patient in accordance with the plan of care, providing information on the frequency, duration, modality and response and identify who provided the care by full name and title;

6. describe changes in the patient's condition in response to the services provided through the rehabilitative plan of care;

7. except for schools, describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals and the patient's discharge destination; and

8. for patients under the care of the schools, include an individualized education program (IEP) which describes the anticipated improvements in functional level in each school year and the time frames necessary to meet these goals.

E. Service limitations. The following general requirements shall apply to all reimbursable physical and occupational therapy and speech-language pathology services:

1. Patients must be under the care of a physician who is legally authorized to practice and who is acting under the scope of his/her license;

2. Services shall be furnished under a written plan of care that is established and periodically reviewed by a physician. The services or items for which reimbursement is sought must be necessary to carry out the plan of care and must be related to the patient's condition;

3. A physician recertification shall be required periodically; shall be signed and dated by the physician who reviews the plan of care; shall indicate the continuing need for the service and estimate how long services will be needed; and, must be available when the plan of care is reviewed by the Medicaid program;

4. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care and indicate the frequency and duration of services;

5. Utilization review shall be conducted by the Medicaid program or its agent to determine whether services are appropriately provided and to ensure that the services are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and shall not be reimbursed; and

6. Physical therapy, occupational therapy and speech-language services are to be terminated regardless of the approved length of stay (or service) when further progress toward the established rehabilitation goal is unlikely or when services can be provided by someone other than the skilled rehabilitation professional.