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 medical care cannot be obtained except in an appropriate acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admission 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 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(b) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services performed for individuals under twenty-one (21) 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. 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 Columbia laws. Provider qualifications shall meet the requirements of 42 C.F.R. § 440.60(a), and any amendments thereto.

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School-Based Health (SBH) (Continued)

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.

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.

School-Based Health (SBH) (Continued)

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. ASD services are available to Medicaid beneficiaries under the age of twenty-one (21). Pursuant to 42 C.F.R. Section 440.130(c), ASD services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law. 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 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:

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

   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 intellectual 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 9b, 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 (60) calendar 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 delivered 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 per 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.

4. Amount and Duration of Services: Home Health Aide services shall be comprised of fifteen (15) minute units of service for services provided 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.

5. 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.

6. 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: All Physical Therapy services described in this Section require prior authorization and approval by DHCF in order to be reimbursed by Medicaid.

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

8 Private Duty Nursing Services are for the purpose of providing more individualized and continuous care than is available from a visiting nurse under the Skilled Nursing Home Health Services benefit or routinely provided by nursing staff of a hospital or skilled nursing facility.

A. Eligibility: In order to be eligible for Medicaid reimbursement, Private Duty Nursing services shall be ordered by a physician upon verification that the services are medically necessary, as described in District regulation, and provided in accordance with a plan of care developed by a Registered Nurse (R.N.).

B. Plan of Care: Private Duty Nursing services shall be provided pursuant to a written plan of care. The plan of care must be developed and signed and dated by a R.N. who is employed or under contract to the Private Duty Nursing services provider. The signature of the R.N. on the plan of care constitutes a certification 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) days of the development of the plan of care and noting his or her license number and National Provider Identification (NPI) number on the plan of care. The plan of care shall be reviewed and signed and dated by the physician every sixty (60) calendar days.

C. Face-to-Face Encounters - Ordering Physician Requirements: Effective October 1, 2016, the ordering physician for any Private Duty Nursing services shall:

(1) Document that a face-to-face encounter related to the primary reason the beneficiary requires Private Duty Nursing services occurred between the beneficiary and the health 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 practitioner who conducted the face-to-face encounter, and the date of the encounter.

D. Face-to-Face Encounters- Qualified Practitioners: A 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 physician;

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

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

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

E. Providers: Private Duty Nursing services shall be provided by a Home Care Agency that meets the following requirements:

(1) Be enrolled as a Medicare Home Care Agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 C.F.R. § 484 *et seq.*;

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

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

(4) Be enrolled as a Medicaid provider of Private Duty Nursing services and meet all requirements as set forth under District regulations;

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

(6) A Home Care Agency shall accept a ventilator-dependent beneficiary only if:

(a) The beneficiary is ventilator stabilized;

(b) A successful home equipment trial has been conducted by the Home Care Agency provider; and

(c) The Home Care Agency has developed a plan for emergency services notification.

F Scope of Services: Private Duty Nursing services shall be provided by a licensed R.N. or L.P.N. licensed in accordance with District law and implementing rules. The duties of a R.N. or L.P.N. shall include, but not be limited to, the following:

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

(2) Coordinating the beneficiary's care and referrals among all Home Care Agency providers;

(3) Implementing preventive and rehabilitative nursing procedures;

(4) Administering medications and treatment as prescribed by a physician licensed in accordance with District law, as outlined under the plan of care;

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

(6) Making necessary updates to the plan of care, and reporting any changes in the beneficiary's condition to his or her physician;

(7) Instructing the beneficiary on treatment regimens identified under the plan of care.

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

(9) For R.N.s who supervise nursing services delivered by skilled nurses, duties shall include, at minimum, the following:

(a) Supervising the beneficiary's skilled nurse on site, at least once every sixty (60) calendar days or more frequently if specified in the plan of care;

(b) Ensuring that Private Duty Nursing services provided by a L.P.N. are supervised consistent with District regulations;

(c) Conducting the initial assessment and evaluation and certifying in writing that the assessment is true and accurate;

(d) 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;

(e) Reviewing the beneficiary's plan of care;

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

(g) Determining if the beneficiary has any unmet needs;

(h) Ensuring that all home health services are provided safely and in accordance with the plan of care;

(i) Ensuring that the beneficiary has received education on any needed services;

(j) Ensuring the safe discharge or transfer of the beneficiary;

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

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

(m) Reporting any instances of abuse, neglect, exploitation or fraud to DHCF to promote a safe and therapeutic environment in accordance with District regulations;

(10) Maintaining the beneficiary's equipment and supplies;

(11) Providing ventilator and/or tracheostomy tube maintenance;

(12) Ensuring that progress notes taken during each visit shall meet the standards of nursing care established under District regulations and including notations regarding the following:

(a) Any unusual health or behavioral events or changes in status;

(b) Any matter requiring follow-up on the part of the service provider or DHCF; and

(c) A clearly 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 demonstrates that the beneficiary's services continue to be reasonable and necessary.

(13) Applying independent emergency measures to counteract adverse developments; and

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

G. Amount and Duration of Services: Private Duty Nursing services may be provided up to twelve (12) hours per day with a prior authorization issued by DHCF. The twelve (12) hour per day limit on Private Duty Nursing Services may be exceeded based on medical necessity, determined in accordance with applicable District regulations.

H. Prior Authorization: All requests for Private Duty Nursing services must be prior authorized by DHCF or its designee, in accordance with applicable District regulations.

I. Service Delivery Limitations: Private Duty Nursing services shall have the following service limitation:

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

(2) When a private duty nurse performs the duties described in this Supplement during an initial assessment or reassessment, these services shall not be billed separately as Private Duty Nursing services under the twelve (12) hour daily cap, but shall be included as part of the rate paid for an initial assessment or reassessment;

(3) When a private duty nurse is providing personal care aide services, the services shall be billed and reimbursed as personal care aide services; and

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

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 are 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 CFR §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 or its agent. 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 the 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 [illegible] element of hospital inpatient or outpatient care, nursing facility [illegible] 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 a 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 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.

12. Prescribed Drugs, Dentures and Prosthetic Devices and Eyeglasses

A. Prescribed Drugs

1) a. Prescribed drugs are limited to legend drugs approved as safe and effective by the Federal Food and Drug Administration.

b. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D:

i. ☒ Select agents when used for anorexia, weight loss, weight gain (Megestrol).

ii. ☐ Agents when used to promote fertility.

iii. ☐ Agents when used for symptomatic relief cough and colds.

iv. ☒ Select prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations (e.g., single agent Vitamin B1, Vitamin B6, Vitamin B12, Vitamin D, folic acid products, geriatric vitamins).

v. ☒ Select nonprescription drugs (e.g., oral analgesics with a single active ingredient, antacids, family planning drugs, senna extract, single ingredient antihistamine medications).

vi. ☐ Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

c. i. The District of Columbia will provide reimbursement for covered outpatient drugs consistent with prior authorization and other requirements under Section 1927 of the Social Security Act.

ii. Prenatal vitamins and fluoride preparations will be covered as required under Section 1927 of the Social Security Act.

2) The Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

3) Agents when used for the treatment of sexual or erectile dysfunction are excluded from coverage through the Outpatient Pharmacy Program, except for limited medical uses as required by federal law.

4) a. Investigational drugs shall be excluded from coverage.

b. Over-the-counter drugs provided by nursing home pharmacies are excluded from coverage through the Outpatient Pharmacy Program.

c. The state will cover agents when used for cosmetic purposes or hair growth only when the state has determined that use to be medically necessary.

5) The District provides coverage for other drugs or products used for mitigating disease in the event of a public health emergency.

6) Supplemental Rebate Program:
The District is in compliance with section 1927 of the Social Security Act. The District has the

following policies for the Supplemental Rebate Program for the Medicaid population:

a. The "Supplemental Drug Rebate Agreement" between the participating states, Magellan Medicaid Administration, and the participating manufacturers, has been submitted to CMS and authorized by CMS effective October 1, 2013.

b. CMS has authorized the District of Columbia to enter into the National Medicaid Pooling Initiative (NMPI) for outpatient drugs provided to Medicaid beneficiaries. The Supplemental Drug Rebate Agreement authorizes the District to enter into new or renewal agreements with pharmaceutical manufacturers for outpatient drugs provided to Medicaid beneficiaries.

c. Supplemental rebates received by the District in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

d. Manufacturers who do not participate in the supplemental rebate program will continue to have their drugs made available to Medicaid participants through either the preferred drug list or the prior authorization process.

depending on the results of the Pharmacy and Therapeutics Committee recommendations and Departmental review.

e. As specified in Section 1927(b)(3)(D) of the Act, notwithstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the District for purposes other than rebate invoicing and verification.

7) All anorexic drug (amphetamine and amphetamine-like) are eliminated as reimbursable pharmaceuticals except for diagnosed conditions of narcolepsy and minimal brain dysfunction in children.

8) Prior authorization (PA) is required for the dispensing of the following prescribed drugs.

a. All prescriptions for Oxycodone HCL and Aspirin (more commonly known as Percodan), and Flurazepam (more commonly known as Dalmane);

b. Anorexic drugs (amphetamine and amphetamine-like) may be dispensed with prior authorization for the diagnosed conditions of narcolepsy and minimal brain dysfunction in children; and

c. Any injectable drugs on an ambulatory basis.

9) Pharmacy Lock-In Program

a. The Department of Health Care Finance (DHCF), along with the District of Columbia Drug Utilization Review (DUR) Board, will implement a Pharmacy Lock-In Program to safeguard the appropriate use of medications when a beneficiary enrolled in the District of Columbia Medicaid Program misuses drugs in excess of the customary dosage for the proper treatment of the given diagnosis, or misuses multiple drugs in a manner that can be medically harmful. Beneficiaries listed in section 9(k) are exempt from the Pharmacy Lock-In Program. Additional DUR Board requirements are found in Section 4.26.

b. DHCF will use the drug utilization guidelines established by the DUR Board to monitor inappropriate or excessive utilization.

c. If a beneficiary is identified by the Department of Health Care Finance (DHCF) as misusing drugs in excess of the customary dosage, DHCF will notify the Medicaid beneficiary in writing of their designation as a restricted Medicaid beneficiary.

d. The Medicaid beneficiary shall have fifteen (15) days from the date of the notice to file a request for a hearing with the Office of Administrative Hearings (OAH).

e. If the Medicaid recipient requests a hearing, the agency will defer further action on the restriction designation until the hearing is dismissed or a final decision has been rendered by OAH.

f. A restriction may be required for a reasonable amount of time, not to exceed twelve (12) months, without a review by the DUR Board. Subsequent restrictions will not be imposed until after the review has concluded.

g. DHCF will ensure that when a lock-in has been imposed, the beneficiary will continue to have reasonable access to Medicaid services of adequate quality.

h. When a restriction is imposed upon a beneficiary, the beneficiary may choose the pharmacy of his or her choice, based upon a list of three (3) pharmacy providers identified by DHCF.

i. When a restriction is imposed and a beneficiary fails to request a hearing with OAH or fails to select a designated pharmacy after a decision has been rendered by OAH upholding the restriction within the specified time period, DHCF shall designate a pharmacy for the beneficiary's pharmacy services for the duration of the restriction on the beneficiary's behalf.

j. DHCF will not apply any restrictions that have been imposed in situations where the beneficiary uses emergency services.

l. If a beneficiary, who is enrolled in the Medicaid Managed Care Organization (MCO) and is also required to participate in its Pharmacy Lock-In Program, subsequently becomes enrolled in the Medicaid Fee-For-Service Program, that beneficiary will be automatically enrolled in the Medicaid Fee-For-Service Pharmacy Lock-In Program. The lock-in will remain in force for a period not to exceed the length of the initial lock-in period first imposed by the MCO, or twelve (12) months, whichever is less.

(10) Medication Assisted Treatment (MAT) under DUL Substance Abuse Rehabilitative Services (described in Supplement 6 to Attachment 3.1-A).

a. MAT is the use of pharmacotherapy as long-term treatment for opiate or other forms of dependence. A beneficiary who receives MAT must also receive SUD Counseling. Use of this service should be in accordance with ASAM service guidelines and practice guidelines issued by the Department of Behavioral Health.

b. Unit of Service: A beneficiary can be prescribed a maximum of one (1) does/unit per day.

c. Limitations: An initial and second authorization cover a period of ninety (90) days each; subsequent authorizations must not exceed one hundred and eighty (180) days each. The maximum number of MAT services over a twelve (12) month period is two hundred-fifty (250) units of medication and up to fifty-two units of administration. Any dosing over two hundred–fifty units will require DBH review and authorization.

d. Location/Setting: In accordance with 42 CFR part 8, Certification of Opioid Treatment Programs, MAT providers must also be certified by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by a national body that has been approved by SAMHSA.

SUD treatment programs providing MAT with opioid replacement therapy shall comply with Federal; requirements for opioid treatment, as specified in 21 CFR, part 291, and shall comply with District and Federal regulations for maintaining controlled substances as specified in Chapter 10, Title 22 of the District of Columbia Municipal Regulations and 21 CFR, part 1300, respectively. Each MAT program shall submit applications to the District of Columbia Department of Behavioral Health and to the U.S. Food and Drug Administration (FDA), respectively, and shall require the approval of both agencies prior to its initial operation.

(e) Qualified Practitioners: Qualified Physicians; APRNS; Physicians Assistants, supervised by Qualified Physicians; RNs; or LPNs, supervised by an MD, RN or APRN.

B. Dentures and Other Removable Dental Prostheses

1. Initial placement or replacement of a removable prosthesis (any dental device or appliance replacing one or more missing teeth, including associated structures, if required, that is designed to be removed and reinserted), once every five (5) years per beneficiary, unless the prosthesis:

   a. was misplaced, stolen, or damaged due to circumstances beyond the beneficiary's control; or

   b. cannot be modified or altered to meet the beneficiary's dental needs.

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

3. Denture replacements within the five (5) year frequency limitation require prior authorization from DHCF.

C. Prosthetic Devices

1. Prosthetic devices are limited to items on the Durable Medical Equipment/ Medical Supplies Procedure Codes and Price List except where prior authorized by the State Agency.

2. Medical supplies and equipment in excess of specific limitations, i.e., cost, rental or lease equipment, or certain procedure codes must be prior authorized by the State Agency.

D. Eyeglasses

1. This item includes lenses required to aid or improve vision with frame when necessary that are prescribed by a physician skilled in diseases of the eye or by an optometrist at the discretion of the patient.

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 justified in writing by the ophthalmologist or optometrist. Special tints and sunglasses are not allowed in addition to untinted eyewear.

4) Contact lenses must be prior authorized by the State Agency.

13. Other Diagnostic, Screening, Preventive and Rehabilitative Services, i.e., Other Than Those Provided Elsewhere in This Plan include:

a. Diagnostic, Screening, and Preventive clinical services that are assigned a grade of A or B (strongly recommended or recommended, respectively) by the United States Preventive Services Task Force; approved vaccines recommended by the Advisory Committee on Immunization Practices; preventive care and screening of infants, children and adults recommend by the Health Resources and Services Administration's Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine. Preventive services shall be recommended by a physician or other licensed practitioner of the healing arts acting within the authorized scope of practice under the Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 et seq.), or comparable law in the state where the provider is licensed.

b. Rehabilitative services must be prior authorized and are covered for eligible Medicaid beneficiaries who are in need of mental health or substance abuse treatment, due to mental illness, serious emotional disturbance, or substance use disorder. Covered services include: 1) Mental Health Rehabilitation Services (MHRS); and 2) Adult Substance Abuse Rehabilitative Services (ASARS). These services are described in Supplement 6 to Attachment 3.1-A.

c. d. Preventive services must be prior authorized.

14. Services for individuals age 65 or older in institutions for Mental Diseases.

a. Inpatient hospital services are limited to services certified as medically necessary by the Peer Review Organization.
b. Skilled nursing facility services are limited to services certified as medically necessary by the Peer Review Organization.
c. Intermediate care facility services are limited to services certified as medically necessary by the Peer Review Organization.

15.a. Intermediate Care Facility Services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care are provided with no limitations.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions are provided with no limitations.

16. Inpatient Psychiatric Facility Services for individuals under 22 years of age are provided with no limitations.

17. Nurse Midwife Services are provided in accordance with D.C. Law 10-247.

18. Hospice Care (in accordance with Section 1905(c) of the Act).

I. GENERAL PROVISIONS

Hospice care is a comprehensive set of services, described in Section 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary team to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill beneficiary and/or family members, as delineated in a specific, written plan of care.

Adult Hospice care is limited to beneficiaries twenty-one (21) years of age and older, who reside in home settings. For purposes of Medicaid coverage, a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) may be considered the home setting of a beneficiary electing Adult Hospice. An Adult Hospice provider delivering services to an individual residing in a nursing facility or ICF/IID shall also adhere to the specific requirements outlined in Item 14 of Attachment 4.19-B, Part I of the State Plan.

A. Adult Hospice Provider Overview

1. An Adult Hospice provider is a public agency or private organization, or a subdivision of either, that is primarily engaged in providing care to terminally ill adult beneficiaries.

2. An Adult Hospice provider participating in the District of Columbia's Medicaid program shall meet the Medicare conditions of participation for hospices, 42 CFR Part 418, Subparts C, D, and F, be enrolled in the Medicare program, and be enrolled as a District Medicaid provider with DHCF.

3. For purposes of Adult Hospice, "attending physician" refers to a qualified physician who is identified by the beneficiary, at the time of election to receive Adult Hospice care, as the provider with the most significant role in determining and delivering the beneficiary's medical care.

B. Beneficiary Eligibility, Election, and Physician Certification of Terminal Illness

1. General Eligibility: Adult Hospice services shall be reasonable and necessary for the palliation or management of terminal illness and related conditions, and shall be available to beneficiaries who meet the following criteria:

a. Enrolled in District Medicaid;

b. Aged twenty-one (21) years or older;

c. Resides in a home setting, or a nursing facility or ICF/IID;

d. Is certified as terminally ill with a life expectancy of six (6) months or less, in accordance with Section B.4; and

e. Has elected to receive Adult Hospice care.

2. Beneficiary Election:

a. In accordance with 42 C.F.R. § 418.21, Adult Hospice election periods under the District's Medicaid program are organized as follows:

i. Initial: Ninety (90) day period;

ii. Second: Ninety (90) day period;

iii. Third: Sixty (60) day period; and

iv. Unlimited Subsequent: Sixty (60) day periods.

b. A beneficiary must complete and sign an election statement in order to receive Adult Hospice services. An election to receive Adult Hospice care is considered to continue through the initial election period and any subsequent election periods, without a break in care, as long as the beneficiary remains in the care of an enrolled Adult Hospice provider, does not revoke the election, and is not discharged from Adult Hospice care.

c. An Adult Hospice physician or Adult Hospice nurse practitioner must have a face-to-face encounter with each beneficiary whose total stay in Adult Hospice is anticipated to exceed one hundred eighty (180) days. The face-to-face encounter must occur prior to, but no more than thirty (30) calendar days prior to, the third election period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for Adult Hospice care.

3. Election Statement. An election statement shall include the following information:

a. Identification of the Adult Hospice provider that will care for the beneficiary;

b. The beneficiary's or authorized representative's acknowledgement that the beneficiary has been given a full explanation of the

palliative rather than curative nature of hospice care as it relates to the beneficiary's terminal illness; and

c. The beneficiary's or authorized representative's acknowledgement that the beneficiary fully understands that an election to receive hospice care is a waiver of the right to Medicaid coverage for the following services for the duration of the election to receive hospice care:

   i. Hospice care provided by a hospice other than the hospice designated by the beneficiary (unless provided under arrangements made by the designated hospice); and

   ii. Any Medicaid services related to treatment of the terminal condition for which hospice care was elected; or a related condition; or services that are equivalent to hospice care, except for:

      (a) Services provided by the designated hospice;

      (b) Services provided by another hospice under arrangements made by the designated hospice; and

      (c) Services provided by the beneficiary's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

4. Certification of Terminal Illness:

   a. Adult Hospice services shall only be initiated based on a written certification of terminal illness that is obtained by the hospice within two (2) calendar days of commencing hospice services.

   b. For all subsequent election periods, the hospice shall obtain written certification within two (2) calendar days of the first day of the new election period.

   c. The written certification of terminal illness shall include a statement that the beneficiary's medical prognosis is a life expectancy of six (6) months or less if the terminal illness runs its normal course. This statement shall be located immediately above the certifying physicians' signatures and shall also state whether the determination was based on medical chart review or a face-to-face encounter conducted in accordance with Section B.2.c.

d. For each election period, the written certification shall be signed by:

   i. The hospice medical director or the physician member of the hospice interdisciplinary team; and

   ii. The beneficiary's attending physician, specialty care, or primary care physician.

e. Certifications and recertifications shall be completed no earlier than fifteen (15) calendar days prior to the effective date of the election period.

f. No payment is available for Adult Hospice care days that a beneficiary accrues before the hospice obtains physician certification of terminal illness.

C. Plan of Care Requirements: An Adult Hospice provider shall ensure that all beneficiaries have a written plan of care before delivering Adult Hospice services. The written plan of care shall be developed by the Adult Hospice's interdisciplinary team, which must include at least one (1) of each of the following:

1. Doctor of medicine or osteopathy;

2. Registered nurse (RN) or advanced practice registered nurse (APRN);

3. Licensed clinical social worker (LICSW); and

4. Pastoral or other counselor.

D. Revocation of Election & Coverage Limitations

1. A beneficiary or authorized representative may revoke election to Adult Hospice during any election period by providing a signed statement memorializing the revocation and the effective date to the Adult Hospice provider.

2. A beneficiary may change to a different Adult Hospice provider a maximum of one (1) time during any individual election period. In such circumstances, the beneficiary will not begin a new election period. Each Adult Hospice provider shall be required to coordinate the provision of services during the beneficiary's transition in order to ensure continuity of care.

3. If a beneficiary has both Medicare and Medicaid coverage ("dually eligible"), the beneficiary must elect and revoke the Adult Hospice benefit simultaneously under both programs.

4. A beneficiary electing to receive Adult Hospice care may receive other medically necessary Medicaid-covered services unrelated to the terminal condition for which hospice care was elected.

5. A beneficiary electing to receive Adult Hospice care may not simultaneously receive covered hospice services under a home and community-based services (HCBS) waiver authorized under Section 1915(c) of the Social Security Act.

II. ADULT HOSPICE SERVICES

Adult Hospice services shall be provided to eligible Medicaid beneficiaries who elect to receive Adult Hospice care. Adult Hospice services shall be consistent with the beneficiary's plan of care and reasonable and necessary for the palliation or management of terminal illness and related conditions.

Adult Hospice services shall be delivered by qualified practitioners operating in accordance with 42 C.F.R. § 418.114 and requirements set forth in the District of Columbia Health Occupations Revision Act of 1985, as amended effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*), implementing rules, and any subsequent amendments thereto.

A. Covered Services

1. Physician Services performed by a physician as defined in 42 C.F.R. § 410.20, except that the services of the hospice medical director or the physician member of the interdisciplinary team shall be performed by a doctor of medicine or osteopathy.

2. Nursing Care provided by or under the supervision of a registered nurse.

3. Medical Social Services provided by a licensed clinical social worker practicing under the direction of a physician.

4. Counseling Services provided to the terminally ill beneficiary, family members, and others who care for the beneficiary at home. Counseling, including dietary counseling, may be provided both for the purpose of training the beneficiary's family or other caregivers to provide care, and for the purpose of helping the beneficiary and those caring for him or her to adjust to the beneficiary's approaching death. Counseling Services shall not be available to nursing facility or ICF/IID personnel who care for beneficiaries receiving Adult Hospice care in the facility.

5. Short-Term Inpatient Care provided in a participating Medicare or Medicaid hospice inpatient unit, hospital or nursing facility that additionally meets hospice staffing and space requirements described in 42 C.F.R. Part 418, Subparts C and D. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management, and may also be furnished as a means of providing respite for the individual's family or others caring for the beneficiary at home. Respite care must be furnished as specified in 42 C.F.R. § 418.108(b). Payment for inpatient care will be made at the rate appropriate to the level of care as specified in Item 14 of Attachment 4.19-B, Part I of the State Plan.

6. Durable Medical Equipment (DME) and Medical Supplies for the palliation and management of terminal illness or related conditions, which shall be part of the written plan of care and provided by the Adult Hospice provider for use in the beneficiary's home.

7. Prescription Drugs used primarily for the relief of pain and symptom control related to the beneficiary's terminal illness.

8. Physical, Occupational, and Speech Therapy Services provided for symptom control and to enable a beneficiary to maintain activities of daily living and basic functional skills.

9. Home Health Aide and Homemaker Services

   a. Home health aides shall provide personal care services and may also perform household chores necessary to maintain a safe and sanitary environment in areas of the home used by the beneficiary. Home health aides shall deliver services under the general supervision of a registered nurse.

   b. Homemaker services may include assistance in maintenance of a safe and healthy environment and other services that enable the beneficiary, caregiver(s), and Adult Hospice provider to carry out the plan of care.

   c. A beneficiary may receive personal care aide (PCA) services consistent with the scope of services covered under the Medicaid State Plan PCA benefit.

   d. The Adult Hospice provider shall ensure coordination between home health aide and homemaker services under Adult Hospice with PCA services provided under the Medicaid State Plan PCA benefit, and shall be responsible for submitting a request for a PCA Service Authorization to DHCF or its designated agent and for

integrating the plan of care prepared by the PCA provider into the Adult Hospice plan of care.

10. Any other service specified in the beneficiary's plan of care as reasonable and necessary for the palliation and management of the terminal illness and related conditions and for which payment may otherwise be made under Medicaid.

B. Standards for Service Delivery

1. Core Services. An Adult Hospice shall routinely provide all core services directly by hospice employees, except that the hospice may contract for physician services. These services must be provided in a manner consistent with acceptable standards of practice. An Adult Hospice may use contracted staff for core services, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. An Adult Hospice may also enter into a written arrangement with another Adult Hospice provider that meets the criteria set forth in Section I.A. for the provision of core services to supplement hospice employees to meet the needs of patients.

   Circumstances under which an Adult Hospice may enter into a written arrangement for the provision of core services include unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care, and temporary travel of a patient outside of the hospice's service area.

   Core Adult Hospice services include:

   a. Physician Services;

   b. Nursing Care;

   c. Medical Social Services; and

   d. Counseling.

2. Non-Core Services. An Adult Hospice shall ensure that the following non-core services are provided directly by, or under arrangements made by, the hospice provider as specified in 42 CFR § 418.100. These services must be provided in a manner consistent with current standards of practice.

   Non-core services include:

   a. Short-Term Inpatient Care;

   b. DME and Medical Supplies;

c. Prescription Drugs;

d. Physical, Occupational, and Speech Therapy;

e. Home Health Aide and Homemaker Services; and

f. Other services specified in the beneficiary's plan of care as reasonable and necessary for the palliation and management of the terminal illness and related conditions and for which payment may otherwise be made under Medicaid.

3. For any services delivered by other providers, the Adult Hospice shall have current, written agreements memorializing the nature its relationship with these providers (contractors). The written agreement shall clearly describe the contractor's duties on behalf of Medicaid beneficiaries.

4. An Adult Hospice provider shall ensure that nursing care, physician services, and prescription drugs are routinely available on a twenty-four (24) hour basis, seven (7) days per week. Other covered Adult Hospice services shall be made available on a twenty-four (24) hour basis when reasonable and necessary to meet the needs of the beneficiary and the beneficiary's family or other caregivers.

III. QUALITY REPORTING

A. An Adult Hospice enrolled as a District Medicaid provider shall perform the following actions related to quality reporting and improvement:

1. Demonstrate compliance with all federal quality of care standards, in accordance with 42 C.F.R. § 418.58;

2. Document the availability of a quality management program plan that meets federal quality of care standards in accordance with 42 C.F.R. § 418.58;

3. Demonstrate compliance with all data submission requirements of the Hospice Quality Reporting Program, in accordance with 42 C.F.R. § 418.312; and

4. Appoint a multidisciplinary Quality Management Committee (QMC) that reflects the Adult Hospice's scope of services.

B. The QMC shall develop and implement a comprehensive and ongoing quality management and peer review program that evaluates the quality and appropriateness of patient care provided, including the appropriateness of the

level of service received by patients. The QMC shall establish and use written criteria as the basis to evaluate the provision of patient care. The written criteria shall be based on accepted standards of care and shall include, at a minimum, systematic reviews of:

1. Appropriateness of admissions, continued stay, and discharge;

2. Appropriateness of professional services and level of care provided;

3. Effectiveness of pain control and symptom relief;

4. Patient injuries, such as those related to falls, accidents, and restraint use;

5. Errors in medication administration, procedures, or practices that compromise patient safety;

6. Infection control practices and surveillance data;

7. Patient and family complaints and on-call logs;

8. Inpatient hospitalizations;

9. Staff adherence to the patient's plans of care; and

10. Appropriateness of treatment.

C. The Adult Hospice shall submit its quality management and peer review program findings to DHCF or its designee by no later than June 30, annually.

IV. PEDIATRIC HOSPICE CARE

J. Pediatric hospice care under Section 2302 of the Act shall be unlimited, so long as the child remains eligible for and elects the hospice benefit.

1. An election to receive hospice care under Section 2302 of the Patient Protection and Affordable Care Act is provided in accordance with a written plan of care for each beneficiary. The initial Hospice election period shall be for ninety (90) days, followed by a second ninety (90) day period. A third period of sixty (60) days, and then one or more sixty (60) day extended election periods may also be available. In the case of the initial Hospice election period of one hundred eighty days (180), the provider shall obtain written certification from the beneficiary's attending physician, specialty care, or primary care physician authorizing the need for services. In the case of election periods of sixty (60) days, the provider shall obtain written certification from the beneficiary's attending physician, specialty care, or primary care physician authorizing the need for services before each sixty (60) day election period. In all cases, the beneficiary's medical prognosis is for a life expectancy of six months or less and must be verified.

g. Include the time frames necessary to complete the treatment and the patient's discharge destination.

Services provided to patients without an approved plan of care shall not be reimbursed.

3. Service limitations: The following general requirements shall apply to all reimbursable tuberculosis-related services:

a. 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.

b. Services shall be furnished under a written plan of care that is established and reviewed periodically 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.

c. A physician's re-certification of a plan 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 or its agent.

d. The physician's orders for services shall include the specific treatment to be provided and shall indicate the frequency and duration of services.

e. 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 services found not to be medically necessary as a result of utilization review shall not be reimbursed.

Prescription drugs which are used primarily for the relief of pain and symptom control [illegible] recipient's terminal illness;

8. Physical, occupational and speech therapy services;

9. Home health aide, personal care aide, and homemaker services; and

10. Chemotherapy and radiation therapy to provide pain control or symptom relief

F. Continuous Home Care - care to maintain a recipient at home during a brief period of crisis is covered for.

1. Nursing care, provided by either a registered nurse or a licensed practical nurse, and accounting for more than half of the period of care;

2. A minimum of eight (8) hours of care, not necessarily consecutive, provided during a twenty-four (24) hour day which begins and ends at midnight; and

3. Homemaker, home health, and personal care aide services if needed, to supplement the nursing care.

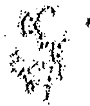
19. Case Management Services and Tuberculosis Related Services

A. Case Management Services as Defined in, and to The Group Specified in, Supplement 2 to Attachment 3.1A (in accordance with section 1905(a)(19) or section 1915(g) of the Act) are provided with limitations.

B. Tuberculosis Related Services

1. Covered services shall be defined as those services listed in Section 13603 of the Omnibus Reconciliation Act of 1993 as being related to the treatment of those persons with a diagnosis of tuberculosis disease. In accordance with Section 13603, room and board are not a covered service for patients completing treatment under observation

These services shall be prescribed by a physician and shall be part of a written plan of care approved by the Bureau of Tuberculosis Control of the Department of Health



20. Extended Services for Pregnant Women

A. Pregnancy-related and postpartum services for 60 days after the pregnancy ends are provided with no limitations. The Department of Health will provide the full range of services available under the District of Columbia Medicaid State Plan, as long as the required medical service is pregnancy related.

B. Services for any other medical condition that may complicate pregnancy are provided with no limitations. The Department of Health will provide the full range of services available under the District of Columbia Medicaid State Plan, as long as the required medical service is pregnancy related.

C. Tobacco Cessation Services include face-to-face counseling and tobacco cessation pharmacotherapy, as recommended in Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline", published by Public Health Service in May 2008, or any subsequent modification of this Guideline. Tobacco cessation services are provided by a Medicaid-enrolled physician or an Advanced Practice Registered Nurse (APRN) under the supervision of a Medicaid-enrolled physician. A physician or APRN, licensed or certified pursuant to District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 et seq. (2007 Repl.; 2011 Supp.)), shall prescribe products used for tobacco cessation pharmacotherapy. Cost Sharing is not imposed for Tobacco Cessation Services for pregnant women.

21. Ambulatory Prenatal Care for Pregnant Women Furnished During A Presumptive Eligibility Period by A Qualified Provider (in accordance with section 1920 of the Act) is provided.

22. Respiratory Care Services (in accordance with section 1902(e)(9)(A) through (C) of the Act) are not provided for ventilator dependent individuals.

23. Nurse practitioner services are provided in accordance with D.C. Law 10-247.

A. The services of the nurse practitioner are subsumed under the broad category, Advanced Practice Registered Nursing which includes, but is not limited to, nurse midwife, nurse anesthetist, nurse practitioner and clinical nurse specialist.

B. The services of the advanced practice registered nurse are to be carried out in general collaboration with a licensed health care provider.

24. Any Other Medical Care and Any Other Type of Remedial Care Recognized under State Law, Specified by the Secretary

A. Transportation services are not discussed under this section of the state plan. See Attachment 3.1-D.

B. Services of Christian Science Nurses are not provided.

C. Care and Services Provided in Christian Science Sanitaria are not provided.

24. Any Other Medical Care and Any Other Type of Remedial Care Recognized Under State Law, Specified by the Secretary (cont'd)

D. Nursing Facility Services provided for Patients under 21 Years of Age are provided with no limitations.

E. Emergency Hospital Services

1. The emergency room clinic physician encounter must be authenticated in the medical record by the signature of a licensed physician to be considered for reimbursement by the program.

2. Reimbursement by the State Agency is restricted to one encounter when the same patient is seen in both the emergency room and/or outpatient clinic department on the same day.

3. Reimbursement for induced abortions is provided only in cases where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy occurred as a result of rape or incest, and when the claim is accompanied by the following documentation:

a. Documentation that services were performed by a provider licensed to provide such services; and

b. Written documentation from the treating physician that the life of the mother would be endangered if the fetus were carried to term; or

c. Documentation that the pregnancy occurred as a result of rape or incest. For purposes of this requirement, documentation may consist of official reports; a written certification from the patient that the pregnancy occurred as a result of rape or incest; certification from the physician that the patient declared the pregnancy occurred as a result of rape or incest; or certification from the physician that in his or her professional opinion, the pregnancy resulted from 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).

(continued). Any other medical care and any other types of remedial care recognized under State law, specifically by the Secretary.

f. Personal Care Services, Prescribed in Accordance with a Plan of Treatment and Furnished by Qualified Persons Under Supervision of a Registered Nurse are covered with limitations

a. Covered Services

1. Personal Care Aide (PCA) services are services provided to individuals who require assistance with activities of daily living. Covered services include cueing, hands-on assistance, and safety monitoring related to activities of daily living including bathing, dressing, toileting, transferring and ambulation.

2. Section 1905(a)(24) of the Social Security Act authorizes the provision of PCA services in a person's home or, at the State's option, in another location.

3. Under Section 1905(a)(24) of the Social Security Act, PCA services shall not be provided to individuals who are inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled, or institution for mental disease. Additionally, PCA services must not be provided in any other living arrangement which includes personal care as a reimbursed service under the Medicaid program.

4. The District of Columbia will comply with the Electronic Visit Verification System (EVV) requirements for PCA services by January 1, 2021.

b. Service Authorization

1. All PCA services must be prior authorized. To be eligible for PCA services, a person must:

   (a) Be in receipt of a written order for PCA services, signed by a physician or Advanced Practice Registered Nurse (A.P.R.N) who: (1) is enrolled in Medicaid; and (2) has had a prior professional relationship with the person that included an examination(s) provided in a hospital, primary care physician's office, nursing facility, or at the person's home prior to the prescription of the personal care services.

   (b) Be unable to independently perform one or more activities of daily living for which personal care services are needed as established by the face-to face assessment conducted by DHCF or its agent.

   (c) Be in receipt of a PCA Service Authorization, which serves as the service plan approved by the state required by 42 C.F.R. § 440.167(a)(1), that authorizes the hours for which the individual is eligible.

2. For new beneficiaries, a request for an assessment shall be made to DHCF by the person seeking services, the person's representative, family member, or health care professional.

3. An R.N. or Licensed Independent Clinical Social Worker (LICSW) employed by DHCF or its designated agent shall conduct the initial face-to-face assessment or reassessment following the receipt of a request for an assessment.

4. The face-to-face assessment will utilize a standardized assessment tool, adopted by DHCF, to determine each person's level of need for Long Term Care Supports Services (LTCSS).

5. DHCF shall issue an assessment determination (PCA Service Authorization) that specifies the amount, frequency, duration, and scope of PCA services authorized to be provided to the person.

6. The supervisory nurse employed by the home health agency shall request that a face-to-face reassessment be conducted for each beneficiary at least once every twelve (12) months or upon a significant change in the beneficiary's health status.

7. Requests to conduct a reassessment based upon a significant change in the beneficiary's health status may be made at any time by the beneficiary, the beneficiary's representative, family member, or healthcare professional.

8. Through December 31, 2017, DHCF may authorize the validity of the face-to-face reassessment for a period not to exceed eighteen (18) months to align the level of need assessment date with the Medicaid renewal date.

9. Any reassessment based upon a significant change in the person's condition shall be accompanied by an order for services signed by the person's physician or APRN.

10. DHCF, or its agent, will make a referral for services to the person's choice of qualified provider upon completion of the initial assessment determination that authorizes PCA services (PCA Service Authorization).

c. **Scope of Services**

1. PCA services are provided to individuals who require assistance with activities of daily living.

2. In order to receive Medicaid reimbursement, PCA services shall include, but not be limited to, the following:

   (a) Cueing or hands-on assistance with performance of routine activities of daily living (such as, bathing, transferring, toileting, dressing, feeding, and maintaining bowel and bladder control);

   (b) Assisting with incontinence, including bed pan use, changing urinary drainage bags, changing protective underwear, and monitoring urine input and output;

   (c) Assisting persons with transfer, ambulation and range of motion exercises;

(1) Ensuring that the planning process includes individuals chosen by the person;

(2) Ensuring that the planning process incorporates the person's needs, strengths, preferences, and goals for receiving PCA services;

(3) Providing sufficient information to the person to ensure that he/she can direct the process to the maximum extent possible;

(4) Reflecting cultural considerations of the person and is conducted by providing all information in plain language or consistent with any Limited English Proficient (LEP) considerations;

(5) Strategies for solving conflicts or disagreements; and

(6) A method for the person to request updates to the plan.

3. After an initial plan of care is developed, all subsequent annual updates and modifications to plans of care shall be submitted to DHCF or its agent for approval in accordance with Section e.2 (Plan of Care), except the signature requirements prescribed under e.2 (e).

4. The Provider shall initiate services no later than twenty-four (24) hours after completing the plan of care unless the person's health or safety warrants the need for more immediate service initiation or the person and his/her representative agree that services should start at a later date.

5. The R.N. at minimum, shall visit each beneficiary within forty-eight (48) hours of initiating personal care services, and no less than every sixty (60) days thereafter, to monitor the implementation of the plan of care and the quality of PCA services provided to the beneficiary.

6. The R.N. shall notify the person's physician of any significant change in the person's condition.

7. The R.N. shall provide additional supervisory visits to each person if the situation warrants additional visits, such as in the case of an assignment of a new personal care aide or change in the person's condition.

8. If an update or modification to a person's plan of care requires an increase or decrease in the number of hours of PCA services provided to the person, the Provider must obtain an updated PCA Service Authorization from DHCF or its designated agent, subsequent to the request for reassessment for services.

9. Each Provider shall coordinate a beneficiary's care by sharing information with all other health care and service providers, as applicable, to ensure that the beneficiary's care is organized and to achieve safer and more effective health outcomes.

(f) Have an individual National Provider Identification (NPI) number obtained from National Plan and Provider Enumeration System (NPPES);

(g) Obtain at least twelve (12) hours of continuing education or in-service training annually in accordance with the Department of Health's Home Care Agency training requirements under 22-B DCMR§ 3915;

(h) Meet all of the qualifications for Home Health Aide trainees in accordance with Chapter 93 of Title 17, which includes the following:

(1) Be able to understand, speak, read, and write English at a fifth (5th) grade level;

(2) Be knowledgeable about infection control procedures; and

(3) Possess basis safety skills including being able to recognize an emergency and be knowledgeable about emergency procedures.

h. Service Limitations

1. The reimbursement of relatives other than the person's spouse, a parent of a minor child, or any other legally responsible relative or court-appointed guardian may provide PCA services. Legally responsible relatives do not include parents of adult children.

2. Family members providing PCA services must meet the PCA Requirements described under Section g.

25(i). **Licensed or Otherwise State-Approved Freestanding Birth Centers**

Provided: No limitations X Provided With limitations None licensed or approved

Please describe any limitations: See below

(A) Facilities must:

(1) Be licensed by the Department of Health (DOH) under Chapter 26 of Title 22 of the District of Columbia Municipal Regulations (DCMR);

(2) Be specifically approved by DOH to provider birth center/maternity center services; and

(3) Maintain standards of care required by DOH for licensure.

(B) Birth Centers shall cover services relating to three main components of care:

(1) Routine ante-partum care in any trimester shall include the following:

(a) Initial and subsequent history;

(b) Physical Examination;

(c) Recording of weight and blood pressure;

(d) Recording of fetal heart tones;

(e) Routine chemical urinalysis;

(f) Maternity counseling, such as risk factor assessment and referrals;

(g) Limitations on services for billing related to a normal, uncomplicated pregnancy (approximately fourteen (14) ante-partum visits include:

(i) Monthly visits up to 28 weeks gestation;

(ii) Thereafter, biweekly visits up to 36 weeks gestation;

(iii) Thereafter, weekly visits until delivery; and

(iv) Additional visits for increased monitoring during the ante-partum period beyond the fourteen (14) routine visits must be medically necessary to qualify for payments.

(2) Delivery services shall include:

(a) Admission history and physical examination;

(b) Management of uncomplicated labor;

(c) Vaginal delivery.

(3) Postpartum care

(a) Mother's Postpartum check within six (6) weeks of birth;

(b) Newborn screening test. Screening panel includes but is not limited to the following:

(i) PKU;

(ii) CAH;

(iii) Congenital hypothyroidism;

(iv) Hemogobinopathies;

(v) Biotinidase deficiency;

(vi) MSUD;

(vii) MCAD deficiency;

(viii) Homocystinuria; and

(ix) Galactosemisa.

(c) Limitations of services for a Well Baby Check (newborn assessment) include:

(i) One postpartum check per beneficiary;

(ii) Two tests per new born for screening on two separate dates of service; and

(iii) Two Well Baby Checks/assessments per newborn.

(ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: No limitations X Provided with limitations (please describe below)
Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations: Professionals will be reimbursed for those services included under Birth Center Services under 25 (i).

Please check all that apply:

X (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

The following practitioners may provide birth center services and must be licensed in the District of Columbia as a:

(a) Physician under Chapter 46 of Title 17 of the DCMR
(b) Pediatric nurse practitioner under Chapter 56 of Title 17 of the DCMR
(c) Family nurse practitioner under Chapter 56 of Title 17 of the DCMR
(d) Nurse midwife under Chapter 56 of Title 17 of the DCMR

X (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

(i) Licensed certified professional midwives

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*
N/A

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: (see b (i) above).

26. Rural Health Clinics and Federally Qualified Health Centers

A. Rural Health Clinic Services

The District of Columbia does not have any rural areas.

B. Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) services, as described in 26.B.2 through 5 of this section, are included in the reimbursement methodology described in Attachment 4.19-B, Part 1, beginning page 6f, Section 12.b.

1. General Provisions:

a. Prior to seeking Medicaid reimbursement, each FQHC must:

i. Be approved by the federal Health Resources Services Administration (HRSA) and meet the requirements set forth in the applicable provisions of Title XVIII of the Social Security Act and attendant regulations;

ii. Be screened and enrolled in the District of Columbia Medicaid program;

iii. Obtain a National Provider Identifier (NPI). The NPI shall be obtained for each site operated by an FQHC; and

iv. Submit the FQHC's Scope of Project approved by the Health Resources Services Administration (HRSA).

b. Medicaid reimbursable services provided by an FQHC shall be consistent with the Section 1905(a)(2) of the Social Security Act and furnished in accordance with section 4231 of the State Medicaid Manual.

c. Services may be provided at other sites including mobile vans, intermittent sites such as a homeless shelter, seasonal sites and a beneficiary's place of residence, provided the claims for reimbursement are consistent with the services described covered under Section 1905(a)(2) of the Social Security Act and in Section 26.B.2 through 5.

d. All services provided by an FQHC shall be subject to quality standards, measures and guidelines established by National Committee for Quality Assurance (NCQA), HRSA, CMS and the Department of Health Care Finance (DHCF).

e. Services for which an FQHC seeks Medicaid reimbursement pursuant to this Section and Attachment 4.19-B, Part 1, beginning page 6f, Section 12.b shall be delivered in accordance with the corresponding standards for service delivery, as

described in relevant sections of the District of Columbia State Plan for Medical Assistance and implementing regulations.

2. Primary Care Services

a. Covered Primary Care services provided by the FQHC shall be limited to the following services:

i. Health services related to family medicine, internal medicine, pediatrics, obstetrics (excluding services related to birth and delivery), and gynecology which include but are not limited to:

(1) Health management services and treatment for illness, injuries or chronic conditions (examples of chronic conditions include diabetes, high blood pressure, etc.) including, but not limited to, health education and self-management training;

(2) Services provided pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for Medicaid eligible children under the age of twenty-one (21);

(3) Preventive fluoride varnish for children, provided the service is furnished during a well-child visit by a physician or pediatrician who is acting within the District of Columbia's authorized scope of practice, or in accordance with the applicable professional practices act within the jurisdiction where services are provided ;

(4) Preventive and diagnostic services including but not limited to the following:

i. Prenatal and postpartum care rendered at an FQHC, excluding labor and delivery;

ii. Lactation consultation, education and support services if provided by a certified nurse mid-wife, who shall be licensed in accordance with the District of Columbia's statutory requirements on scope of practice or the applicable professional practices act within the jurisdiction where services are provided, and certified by the International Board of Lactation Consultant Examiners (IBLCE) or a registered lactation consultant certified by IBLCE;

iii. Physical exams;

iv. Family planning services;

v. Screenings and assessments, including but not limited to, visual acuity and hearing screenings, and nutritional assessments and referrals;

vi. Risk assessments and initial counseling regarding risks for clinical services;

vii. PAP smears, breast exams and mammography referrals when provided as part of an office visit; and

viii. Preventive health education.

ii. Incidental services and supplies that are integral, although incidental, to the diagnostic or treatment components of the services described in 26.B.1.a of this Section and included in allowable costs as described in Attachment 4.19-B, Part 1, page 6q, Section 12.b.viii. Incidental services and supplies include, but are not limited to, the following:

(1) Lactation consultation, education and support services that are provided by health care professionals described in 26.B.2 of this Section;

(2) Medical services ordinarily rendered by an FQHC staff person such as taking patient history, blood pressure measurement or temperatures, and changing dressings;

(3) Medical supplies, equipment or other disposable products such as gauze, bandages, and wrist braces;

(4) Administration of drugs or medication treatments, including administration of contraceptive treatments, that are delivered during a Primary Care visit, not including the cost of the drugs and medications;

(5) Immunizations;

(6) Electrocardiograms;

(7) Office-based laboratory screenings or tests performed by FQHC employees in conjunction with an encounter, which shall not include lab work performed by an external laboratory or x-ray provider. These services include, but are not limited to, stool testing for occult blood, dipstick urinalysis, cholesterol screening, and tuberculosis testing for high-risk beneficiaries; and

(8) Hardware and software systems used to facilitate patient record-keeping.

iii. Enabling services are those services that support an individual's management of their health and social service needs or improve the FQHC's ability to treat the individual and shall include the following:

(1) Health education and promotion services including assisting the individual in developing a self-management plan, executing the plan through self-monitoring and management skills, educating the individual on accessing care in appropriate settings and making healthy lifestyle and wellness choices; connecting the individual to peer and/or recovery supports including self-help and advocacy groups; and providing support for improving an individual's social network. These services shall be provided by health educators, with or without specific degrees in this area, family planning specialists, HIV specialists, or other professionals who provide information about health conditions and guidance about appropriate use of health services;

(2) Translation and interpretation services during an encounter. These services are provided by staff whose full time or dedicated time is devoted to translation and/or interpretation services or by an outside licensed translation and interpretation service provider. Any portion of the time of a physician, nurse, medical assistant, or other support and administrative staff who provides interpretation or translation during the course of his or her other billable activities shall not be included;

(3) Referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services). Such services shall not be reimbursed separately as enabling services where such

referrals are provided during the course of other billable treatment activities;;

(4) Eligibility assistance services designed to assist individuals in establishing eligibility for and gaining access to Federal, State and District programs that provide or financially support the provision of medical related services;

(5) Health literacy;

(6) Outreach services to identify potential patients and clients and/or facilitate access or referral of potential health center patients to available health center services, including reminders for upcoming events, brochures and social services; and

(7) Care coordination, which consists of services designed to organize person-centered care activities and information sharing among those involved in the clinical and social aspects of an individual's care to achieve safer and more effective healthcare and improved health outcomes. These services shall be provided by individuals trained as, and with specific titles of care coordinators, case managers, referral coordinators, or other titles such as nurses, social workers, and other professional staff who are specifically allocated to care coordination during assigned hours but not when these services are an integral part of their other duties such as providing direct patient care.

b. Primary Care services as set forth in this 26.B.1 of this Section shall be delivered by the following health care professionals, who shall be licensed in accordance with the District of Columbia's statutory requirements on scope of practice or the applicable professional practices act within the jurisdiction where services are provided:

i. A physician;
ii. An Advanced Practiced Registered Nurse (APRN);
iii. A physician assistant working under the supervision of physician; or
iv. A nurse-mid-wife.

3. Behavioral Health Services

a. Covered Behavioral Health services provided by an FQHC shall be limited to ambulatory mental health and substance abuse evaluation, treatment and management services identified by specific Current Procedural

Terminology (CPT) codes. Such codes include psychiatric diagnosis, health and behavioral health assessment treatment, individual psychotherapy, family therapy and pharmacologic management. DHCF shall issue a transmittal to the FQHCs which shall include the specific CPT codes including any billing requirements for covered Behavioral Health services. FQHCs that deliver substance abuse services must be certified by the Department of Behavioral Health.

b. Covered Behavioral Health services as set forth in this section shall be delivered by the following health care professionals, who shall be licensed in accordance with the District of Columbia's statutory requirements on scope of practice or the applicable professional practices act within the jurisdiction where services are provided:

i. A physician, including a psychiatrist;
ii. An APRN;
iii. A psychologist;
iv. A licensed independent clinical social worker;
v. A licensed independent social worker;
vi. A licensed graduate social worker;
vii. A licensed professional counselor;
viii. A licensed marriage and family therapist; and,
ix. A licensed psychologist associate.

4. Preventive and Diagnostic Dental Services

a. Covered Preventive and Diagnostic Dental services may include the following procedures:

i. Diagnostic procedures – clinical oral examinations, radiographs, diagnostic imagining, tests and examinations; and
ii. Preventive procedures – dental prophylaxis, topical fluoride treatment (office procedure), space maintenance (passive appliances and sealants).

b. All Preventive and Diagnostic Dental services shall be provided in accordance with the requirements, including any limitations, as set forth in Supplement 1 to Attachment 3.1-A, page 12, Section 10; Supplement 1 to Attachment 3.1-B, page 11, section 10.

c. Each provider of preventive Diagnostic Dental services, with the exception of children's fluoride varnish treatments, shall be a dentist or dental hygienist, working under the supervision of a dentist, who provide services consistent with the District of Columbia's statutory requirements on authorized scope of practice, or consistent with the applicable professional practices act within the jurisdiction where services are provided.

services consistent with the District of Columbia's statutory requirements on authorized scope of practice, or consistent with the applicable professional practices act within the jurisdiction where services are provided.

5. Comprehensive Dental Services

a. Covered Comprehensive Dental services provided by the FQHC shall include the following procedures:

i. Restorative procedures - amalgam restoration, resin-based composite restorations, crowns (single restorations only), and additional restorative services;
ii. Endodontic procedures- pulp capping, pulpotomies, endodontic therapy of primary and permanent teeth, endodontic retreatment, apexification/recalcification procedures, apicoectomy/periradicular services, and other endodontic services;
iii. Peridontic procedures - surgical services, including usual postoperative care), nonsurgical periodontal services, and other periodontal services;
iv. Prosthodontic procedures- complete and partial dentures treatment including repairs and rebasing, interim prosthesis, and other removable prosthetic services;
v. Maxillofacial Prosthetics procedures- the surgical stent procedure;
vi. Implants Services - Pre-surgical and surgical services, implant-supported prosthetics, and other implant services;
vii. Oral and Maxillofacial Surgery - treatment and care related to extractions, alveoloplasty, vestibuloplasty, surgical treatment of lesions, treatment of fractures, repair traumatic wounds including complicated suturing;
viii. Orthodontics - orthodontic treatments and services; and
ix. Adjunctive General Services - unclassified treatment, anesthesia, professional consultation, professional visits, drugs and miscellaneous.

b. All Comprehensive Dental services shall be provided in accordance with the requirements, including any limitations, as set forth in Supplement 1 to Attachment 3.1-A, page 12, Section 10; and Supplement 1 to Attachment 3.1-B, page 11, Section 10

c. Each provider of Comprehensive Dental services, with the exception of children's fluoride varnish treatments, shall be a dentist or dental hygienist, working under the supervision of a dentist, who provide services consistent with the District of Columbia's statutory requirements on authorized scope of practice, or consistent with the applicable

professional practices act within the jurisdiction where services are provided.

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy

29. 1905(a)(29) __X__ MAT as described and limited in Supplement __1__ to Attachment 3.1-A.

29. 1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020, and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

The state covers the following counseling services and behavioral health therapies as part of MAT.

a. Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

Medication Assisted Treatment Counseling and Behavioral Therapy Services

Service	**Service Description**	**Provider**
Crisis Intervention	An immediate, short-term opioid abuse treatment approach that is intended to	1. Qualified counselors in Department of Behavioral Health (DBH) certified

	assist an individual to resolve a personal crisis. Crises are events that significantly jeopardize treatment, recovery progress, health, and/or safety.	treatment facilities, programs or community-based settings. 2. Qualified practitioners who may serve as a counselor and provide crisis intervention services include: • Physicians • Psychologists • Licensed Independent Clinical Social Workers • Advanced Practice Registered Nurses • Registered Nurses • Licensed Professional Counselors • Licensed Independent Social Workers • Licensed Marriage and Family Therapists • Licensed Graduate Social Workers • Certified Addiction Counselors
Opioid Abuse Counseling (Individual, Group, and Family)	A face-to-face, interactive process conducted in individual, group, or family settings and focused on assisting an individual who is manifesting an opioid use disorder. The aim of Opioid Abuse Counseling is to cultivate the awareness, skills, and supports to facilitate long-term recovery from opioid abuse.	1. Qualified counselors in DBH certified treatment facilities, programs or community-based settings. 2. Qualified practitioners who may serve as a counselor and provide opioid abuse counseling include: • Physicians • Psychologists • Licensed Independent Clinical Social Workers • Advanced Practice Registered Nurses • Registered Nurses

	Opioid Abuse Counseling addresses the specific issues identified in a treatment plan. Opioid Abuse Counseling shall be conducted in accordance with the requirements established in District regulations as follows: • Individual Opioid Abuse Counseling is face-to-face interaction with an individual for the purpose of assessment or supporting the patient's recovery. • Group Opioid Abuse Counseling facilitates disclosure of issues that permit generalization to a larger group; promotes help-seeking and supportive behaviors; encourages productive and positive interpersonal communication; provides psycho-education; and develops motivation through peer pressure, structured confrontation and constructive feedback. • Family Opioid Abuse Counseling is planned, goal-oriented therapeutic interaction between a qualified practitioner, the beneficiary, and his or her family. Family Counseling may also occur without the beneficiary present if it is for the benefit of the	• Licensed Professional Counselors • Licensed Independent Social Workers • Licensed Marriage and Family Therapists • Licensed Graduate Social Workers • Certified Addiction Counselors

	beneficiary and related to opioid use disorder recovery. A family member is an individual identified by the beneficiary as a person with whom the beneficiary has a significant relationship and whose participation is important to the beneficiary's recovery. Family therapy service that involves the participation of a non-Medicaid eligible individual is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.	

b. Please include each practitioner and provider entity that furnishes each service and component service.

See table above.

c. Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

Medication Assisted Treatment Provider Qualifications

Provider	Qualifications
Physician	Licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.
Psychologist	Licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.
Licensed Independent Clinical Social Worker	Licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.
Advanced Practice Registered Nurse	Licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.
Registered Nurse	Licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.
Licensed Professional Counselor	Licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.
Licensed Independent Social Worker	Licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.
Licensed Marriage and Family Therapist	Licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.
Licensed Graduate Social Worker	Licensed by the District of Columbia to furnish services within their scope of practice in accordance with state law.
Certified Addiction Counselor	1. Certified by the Board of Professional Counseling (Board) as an addiction counselor in accordance with state law. 2. Meets one of the following educational or experience requirements: • Graduated with an associate degree in health or human services from an accredited institution that incorporates the academic course work and minimum hours of supervised training required by the Board and whose program is accredited by an agency recognized by the U.S. Department of Education; or

	• Has at least 2 years of documented, supervised experience in the field of addiction counseling. 3. Passed a national exam approved by the Board. 4. Practices addiction counseling under the supervision of a qualified health professional.

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)

__X__ Generic first policy
__X__ Preferred drug lists
__X__ Clinical criteria
__X__ Quantity limits

_____ The state does not have drug utilization controls in place.

v. Limitations: Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

Service	**Limitations**
Methadone for MAT	A beneficiary can be prescribed a maximum of one (1) dose/unit per day. An initial and second authorization cover a period of ninety (90) days each; subsequent authorizations must not exceed one hundred and eighty (180) days each. The maximum number of doses over a twelve (12) month period is two hundred-fifty (250) units of medication. Any dosing over two hundred-fifty (250) units will require DBH review and authorization. These limitations may be exceeded based on a determination of medical necessity through the prior authorization (PA) process.
All other non-Methadone MAT drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355)	May be prescribed and dispensed without PA up to the U.S. Food and Drug Administration (FDA) approved maximum daily dose, but PA is required to prescribe and dispense at amounts

	above the FDA approved maximum daily dose.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden,

to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.