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 derined 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 approved and enrolled as a Qualified Provider provided pursuant to 42 CFR § 440.

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 §§ 3-1205.04(g). 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.

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 therapist in accordance with 34 C.F.R. § 300.34(c)(9); D.C. Code §§ 3-1205.04(j). 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 specially adapted school bus or van to ensure a recipient is taken to and from the recipient's residence for school-based health services and are available to Medicaid-eligible beneficiaries for whom the transportation services are medically necessary and documented in an IEP/IFSP. Authorized transportation services must be provided on the same date of service that a Medicaid covered service required by the student's IEP/IFSP is received and will only be claimed when a beneficiary has a specific school-based health service on the date the transportation service is provided. Transportation services are described in Attachment 3.1-D of the D.C. State Plan for Medical Assistance. Providers of transportation services include direct services personnel, e.g. bus drivers, attendants, etc. who are employed or contracted by District of Columbia Public Schools (DCPS) or District of Columbia Public Charter Schools (DCPCS).

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;.

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

C. **Autism Spectrum Disorder (ASD) Services**

General Provisions:

Autism Spectrum Disorder (ASD) services are services necessary to screen, diagnose, and treat behavioral, social interaction, communication, and physical conditions associated with ASD, as defined in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. These EPSDT services are available to Medicaid beneficiaries under the age of twenty-one (21) under the Preventive Services benefit at section 1902(a)(13)(c) of the Social Security Act. Services include the following:

- Screening;
- Diagnostic Evaluation;
- Treatment Planning; and

- ASD treatment services.

ASD treatment services must be identified in a treatment plan as further described under 4.C.iii.

Qualified Practitioners:
Services shall be furnished by practitioners as identified in 4.C.i. through iii, and shall comply with: (1) the District's Medicaid provider screening and enrollment requirements, as applicable; and (2) the District's statutory and regulatory licensing and scope of practice requirements, or the applicable scope of practice or professional practices act within the jurisdiction where services are provided, as applicable.

Services:

i. Screening:

a. Scope: Beneficiaries who are displaying signs of ASD or are at risk of having ASD may be screened using a screening tool that is supported by clinical best practices or emerging best practices, as medically necessary. If further evaluation is necessary after screening, a referral may be made (by one of the qualified practitioners listed in 4.C.i.b.1-7 of this section) for a diagnostic evaluation.

b. Qualified practitioners: The screening shall be completed by one of the following:

1. Physician;
2. Physician assistant who is working under the supervision of a physician;
3. Psychologist;
4. Psychologist associate who is working under the supervision of a psychologist;
5. Licensed professional counselor;
6. Licensed independent clinical social worker (LICSW); or
7. Advance practice registered nurse (APRN).

ii. Diagnostic Evaluation:

a. Scope: A diagnostic evaluation is a comprehensive review of a child's cognitive, speech language, behavioral, fine motor, adaptive, and social functioning. The diagnostic evaluation shall be completed using a validated assessment tool or instrument. The diagnostic evaluation shall indicate whether evidence-based ASD services are medically necessary and recognized as therapeutically appropriate.

b. Qualified practitioners for diagnostic evaluations: A diagnostic evaluation shall be completed by one of the following qualified practitioners ("diagnosing providers"):

1. Physician (including a psychiatrist);
2. Physician assistant under the supervision of a physician;
3. Psychologist;
4. Psychologist associate under the supervision of a psychologist;
5. Licensed professional counselor;
6. LICSW; or
7. APRN.

iii. Development of Treatment Plan

a. Scope: After an ASD diagnosis is determined through a diagnostic evaluation, a qualified practitioner shall develop an appropriate treatment plan that is individualized to meet the specific need of the beneficiary and help the beneficiary reach functional and meaningful outcomes. The qualified practitioner who completes the treatment plan may develop the treatment plan in collaboration with a multidisciplinary team (as described in 4.c.iii.b), depending on the need of the child.

1. The treatment plan must:

A. Be completed and reviewed every six (6) months and adjusted as appropriate based on data collected by the diagnosing provider or the treating qualified practitioner (described under 4.C.iii.b) to maximize the effectiveness of services;

B. Be individualized to meet the specific need of the beneficiary and help the beneficiary reach functional meaningful outcomes;

C. Be centered on the beneficiary's and family's needs and goals;

D. Include, at a minimum, the following:

i. Identify long, intermediate, and short-term goals that are measurable, and expected outcomes to determine if treatment services are effective;
ii. Identify specific service type with the recommended amount, frequency, and setting and duration of evidence-based ASD services;
iii. Include outcome measurement assessment criteria that will be used to measure achievement of objectives;
iv. Identify whether services are consistent with evidence-based ASD interventions; and

v. Identify the frequency at which the beneficiary's progress is reported, and identify the individual providers responsible for delivering the services; and

E. Be submitted to DHCF every six (6) months for review and prior approval, along with the screening, diagnostic evaluation, and supporting clinical documentation.

b. Qualified practitioners: treatment plans may be developed either by the same qualified practitioner identified as a diagnosing provider under 4.C.ii.b of this section who completes the diagnostic evaluation, or by treating qualified practitioners that are referred for treatment services, as described under 4.C.iv. Depending on the need of the child, the treatment plan may be developed in collaboration with a multidisciplinary team, who may include but not be limited to:

1. Physician (including a psychiatrist);
2. Physician assistant who works under the supervision of a physician;
3. Psychologist;
4. Psychologist associate who works under the supervision of a psychologist;
5. Speech language pathologist and audiologist;
6. Speech language pathology assistant who is under the supervision of a speech language pathologist; or
9. APRN.

iv. ASD Treatment Services: ASD treatment services must be identified in a treatment plan or plan of care if services are provided through a home health agency (as described under 4.C.iii.a.1), and include services and interventions that have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized substantial scientific and clinical evidence.

ASD treatment services, as appropriate, include:

- Applied Behavior Analysis (ABA) Therapy; and
- Psychological Services.

a. ABA Therapy

1. Scope: ABA therapy services are targeted, evidence-based interventions that include the design, implementation, and evaluation of environmental modifications using stimuli and consequences to produce socially significant improvement in behavior, including direct observation, measurement, and functional analysis of the relationship between environment and behavior and skills.

2. Qualified practitioners: ABA therapy shall be delivered by the following practitioners:

A. Psychologist;
B. LICSW;
C. Speech Language Pathologist and Audiologist; and
D. A practitioner who is certified by the Behavior Analyst Certification Board (BACB) and meets all required training and educational requirements set forth by the BACB, which shall include:
   i. Board Certified Behavior Analyst (BCBA), who must also comply with the District's Medicaid screening and enrollment requirements;
   ii. Board Certified Behavior Analyst-Doctoral (BCBA-D), who must also comply with the District's Medicaid screening and enrollment requirements;
   iii. Registered Behavior Technician (RBT) who is working under the supervision of a BCBA, BCBA-D, or BCaBA; and
   iv. Board Certified Assistant Behavior Analyst (BCaBA) who is working under the supervision of a BCBA or BCBA-D.

b. Psychological Services

1. Scope: psychological services may include:

A. Obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning, mental health, and development;
B. Administration and interpretation of psychological or other appropriate developmental screening, assessment, or diagnostic impressions;
C. Assessment and diagnosis of social or emotional development of the child;
D. Cognitive behavioral therapy;
E. Individual, group, or family counseling with the parents and other family members, including appropriate skill-building activities; or
F. Family training, education, and support provided to assist the family of the child in understanding the special needs of the child as related to development, behavior or social-emotional functioning, and enhancement of the child's development.

2. Qualified practitioners: psychological services shall be delivered by the following practitioners:

A. Physician (including psychiatrist);

B. Physician assistant who works under the supervision of a physician;
C. Psychologist;
D. Psychologist associate who works under the supervision of a psychologist;
E. LICSW; or
F. Licensed professional counselor.

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.

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 Manual (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.

C. Chiropractors' Services

Chiropractors' services are not covered by the District of Columbia Medicaid Program.

D. Other Practitioners' Services

1. Emergency Medical Providers

a. Paramedics are licensed providers in the District of Columbia. Licensed paramedics are covered within their scope of practice defined by state law.
b. Emergency medical responders are licensed providers in the District of Columbia. Licensed emergency medical responders are covered within their scope of practice defined by state law.
c. Emergency medical technicians (EMTs), as well as advanced EMTs and EMT-Intermediate, are licensed providers in the District of Columbia. Licensed EMTs, advanced EMTs, and EMT-Intermediate are covered within their scope of practice defined by state law.

2. Pharmacist's Services

a. Licensed pharmacists are covered within their scope of practice in accordance with state law.

7. Home Health Services

General Provisions

In accordance with 42 CFR § 440.70, Home Health Services are physician-ordered services provided to a beneficiary in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellcctual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board, as part of a written plan of care that the physician reviews every sixty (60) days.

An order for Home Health Services must be signed and dated by the beneficiary's physician and shall state the amount, frequency, scope, and duration of each Home Health service ordered. The physician's signature on the order constitutes a certification

by the physician that the services ordered reflect the health status and needs of the beneficiary.

The Home Care Agency is responsible for developing and updated the plan of care and ensuring that services provided are in accordance with the physician's order and health status and needs of the beneficiary.

The plan of care must be developed and signed and dated by a Registered Nurse (R.N.) who is employed or under contract to the Home Care Agency. The signature of the R.N. on the plan of care constitutes a certification by the R.N. that the plan of care accurately reflects the health status and needs of the beneficiary and that the services identified in the plan of care are in accordance with the physician's order. The beneficiary's physician shall approve the initial plan of care by signing and dating it, within thirty (30) calendar days of its development, and noting his/her license number, and National Provider Identification (NPI) number on the plan of care.

In accordance with 42 CFR § 440.70, the plan of care for Home Health services, with the exception of medical supplies, equipment and appliances, must be reviewed, signed and dated by the physician every sixty (60) calendar days. The physician must review a beneficiary's continuing need for medical supplies, equipment and appliances on an annual basis.

The signature of the physician on an initial or subsequent plan of care constitutes a certification that the plan of care accurately reflects the health status and needs of the beneficiary.

Home Health Services include the following:

(1) Skilled Nursing services;

(2) Home Health Aide services;

(3) Medical supplies, equipment and appliances; and

(4) Therapy services, including the following:

(i) Physical Therapy;

(ii) Occupational Therapy; and

(iii) Speech Pathology and Audiology.

For all Home Health services, excluding medical supplies, equipment and appliances, which are subject to the requirements on page 8b, and in accordance with 42 CFR § 440.70(f)(1) and (5) (i-ii)), the ordering physician must:

(1) Document that a face-to-face encounter, related to the primary reason the beneficiary requires Home Health services, occurred between the beneficiary and the health care practitioner within the ninety (90) days before or within the thirty (30) days after the start of services; and

(2) Indicate on the order the name of the health care practitioner who conducted the face-to-face encounter, and the date of the encounter.

In accordance with 42 CFR § 440.70 (f)(1)(3), the face-to-face encounter may be conducted by one of the following providers:

(1) The ordering physician;

(2) A nurse practitioner working in collaboration with the ordering physician;

(3) A certified nurse mid-wife as authorized under District law;

(4) A physician assistant acting under the supervision of the ordering physician; and

(5) For beneficiaries receiving Home Health services immediately after an acute or post-acute stay, the attending acute or post-acute physician.

In accordance with 42 CFR § 440.70 (f)(3)(v), the following requirements are applicable to medical supplies, equipment and appliances provided under the Home Health services benefit:

(1) For the initiation of medical supplies, equipment and appliances, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment, and must occur no more than six (6) months prior to the start of services;

(2) The initial order for services must be conducted by a physician and the face-to-face encounter may be conducted by any of the non-physician practitioners allowed to conduct face-to-face encounters referenced above, with the exception of nurse-midwives; and

(3) The physician responsible for ordering the services or allowed non-physician practitioner as described in 42 CFR § 440.70(g)(1) must:

(i) Document the face-to-face encounter which is related to the primary reason the beneficiary requires home health services, occurred within the required timeframes prior to the start of home health services; and

(ii) Must indicate the practitioner who conducted the encounter, and the date of the encounter.

All Home Health Services described in this Section require prior authorization and approval by DHCF in order to be reimbursed by Medicaid. . These approved services must be certified as medically necessary by a physician in the beneficiary's plan of care. Skilled Nursing service requirements and limits are described in Section 7 A. Home Health Aide service requirements and limits are described in Section 7B.

A. Skilled Nursing services are part-time or intermittent Skilled Nursing care that is needed temporarily by a beneficiary due to an illness or injury, and are furnished by nurses in accordance with the beneficiary's plan of care.

1. Eligibility: Skilled Nursing services shall be ordered by a physician in accordance with the requirements set forth in General Provisions for all Home Health services.

2. Providers: Skilled Nursing services are provided by a Home Care Agency licensed pursuant to District law which must meet the following requirements:

(a) Be enrolled as a Medicare Home Health Agency qualified to offer Skilled Nursing services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 C.F.R Part 484.;

(b) Have sufficient funds or "initial reserve operating funds" available, in accordance with federal special capitalization requirements for Home Care agencies participating in the Medicare program as set forth under 42 C.F.R. § 489.28;

(c) Meet the District of Columbia Department of Health licensure requirements in accordance with District regulations;

(d) Be enrolled as a Medicaid provider of Home Health services and meet all requirements as set forth under District regulations; and

(e) Except for government-operated Home Care Agencies, obtain a surety bond, in accordance with federal requirements for Home Care Agencies participating in Medicaid, as set forth under 42 C.F.R. § 441.16 and District regulations, and furnish a copy of such bond to DHCF.

3. Scope of services: Skilled Nursing services shall be provided by a R.N. or a licensed practical nurse (L.P.N.) under the supervision of a R.N. Duties of the nurse shall be consistent with District licensure and scope of practice laws and as set forth under District regulations, which includes the following requirements:

(a) Conducting initial assessments either prior to service provision or at the onset of care and reassessments every sixty calendar (60) days to develop and update a plan of care;

(b) Coordinating the beneficiary's care and referrals among all home care agency providers;

(c) Implementing preventive and rehabilitative nursing procedures;

(d) Administering medications and treatments as prescribed by a licensed physician, pursuant to District laws, as outlined under the plan of care;

(e) Recording daily progress notes and summary notes at least once every sixty (60) calendar days;

(f) Making necessary updates to the plan of care, and reporting any changes about the beneficiary's condition to his/her physician;

(g) Instructing the beneficiary on treatment regimens identified under the plan of care;

(h) Updating the physician on changes in the beneficiary's condition and obtaining orders to implement those changes; and

(i) For R.N.s who supervise Skilled Nursing services, duties shall include, at minimum, the following:

i. Supervising the beneficiary's skilled nurse on site, at least once every sixty (60) calendar days;

ii. ensuring that new or revised physician orders have been obtained from the treating physician initially, as needed, and every sixty (60) calendar days thereafter, to promote continuity of care;

iii. Reviewing the beneficiary's plan of care;

iv. Monitoring the beneficiary's general health outcomes, including taking vital signs, conducting a physical examination, and determining mental status;

v. Determining if the beneficiary has any unmet needs;

vi. Ensuring that all Home Health services are provided safely and in accordance with the plan of care;

vii. Ensuring that the beneficiary has received education on any needed services;

viii. Ensuring the safe discharge or transfer of the beneficiary;

ix. Ensuring that the physician receives progress notes when the beneficiary's health condition changes, or when there are deviations from the plan of care;

x. Ensuring that a summary report of the visit has been sent to the physician every sixty (60) calendar days; and

xi Reporting any instances of abuse, neglect, exploitation or fraud to DHCF to promote a safe and therapeutic environment in accordance with District regulations.

(j) Initial assessments and evaluations to develop the plan of care shall only be conducted by a R.N. Periodic reassessments to update the plan of care may be conducted by a R.N. or L.P.N. The R.N. or L.P.N. conducting the initial assessment or periodic reassessment in accordance with this Section shall certify in writing that the assessment is true and accurate.

(k) Skilled nursing services provided by a L.P.N. shall be supervised by a R.N. pursuant to District regulations.

(l) When a L.P.N. provides skilled nursing services, the duties shall not include supervisory duties.

(m) When a R.N. is supervising a L.P.N., the R.N. shall monitor and supervise the provision of services provided by the L.P.N. including conducting a site visit at least once every sixty (60) calendar days, or more frequently, if specified in the beneficiary's plan of care.

(n) The R.N. or L.P.N. shall record progress notes during each visit which shall comply with the standards of nursing care under District regulations and include notations registering the following:

i. Any unusual health or behavioral events or changes in status;

ii. Any matter requiring follow-up on the part of the service provider or DHCF; and

iii. A concise written statement of the beneficiary's progress or lack of progress, medical conditions, functional losses, and treatment goals as outlined in the plan of care that demonstrate that services received by the beneficiary continue to be reasonable and necessary.

(o) The skilled nurse shall prepare summary notes every sixty (60) calendar days summarizing the daily progress notes and bringing attention to any matter requiring follow-up on the part of the service provider or DHCF.

4. Amount and Duration of Services: Skilled Nursing services shall be comprised of fifteen (15) minute units of service for services by a R.N. or L.P.N. in accordance with the plan of care and the physician's order. Skilled Nursing services shall be prior authorized, and shall be delivered on a part-time or intermittent basis.

5. Prior Authorization and Exceptions:

(a) Skilled Nursing services shall be prior authorized and may not exceed a total of six (6) hours a day unless the criteria described in (b) or (c) have been met. The beneficiary's need for continuing Skilled Nursing services must be reassessed and certified by the physician every sixty (60) days. Documentation supporting the beneficiary's additional need for Skilled Nursing services which aligns with the physician's order and the health status and needs outlined in the plan of care must be submitted to DHCF.

(b) Exception for Immediate Need: Skilled Nursing services may be provided without a prior authorization for up to six (6) hours a day for a period not to exceed five (5) days only when the beneficiary's need for Skilled Nursing services is immediate such as in an emergency situation or to ensure the safe and orderly discharge of the beneficiary from a hospital or nursing home to the beneficiary's home.

(c) Medical Necessity Exception: DHCF may authorize additional hours of Medicaid reimbursable Skilled Nursing services above the six (6) hour per day limit for a beneficiary if DHCF determines that additional hours are medically necessary, that the beneficiary's needs can be safely met in the home, and that the beneficiary's Medicaid-funded services are being delivered in a cost-effective manner appropriate to the beneficiary's level of care.

6. Service Delivery Limitations: The provision of Skilled Nursing services shall be subject to the following service limitations:

(a) Assessments, reassessments or supervisory visits of a skilled nurse or aide shall not be included in the calculation of the daily Skilled Nursing cap;

(b) When a skilled nurse performs the duties described in this Section during an initial assessment or reassessment, these services shall be included as part of the rate paid for an initial assessment or reassessment and shall not be billed separately; and

(c) When a skilled nurse provides assistance with activities of daily living during an assessment, supervisory, or Skilled Nursing visit, a provider shall only bill for Skilled Nursing services and may not also bill for personal care aide services.

(d) A beneficiary shall not concurrently receive State Plan Skilled Nursing and Private Duty Nursing services.

B. Home Health Aide services are required by a beneficiary due to an illness or injury, and include assistance with activities of daily living, medication administration assistance, and/or other clinical tasks to assist with the provision of nursing or skilled services such as cleaning around a feeding tube and administering oxygen therapy.

1. Eligibility: Home Health Aide services shall be ordered by a physician in accordance with the requirements set forth in General Provisions for all Home Health services.

2. Providers: Home Health Aide services are provided by a Home Care Agency which must meet the following requirements:

(a) Be enrolled as a Medicare Home Health Agency qualified to offer Skilled Nursing services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 C.F.R Part 484;

(b) Have sufficient funds or "initial reserve operating funds" available, in accordance with federal special capitalization requirements for Home Care Agencies participating in the Medicare program as set forth under 42 C.F.R. § 489.28;

(c) Meet the District of Columbia Department of Health licensure requirements in accordance with District regulations;

(d) Be enrolled as a Medicaid provider of Home Health services and meet all requirements as set forth under District regulations; and

(e) Except for government-operated Home Care Agencies, obtain a surety bond, in accordance with federal requirements for Home Care Agencies participating in Medicaid, as set forth under 42 C.F.R. § 441.16 and District regulations, and furnish a copy of such bond to DHCF.

3. Scope of Services: Medicaid reimbursable Home Health Aide services shall be provided by a home health aide who is certified in accordance with District regulations and who is supervised in accordance with District law, and shall consist of the following duties:

(a) Performing personal care including assistance with activities of daily living such as bathing, personal hygiene, toileting, transferring from the wheelchair, and instrumental activities such as meal preparation, laundry, grocery shopping, and telephone use;

(b) Changing urinary drainage bags;

(c) Assisting the beneficiary with transfer, ambulation, and exercise as prescribed;

(d) Assisting the beneficiary with self-administration of medication;

(e) Measuring and recording temperature, pulse, respiration, and blood pressure;

(f) Measuring and recording height and weight;

(g) Observing, recording, and reporting the client's physical condition, behavior, or appearance;

(h) Preparing meals in accordance with dietary guidelines;

(i) Assisting with tasks associated with food consumption;

(j) Implement universal precautions to ensure infection control;

(k) Performing tasks related to keeping the beneficiary's living area in a condition that promotes the beneficiary's health and comfort;

(l) Changing simple dressings that do not require the skills of a licensed nurse;

(m) Assisting the beneficiary with activities that are directly supportive of skilled therapy services;

(n) Assisting with routine care of prosthetic and orthotic devices;

(o) Emptying and changing colostomy bags and performing care of the stoma;

(p) Cleaning around a gastrostomy tube site;

(q) Administering an enema; and

(r) Assistance with oxygen therapy.

5. Amount and Duration of Services: Home Health Aide services shall be comprised of fifteen (15) minute units of service for services delivered by a home health aide in accordance with the plan of care and the physician's order. Home Health Aide services shall be prior authorized by DHCF or its agent.

6. Prior Authorization and Exceptions

(a) Home Health Aide services shall be prior authorized and may not exceed a total of four (4) hours a day unless the criteria described in (b) have been met. The need for continuing Home Health Aide services must be reassessed and certified by the physician every sixty (60) days. Documentation supporting the beneficiary's additional need for Home Health Aide services which aligns with the physician's order and the health status and needs outlined in the plan of care must be submitted to DHCF.

(b) Medical Necessity Exception: DHCF may authorize additional hours of Medicaid reimbursable Skilled Nursing services above the six (6) hour per day limit for a beneficiary if DHCF determines that additional hours are medically necessary, that the beneficiary's needs can be safely met in the home, and that the beneficiary's Medicaid-funded services are being delivered in a cost-effective manner appropriate to the beneficiary's level of care.

7. Service Delivery Limitations: Home Health Aide services shall comply with the following service limitations:

   (a) A beneficiary shall not receive Personal Care Aide (PCA) services under the State Plan or a 1915(c) waiver and Home Health Aide services at the same time.

C. Medical Supplies, Equipment, and Appliances suitable for use in any setting in which normal life activities take place, as defined at § 440.70(c)(1), and requested in accordance with applicable District regulations.

D. Physical Therapy services are skilled services provided in accordance with the beneficiary's plan of care that are designed to treat a beneficiary's identified physical dysfunction or reduce the degree of pain associated with movement, injury or long term disability. Physical Therapy services should also maximize independence and prevent further disability, maintain health, and promote mobility.

1. Eligibility: Physical Therapy services shall be ordered by a physician in accordance with the requirements set forth in General Provisions for all Home Health services.

   To be eligible for Medicaid reimbursement for Physical Therapy services, a Home Care Agency shall meet the following requirements:

   (a) Be enrolled as a Medicare Home Health Agency qualified to offer skilled nursing services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 C.F.R. Part 484;

   (b) Have sufficient funds or "initial reserve operating funds" available, in accordance with federal special capitalization requirements for Home Care agencies participating in Medicare as set forth under 42 C.F.R. § 489.28;

   (c) Meet the District of Columbia Department of Health licensure requirements in accordance with District regulations;

(d) Be enrolled as a Medicaid provider of Home Health services and meet all requirements as set forth under District regulations; and

(e) Except for government-operated Home Care Agencies, obtain a surety bond, in accordance with federal requirements for Home Care Agencies participating in Medicaid, as set forth under 42 C.F.R. § 441.16 and District regulations, and furnish a copy of such bond to DHCF.

2. Providers: Physical Therapy services shall be provided by a physical therapist or physical therapy assistant with at least two (2) years of experience, licensed in accordance with District laws and implementing regulations. Consistent with District regulations, Physical Therapy services provided by a physical therapy assistant shall be supervised by a licensed physical therapist.

3. Scope of Services: In accordance with District laws, and in addition to the requirements set forth under District regulations, Medicaid-reimbursable Physical Therapy services shall consist of the following duties:

(a) Conducting an initial evaluation and assessment that summarizes the physician's order and documents the beneficiary's strength, range of motion, balance, coordination, muscle performance, respiration, and motor functions;

(b) Developing and describing therapy plans which explain therapeutic strategies, rationale, treatment approaches and activities to support treatment goals;

(c) Maintaining ongoing involvement and consulting with other service providers and caregivers;

(d) Consulting and instructing the beneficiary, family, or other caregivers on therapy plan;

(e) Recording progress notes during each visit and summary notes at least quarterly, or more frequently as needed;

(f) Assessing the beneficiary's need for the use of adaptive equipment;

(g) Routinely assessing (at least annually and more frequently as needed) the appropriateness, quality, and functioning of adaptive equipment to ensure it addresses the beneficiary's needs;

(h) Accurately completing documentation required to obtain or repair adaptive equipment in accordance with established insurance, Medicare and Medicaid guidelines;

(i) Conducting periodic examinations and modifying treatments for the beneficiary receiving services and ensuring that Physical Therapy recommendations are incorporated into the plan of care; and

(j) In accordance with District laws, and in addition to the requirements set forth under District regulations, Medicaid-reimbursable physical therapy assistant services shall consist of the following duties:

i. Maintaining ongoing involvement with other service providers and caregivers;

ii. Providing instruction to the beneficiary, family, or other caregivers;

iii. Recording progress notes during each visit and summary notes at least quarterly, or more frequently as needed; and

iv. Accurately completing documentation required to obtain or repair adaptive equipment in accordance with established insurance, Medicare and Medicaid guidelines.

4. Amount and Duration of Services: Physical Therapy services shall be provided up to thirty-six (36) visits per year without prior authorization and approval by DHCF. The thirty-six (36) visit limit includes any Physical Therapy or other Home Health services provided during an annual period (excluding Skilled Nursing services). Requests for additional Physical Therapy visits may be approved by DHCF when the beneficiary requests prior authorization, a physician's order documents the need for additional Physical Therapy services, and such services are consistent with the beneficiary's plan of care.

E. Occupational Therapy services are skilled services designed to maximize independence, gain skills, prevent further disability, and develop, restore, or maintain a beneficiary's daily living and work skills. Occupational Therapy services shall be provided in accordance with the beneficiary's plan of care.

1. Eligibility: Occupational Therapy services shall be ordered by a physician in accordance with the requirements set forth in General Provisions for all Home Health services.

   To be eligible for Medicaid reimbursement, a Home Care Agency providing Occupational Therapy services shall meet the following requirements:

   (a) Be enrolled as a Medicare Home Health Agency qualified to offer skilled nursing services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 C.F.R. Part 484;

   (b) Have sufficient funds or "initial reserve operating funds" available, in accordance with federal special capitalization requirements for Home Care agencies participating in Medicare as set forth under 42 C.F.R. § 489.28;

   (c) Meet the District of Columbia Department of Health licensure requirements in accordance with District regulations;

   (d) Be enrolled as a Medicaid provider of Home Health services and meet all requirements as set forth under District regulations; and

   (e) Except for government-operated Home Care Agencies, obtain a surety bond, in accordance with federal requirements for Home Care Agencies participating in Medicaid, as set forth under 42 C.F.R. § 441.16 and District regulations, and furnish a copy of such bond to DHCF.

2. Providers: Occupational Therapy services shall be provided by an occupational therapist or occupational therapy assistant with at least two (2) years of experience who is licensed in accordance with District licensure laws and implementing regulations. Consistent with District regulations, Occupational Therapy services provided by an occupational therapy assistant shall be supervised by a licensed occupational therapist.

3. Scope of Services: In accordance with District laws, and in addition to requirements under District regulations, Medicaid-reimbursable Occupational Therapy services shall consist of the following duties:

   (a) Conducting an initial evaluation and assessment that:

      (i) Summarizes the physician's order;

(ii) Reflects the beneficiary's employment and living goals; and

(iii) Documents the beneficiary's strength, range of motion, balance, coordination, muscle performance, respiration, and motor functions;

(b) Developing and describing therapy plans which explain therapeutic strategies, rationale, treatment approaches and activities to support treatment goals;

(c) Consulting and instructing the beneficiary, family, or other caregivers on the therapy plan;

(d) Recording progress notes during each visit and summary notes at least quarterly, or more frequently as needed;

(e) Assessing the beneficiary's need for the use of adaptive equipment;

(f) Routinely assessing (at least annually and more frequently as needed) the appropriateness, quality, and functioning of adaptive equipment to ensure it addresses the beneficiary's needs;

(g) Completing documentation required to obtain or repair adaptive equipment in accordance with established insurance, Medicare and Medicaid guidelines;

(h) Conducting and documenting quarterly assessments to verify the condition of the adaptive equipment;

(i) Conducting periodic examinations to modify treatments for the beneficiary, when necessary, and ensure that Occupational Therapy recommendations are incorporated into the plan of care; and

(j) In accordance with District laws, and in addition to the requirements under District regulations, Medicaid-reimbursable Occupational Therapy assistant services shall consist of the following duties:

i. Maintaining ongoing involvement with other service provider's caregivers;

ii. Providing instruction to the beneficiary, family, or other caregivers;

iii. Recording progress notes during each visit and summary notes at least quarterly, or more frequently as needed; and

iv. Accurately completing documentation required to obtain or repair adaptive equipment in accordance with established insurance, Medicare and Medicaid guidelines.

4. Amount and Duration: All Occupational Therapy services described in this Section require prior authorization and approval by DHCF in order to be reimbursed by Medicaid.

F. Speech Pathology and Audiology Services: Speech Pathology and Audiology services are skilled therapeutic interventions to address communicative and speech disorders to maximize a beneficiary's expressive and receptive communication skills and are intended to treat the beneficiary's medical or non-medical communicative disorder. Speech Pathology and Audiology services shall be provided in accordance with the beneficiary's plan of care.

1. Eligibility: Speech Pathology and Audiology services shall be ordered by a physician in accordance with the requirements set forth in General Provisions for all Home Health services.

In accordance with the District of Columbia Medicaid State Plan, Speech Pathology and Audiology services shall be limited to beneficiaries eligible through the Early Periodic Screening Diagnostic Treatment (EPSDT) benefit. In accordance with the District of Columbia Medicaid State Plan, Speech Pathology and Audiology services shall only be provided by a facility licensed to provide medical rehabilitation services or a Home Care agency. In order to be eligible for Medicaid reimbursement, a Home Care agency providing Speech Pathology and Audiology services shall meet the following requirements:

(a) Be enrolled as a Medicare Home Health Agency qualified to offer Skilled Nursing services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR Part 484;

(b) Have sufficient funds or "initial reserve operating funds" available, in accordance with federal special capitalization requirements for Home Care agencies participating in Medicare as set forth under 42 CFR § 489.28;

(c) Meet the District of Columbia licensure requirements in accordance with District regulations;

(d) Be enrolled as a Medicaid provider of Home Health services and meet all requirements as set forth under District regulations; and

(e) Except for government-operated Home Care Agencies, obtain a surety bond, in accordance with federal requirements for Home Care Agencies participating in Medicaid, as set forth under 42 C.F.R. § 441.16 and District regulations, and furnish a copy of such bond to DHCF

2. Providers: Speech Pathology and Audiology services shall be provided by a speech language pathologist or audiologist with at least two (2) years of experience that is licensed in accordance with District licensure laws and implementing regulations.

3. Scope of Services: In accordance with District laws, and in addition to the requirements under District regulations, Medicaid-reimbursable Speech Pathology and Audiology services shall consist of the following duties:

(a) Conducting a comprehensive assessment, which shall include the following:

i. A background review and current functional review of communication capabilities in different environments, including employment, residence and other settings in which normal life activities take place;

ii. The beneficiary's potential for using augmentative and alternative speech devices, methods, or strategies;

iii. The beneficiary's potential for using sign language or other expressive communication methods; and

iv. A needs assessment for the use of adaptive eating equipment.

(b) Developing and implementing the treatment plan that describes treatment strategies including, direct therapy, training caregivers, monitoring requirements, monitoring instructions, and anticipated outcomes;

(c) Assisting beneficiaries with voice disorders to develop proper control of vocal and respiratory systems for correct voice production, if applicable;

(d) Conducting aural rehabilitation by teaching sign language and/or lip reading to people who have hearing loss, if applicable;

(e) Recording progress notes during each visit and summary notes at least quarterly, or more frequently as needed;

(f) Conducting periodic examinations and modifying treatments for the beneficiary receiving services and ensuring that the recommendations are incorporated into the Plan of Care, as appropriate; and

(g) Conducting discharge planning.

4. Amount and Duration of Services: All Speech Pathology and Audiology services described in this Section require prior authorization and approval by DHCF in order to be reimbursed by Medicaid.

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.

10. Dental Services.

All dental services must be provided by a licensed dentist or under the supervision of a licensed dentist acting within the scope of practice, in accordance with 42 C.F.R §440.100 and applicable District statutory and regulatory requirements or consistent with the applicable statutory and regulatory requirements in the jurisdiction where services are provided.

Dental services requiring inpatient hospitalization or 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 for the following populations:

A. Beneficiaries under the age of twenty-one (21)
Dental services are comprehensive and covered under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Dental services provided under EPSDT are limited to medically necessary services within the scope of the category of services identified at § 1905(a) of the Social Security Act.

B. Beneficiaries age twenty-one (21) and older
Dental services are limited to the following:

1. General dental examinations consisting of preventive services, which include semi-annual routine cleaning and oral hygiene instruction;

2. Emergency, surgical, and restorative services including crowns and root canal treatment;

3. Denture reline and rebase, limited to one (1) over a five (5) year period unless additional services are prior authorized;

4. Complete radiographic survey, including full and panoramic x-rays, limited to one (1) every three (3) years unless additional services are prior authorized;

5. Periodontal scaling and root planing, provided that medical necessity criteria set forth in District regulations are met;

6. Initial placement or replacement of a removable prosthesis, limited to one (1) every five (5) years per beneficiary unless prior authorized; and

7. Dental implants, only if prior authorized and provided that medical necessity criteria set forth in District regulations are met.

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;