TO: Medical Care Advisory Committee

DATE: May 12, 2022

FROM: Paula Clark, Manager, Medical Benefits, Policy and Program

SUBJECT: Signatures for Medicaid Home Health Services

Agenda Item No.: #6bi

Amendments to: Sections 354.1031, 354.1035, 354.1037, 354.1039, 354.1040, and 354.1043 in the Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A, Division 3, Medicaid Home Health Services.

BACKGROUND: ☐ Federal Requirement ☐ Legislative Requirement ☒ Other: Program Initiative

The purpose of the proposal is in response to recent federal legislation that prompted the Centers for Medicare & Medicaid Services (CMS) to issue interim final rule, CMS-5531-IFC (Interim Final Rule with Comment), to expand the healthcare workforce during the COVID-19 pandemic. CMS-5531-IFC is a permanent federal regulation that is not subject to the COVID-19 Public Health Emergency and became effective on May 8, 2020, with a retroactive application date of March 1, 2020.

To align the Medicaid home health services rules with CMS-5531-IFC, this proposal changes the requirement that a plan of care for covered Medicaid home health services can only be recommended, signed, and dated by a recipient's physician by adding "allowed practitioner" to each rule that currently applies only to a physician. The purpose for these changes is to allow a physician assistant (PA) or an advanced practice registered nurse who is licensed as a certified nurse practitioner (CNP) or clinical nurse specialist (CNS) to order home health services as described in the proposed rules. The proposed amendments define "allowed practitioner" as an individual that has a valid and registered prescriptive authority agreement in accordance with state law and is licensed as a PA, CNP, or CNS.

The proposed amendments remove rules that are no longer needed because of the addition of "allowed practitioner"; relocates the rules on non-billable skilled nursing services; and adds a legally authorized representative and a court appointed guardian to the list of persons who have been or could be taught to administer injections to a recipient in a rule that describes when a nursing visit for the purpose of administering medications is not covered.

ISSUES AND ALTERNATIVES:

There are no anticipated issues or concerns related to the proposed amendments. The proposed amendments decrease the administrative burden on physicians who have been the only practitioner who can perform these functions for recipients who need Medicaid home health services by allowing a PA, CNP, or CNS to certify eligibility for Medicaid home health services and to establish and periodically review the home health plan of care.

STAKEHOLDER INVOLVEMENT:

HHSC posted the draft rules for informal comments from October 25, 2021 to November 8, 2021 and received two comments. A commenter, representing Abundant Health Care Inc., requested that HHSC consider making the skilled nursing service described in §354.1039(b)(6)(A) a billable visit as opposed to a non-billable visit because a nursing visit made by a registered nurse for the primary purpose of assessing a recipient's care needs to develop a plan of care are a financial burden for a home health agency. HHSC did not make any changes in response to the comment. Making the skilled nursing service described in §354.1039(b)(6)(A) a billable visit is outside the scope of this proposal.

A representative of the Texas Nurse Practitioners expressed appreciation to HHSC for making these important changes and expressed there has been a great deal of positive feedback from their members. However, the commenter expressed a concern that there appears to be a conflict between the proposed amendments in §354.1039(a)(5)(C) that states physical therapy is a payable benefit when the patient's condition is expected to improve "based on the physician's or allowed practitioner's assessment" and the current rule in §354.1291(b) that states for physical therapy services to be reimbursed under the Medicaid program, they must be "prescribed by a physician." The commenter asked HHSC to include an amendment to §354.1291(b) in this project to alleviate any confusion for providers or their patients. HHSC did not make any changes in response to this comment because §354.1039 applies to benefits and limitations for Medicaid Home Health Services and §354.1291 applies to the benefits and limitations for physical therapy services covered by Medicaid and are billed by a licensed physical therapist. Amending §354.1291 as suggested is outside the scope of this proposal.

FISCAL IMPACT:

☒ None

RULE DEVELOPMENT SCHEDULE:

May 12, 2022	Present to the Medical Care Advisory Committee
May 19, 2022	Present to HHSC Executive Council
June 2022	Publish proposed rules in *Texas Register*
October 2022	Publish adopted rules in *Texas Register*
October 2022	Effective date

REQUESTED ACTION: ***(Check appropriate box)***

☒ The MCAC recommends approval of the proposed rules for publication.

☐ Information Only

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 354 MEDICAID HEALTH SERVICES
SUBCHAPTER A PURCHASED HEALTH SERVICES
DIVISION 3 MEDICAID HOME HEALTH SERVICES

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §354.1031, concerning General; §354.1035, concerning Recipient Qualifications for Home Health Services; §354.1037, concerning Written Plan of Care; §354.1039, Home Health Services Benefits and Limitations; §354.1040, concerning Requirements for Wheeled Mobility Systems; and §354.1043, concerning Competitive Procurement of Durable Medical Equipment (DME) and Supplies.

BACKGROUND AND PURPOSE

The purpose of the proposal is in response to recent federal legislation that prompted the Centers for Medicare & Medicaid Services (CMS) to issue interim final rule, CMS-5531-IFC (Interim Final Rule with Comment), to expand the healthcare workforce during the COVID-19 pandemic. CMS-5531-IFC is a permanent federal regulation that is not subject to the COVID-19 Public Health Emergency and became effective on May 8, 2020, with a retroactive application date of March 1, 2020.

To align the Medicaid home health services rules with CMS-5531-IFC, this proposal changes the requirement that a plan of care for covered Medicaid home health services can only be recommended, signed, and dated by a recipient's physician and allows a physician assistant (PA) or an advanced practice registered nurse who is licensed as a certified nurse practitioner (CNP) or clinical nurse specialist (CNS) to order home health services as described in the proposed rules.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §354.1031 adds definitions of “allowed practitioner,” “durable medical equipment (DME),” “HHSC,” and “supplies”. The proposed amendment revises the definitions of “home health aide,” “home health agency,” “home health services,” and “plan of care.” The proposed amendment deletes the definitions of “Department,” “Medicare fee schedule,” “expendable medical supply acquisition fee,” and “expendable medical supplies.”

The proposed amendment to §354.1035 adds “allowed practitioner” to allow a PA, CNP, or CNS to order home health services.

The proposed amendment to §354.1037 adds “allowed practitioner” to allow a PA, CNP, or CNS to order home health services.

The proposed amendment to §354.1039 revises the title of the section to "Benefits and Limitations of Home Health Services" and adds "allowed practitioner" to allow a PA, CNP, or CNS to order home health services. The proposed amendment reorganizes the section for readability and updates terminology to align with new definitions in §354.1031. The proposed amendment also adds a legally authorized representative and a court appointed guardian to the list of persons who have been or could be taught to administer injections to a recipient in subsection (b)(3)(D). The proposed amendment includes minor editorial changes that improve clarity.

The proposed amendment to §354.1040 adds "allowed practitioner" in subsection (e)(1). The proposed amendment updates references to state law, and includes minor editorial changes.

The proposed amendment to §354.1043 adds "allowed practitioner" in paragraph (1)(B). The proposed amendment replaces "department" with "HHSC" and includes minor editorial changes.

FISCAL NOTE

Trey Wood, HHSC Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

(1) the proposed rules will not create or eliminate a government program;

(2) implementation of the proposed rules will not affect the number of HHSC employee positions;

(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;

(4) the proposed rules will not affect fees paid to HHSC;

(5) the proposed rules will not create a new rule;

(6) the proposed rules will not expand, limit, or repeal existing rules;

(7) the proposed rules will not change the number of individuals subject to the rules; and

(8) the proposed rules will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there will be no adverse economic effect on small businesses or micro-businesses because there is no requirement to alter current business practices. No rural communities contract as providers of Medicaid home health services.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Stephanie Stephens, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the rules will enhance access to Medicaid home health services by allowing a PA, CNP, or CNS to order home health services for eligible recipients. The proposed rules will also decrease the administrative burden and demands of direct care services provided by physicians.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because the proposed rules do not require a change in business practices nor do they impose additional fees or costs.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 701 W. 51st Street, Austin, Texas 78751; or emailed to HHSRulesCoordinationOffice@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before

midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 22R023" in the subject line.

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration.

The amendments affect recent federal legislation implemented during the COVID-19 pandemic that prompted the Centers for Medicare & Medicaid Services (CMS) to issue interim final rule, CMS-5531-IFC, to expand the healthcare workforce during the COVID-19 Pandemic. CMS-5531-IFC is a permanent federal regulation that is not subject to the COVID-19 Public Health Emergency and became effective on May 8, 2020 with a retroactive application date of March 1, 2020.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 438-2934.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language (No change.) = No changes are being considered for the designated subdivision

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 354 MEDICAID HEALTH SERVICES
SUBCHAPTER A PURCHASED HEALTH SERVICES
DIVISION 3 MEDICAID HOME HEALTH SERVICES

§354.1031. General.

(a) Purpose. The purpose of this division [~~subchapter~~] is to establish rules for the Title XIX (Medicaid) home health services benefit [~~benefits~~].

(b) Definitions. The following words and terms when used in this division [~~subchapter~~], [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) Allowed practitioner--An individual:

(A) that maintains a valid and registered prescriptive authority agreement in accordance with Texas Occupations Code, Chapter 157, Subchapter B; and

(B) is licensed as:

(i) a physician assistant under Texas Occupations Code, Chapter 204; or

(ii) an advanced practice registered nurse licensed by the Texas Board of Nursing as a:

(I) certified nurse practitioner; or

(II) clinical nurse specialist.

(2) Durable medical equipment (DME)--Equipment and appliances that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.

(3) HHSC--The Texas Health and Human Services Commission or its designee.

(4) Home health aide--An individual who meets the Medicare home health agency personnel qualifications and training requirements established for home health aides in 42 CFR §484.80.

(5) Home health aide services--Services which can be provided by a qualified home health aide, including those listed in 42 CFR §484.80.

(6) Home health agency--A public or private agency or organization, licensed by

the State of Texas to provide home health services and qualified to participate as a Medicare home health agency under 42 CFR, Part 484, Subparts A – C (relating to Home Health Services).

(7) [~~(1)~~] Home health services--Covered services, DME [~~equipment, appliances~~] and supplies which are provided to a qualified Medicaid recipient [~~recipients~~] at the recipient's [~~their~~] place of residence by home health agency staff or[~~,~~] providers of DME [~~durable medical equipment,~~] and [~~or expendable medical~~] supplies under [~~federal regulations~~] 42 CFR §440.70 and §354.1037 of this division [~~title~~] (relating to Written Plan of Care) and §354.1039 of this title (relating to Benefits and Limitations of Home Health Services [~~Benefits and Limitations~~]).

(8) Intermittent--Home health aide or skilled nursing services provided less than on a daily basis, less than eight hours per day.

(9) Part-time--Home health aide or skilled nursing services provided any number of days per week, less than eight hours per day.

[~~(2) Home health agency--A public or private agency or organization, licensed by the state to provide home health services and qualified to participate as a Medicare home health agency under 42 CFR, Part 484, §§484.1-484.52 (Conditions for Participation of Home Health Agencies).~~]

(10) [~~(3)~~] Plan of care--A written regimen established and periodically reviewed by a physician or an allowed practitioner in consultation with home health agency staff, which meets the plan of care standards at 42 CFR §484.60 [~~§484.18~~] and §354.1037 of this division [~~title~~].

(11) Supplies--Health care related items that are required to address an individual's medical disability, illness, or injury and are:

(A) consumable or disposable; or

(B) cannot withstand repeated use by more than one individual.

[~~(4) Home health aide--An individual who meets the Medicare home health agency personnel qualifications and training requirements established for home health aides at 42 CFR §484.4 and §484.36.~~]

[~~(5) Home health aide services--Services which can be provided by a qualified home health aide, including those listed at 42 CFR §484.36.~~]

[~~(6) Department--The Texas Department of Health and or its designee.~~]

[~~(7) Part-time--Home health aide or skilled nursing services provided any number of days per week less than eight hours per day.~~]

[~~(8) Intermittent--Home health aide or skilled nursing services provided less than on a daily basis less than eight hours per day.~~]

[~~(9) Medicare fee schedule--The fee schedule established by the Medicare~~

~~program for expendable medical supplies and durable medical equipment.~~]

[~~(10) Expendable medical supply acquisition fee--The fee determined by the department or its designee by periodic sampling of suppliers or from information provided in manufacturer's publications, whichever is lesser.~~]

[~~(11) Expendable medical supplies--Medical supplies which meet one or both of the following criteria:~~

~~(A) the typical term of use is within one year of purchase; or~~

~~(B) reimbursement is made at a cost of $1,000 or less.~~]

[~~(12) Durable medical equipment--Machinery and/or equipment which meets one or both of the following criteria:~~

~~(A) the projected term of use is more than one year; or~~

~~(B) reimbursement is made at a cost more than $1,000.~~]

§354.1035. Recipient Qualifications for Home Health Services.

(a) An eligible Medicaid recipient must meet the following requirements to qualify for Medicaid home health services.[~~:~~]

(1) An eligible recipient must be under the continuing care and medical supervision of a physician or an allowed practitioner who has established a plan of care or submitted a request form for the recipient in accordance with §354.1037 or §354.1039 of this division [~~title~~] (relating to Written Plan of Care and Benefits and Limitations of Home Health Services [~~Benefits and Limitations~~]). A recipient [~~Recipients~~] must be seen by the recipient's [~~their~~] physician or allowed practitioner within 30 days prior to the start of home health services. This [~~physician~~] visit may be waived when a diagnosis has already been established by the physician or allowed practitioner and the recipient is under the continuing care and medical supervision of the physician or allowed practitioner. Any waiver must be based on the physician's or allowed practitioner's statement that an additional evaluation visit is not medically necessary.[~~;~~]

(2) An eligible recipient must have a medical need for covered home health services as documented in the recipient's plan of care or request form for the recipient in accordance with §354.1037 or §354.1039 of this division [~~(of this title (relating to Written Plan of Care and Home Health Services Benefits and Limitations); and~~].

(3) An eligible recipient must receive services that meet the recipient's existing medical needs, subject to §354.1039 of this division[~~, of this title (relating to Home Health Services Benefits and Limitations)~~] and that can be safely provided in the recipient's home.

(b) The home health service, supply, or item of durable medical equipment[~~, or appliance~~] must:

(1) be prior authorized by HHSC [~~the department~~], unless otherwise specified by HHSC [~~the department~~];

(2) be prescribed by a physician or an allowed practitioner who is currently licensed;

(3) be medically necessary, as documented in the plan of care or [~~and/or~~] the request form for the recipient[~~,~~] in accordance with §354.1037 and §354.1039 of this division [~~(of this title (relating to Written Plan of Care and Home Health Services Benefits and Limitations)~~];

(4) be provided to a recipient in the recipient's [~~their~~] place of residence; and

(5) meet accepted industry standards for safety where applicable.

§354.1037. Written Plan of Care.

(a) A plan of care must be recommended, signed and dated by the recipient's [~~attending~~] physician or allowed practitioner.

(b) The plan of care must contain the following information:

(1) all pertinent diagnoses;

(2) mental status;

(3) types of services, including amount, duration and frequency;

(4) equipment required;

(5) prognosis;

(6) rehabilitation potential;

(7) functional limitations;

(8) activities permitted;

(9) nutritional requirements;

(10) medications;

(11) treatments, including amount and frequency;

(12) safety measures to protect against injury;

(13) instructions for timely discharge or referral; and

(14) date the recipient was last seen by the physician or allowed practitioner.

(c) Orders [~~Physician orders~~] for therapy services must include:

(1) the specific procedures and modalities to be used;

(2) the amount, frequency, and duration; and

(3) the therapist who participated in developing the plan of care.

(d) The plan of care must be reviewed by the physician or allowed practitioner and the home health agency personnel as often as the severity of the recipient's [~~patient's~~] condition requires or at least once every 60 days.

(e) Verbal [~~Oral physician~~] orders may only be given to persons authorized to receive them under state and federal law. They must be reduced to writing, signed and dated by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered service, and placed in the recipient's chart.

(f) The plan of care must [~~shall~~] be initiated by a [~~the~~] registered nurse.

§354.1039. Benefits and Limitations of Home Health Services. [~~Home Health Services Benefits and Limitations.~~]

(a) HHSC [~~The Health and Human Services Commission or its designee (HHSC)~~] determines authorization requirements and limitations for covered home health services [~~service benefits~~]. The home health agency is responsible for obtaining prior authorization where specified for the home health [~~healthcare~~] service, supply, or item of durable medical equipment (DME)[~~, or appliance~~]. Home health services [~~service benefits~~] include the following:

(1) Skilled nursing. Nursing services provided by a registered nurse (RN) or licensed vocational nurse (LVN) licensed by the Texas Board of Nursing provided on a part-time or intermittent basis and furnished through an enrolled home health agency are covered home health services [~~benefits~~]. Billable nursing visits may [~~also~~] include:

(A) nursing visits required to teach the recipient, the primary caregiver, a family member, or a [~~and/or~~] neighbor how to administer or assist in a service or activity that is necessary to the care and [~~and/or~~] treatment of the recipient in a home setting; and

(B) RN visits for skilled nursing observation, assessment, and evaluation, provided:

(i) a physician or an allowed practitioner specifically requests that an RN visits [~~a nurse visit~~] the recipient for this purpose; and[~~.~~]

(ii) the request reflects the need for the assessment visit.

[~~(i) The physician's request must reflect the need for the assessment visit.~~]

[~~(ii) Nursing visits for the primary purpose of assessing a recipient's care needs to develop a plan of care are considered administrative and are not billable; and~~]

[~~(C) RN visits for general supervision of nursing care provided by a home health aide and/or others over whom the RN is administratively or professionally responsible.~~]

(2) Home health aide services. Home health aide services to provide personal care under the supervision of an RN, a licensed physical therapist (PT), or a licensed [~~an~~] occupational therapist (OT) employed by the home health agency are covered home health services [~~benefits~~].

(A) The primary purpose of a home health aide visit must be to provide personal care services.

(B) Duties of a home health aide include:

(i) the performance of simple procedures such as personal care, ambulation, exercise, range of motion, safe transfer, positioning, and household services essential to health care at home;

(ii) assistance with medications that are ordinarily self-administered;

(iii) reporting changes in the recipient's [~~patient's~~] condition and needs; and

(iv) completing appropriate records.

(C) Written instructions for home health aide services must be prepared by an RN, a PT, or an OT, [~~or therapist~~] as appropriate.

(D) The requirements for home health aide supervision are as follows.

(i) When only home health aide services are being furnished to a recipient, an RN must make a supervisory visit to the recipient's residence at least once every 60 days. These supervisory visits must occur when the aide is furnishing patient care.

(ii) When skilled nursing care, PT, or OT are also being furnished to a recipient, an RN must make a supervisory visit to the recipient's residence at least every two weeks.

(iii) When only PT or OT is furnished in addition to the home health aide services, the appropriate skilled therapist may make the supervisory visits in place of an RN.

(E) Visits made primarily for performing housekeeping services are not covered services.

(3) Supplies [~~Medical supplies~~]. Supplies [~~Medical supplies~~] are a covered home health services benefit [~~benefits~~] if they meet the following criteria.

(A) Supplies [~~Medical supplies~~] must be:

(i) documented in the recipient's plan of care as medically necessary and

used for medical or therapeutic purposes;

(ii) supplied:

(I) through an enrolled home health agency in compliance with the recipient's plan of care; or

(II) by an enrolled medical supplier under written, signed, and dated physician's or allowed practitioner's prescription; and

(iii) prior authorized unless otherwise specified by HHSC.

(B) Items which are not listed in subparagraph (C) of this paragraph may be medically necessary for the treatment or therapy of a qualified recipient [~~recipients~~]. If a prior authorization request is received for these items, consideration will be given to the request. Approval for reasonable amounts of the requested items may be given if circumstances justify the exception and the need is documented.

(C) Covered items include:

(i) colostomy and ileostomy care supplies;

(ii) urinary catheters, appliances and related supplies;

(iii) pressure pads including elbow and heel protectors;

(iv) incontinent supplies to include incontinent pads or diapers for a recipient [~~clients~~] over the age of four for medical necessity as determined by the physician or allowed practitioner;

(v) crutch and cane tips;

(vi) irrigation sets;

(vii) supports and abdominal binders (not to include braces, orthotics, or prosthetics);

(viii) medicine chest supplies not requiring a prescription (not to include vitamins or personal care items such as soap or shampoos);

(ix) syringes, needles, IV tubing, or [~~and/or~~] IV administration setups, including IV solutions generally used for hydration or prescriptive additives;

(x) dressing supplies;

(xi) thermometers;

(xii) suction catheters;

(xiii) oxygen and related respiratory care supplies; or

(xiv) feeding related supplies.

(4) DME [~~Durable medical equipment (DME)~~]. DME [~~Durable Medical Equipment~~] must meet the following requirements to qualify for reimbursement under Medicaid home health services.

(A) DME must:

(i) be medically necessary and the appropriateness of the medical [~~health care service, supply,~~] equipment[~~,~~] or appliance prescribed by the physician or allowed practitioner for the treatment of the individual recipient [~~and delivered~~] in the recipient's [~~his~~] place of residence must be documented in:

(I) the plan of care; or [~~and/or~~]

(II) the request form described in subsection (b)(2) of this section;

(ii) be prior authorized unless otherwise specified by HHSC;

(iii) meet the recipient's existing medical and treatment needs;

(iv) be considered safe for use in the home; and

(v) be provided through an:

(I) enrolled home health agency under a current physician's or allowed practitioner's plan of care; or

(II) enrolled DME supplier under a written, signed, and dated physician's or allowed practitioner's prescription.

(B) HHSC will determine whether DME will be rented, purchased, or repaired based upon the duration and use needs of the recipient.

(i) Periodic rental payments are made only for the lesser of:

(I) the period of time the equipment is medically necessary; or

(II) when the total monthly rental payments equal the reasonable purchase cost for the equipment.

(ii) Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.

(iii) Repair of DME [~~durable medical equipment and appliances~~] will be considered based on the age of the item and the cost to repair the item.

(I) A request for repair of DME [~~durable medical equipment or appliances~~] must include an itemized estimated cost list of the repairs. Rental equipment may be provided to replace purchased DME [~~medical equipment or appliances~~] for the period of time it will take to make necessary repairs to purchased DME [~~medical equipment or appliances~~].

(II) Repairs will not be authorized in situations where the equipment

has been abused or neglected by the recipient or the recipient's legally authorized representative (LAR), court appointed guardian, [~~patient, patient's~~] family, or caregiver.

(III) Routine maintenance of rental equipment is the responsibility of the provider.

(C) Covered DME that may be rented, purchased, or repaired includes [~~medical appliances and equipment (rental, purchase, or repairs) include~~]:

(i) non-customized manual or powered wheelchairs, including medically justified seating, supports, and equipment;

[~~(I) non-customized including medically justified seating, supports, and equipment; or~~]

(ii) [~~(II)~~] customized manual or power wheelchairs, specifically tailored or individualized, powered wheelchairs, including appropriate medically justified seating, supports, and equipment not to exceed an amount specified by HHSC;[~~.~~]

(iii) [~~(ii)~~] canes, crutches, walkers, and trapeze bars;

(iv) [~~(iii)~~] bed pans, urinals, bedside commode chairs, elevated commode seats, and bath chairs/benches/seats;

(v) [~~(iv)~~] electric and non-electric hospital beds and mattresses;

(vi) [~~(v)~~] air flotation or air pressure mattresses and cushions;

(vii) [~~(vi)~~] bed side rails and bed trays;

(viii) [~~(vii)~~] reasonable and appropriate appliances for measuring blood pressure and blood glucose suitable to the recipient's medical situation to include replacement parts and supplies;

(ix) [~~(viii)~~] lifts for assisting recipient to ambulate within residence;

(x) [~~(ix)~~] pumps for feeding tubes and IV administration; and

(xi) [~~(x)~~] respiratory or oxygen related equipment.

(D) DME [~~Medical equipment or appliances~~] not listed in subparagraph (C) of this paragraph may, in exceptional circumstances, be considered for payment when it can be medically substantiated as a part of the treatment plan that such service would serve a specific medical purpose on an individual case basis.

(5) Physical therapy. To be payable as a home health benefit, physical therapy services must:

(A) be provided by a physical therapist who is currently licensed by the Texas Board of Physical Therapy Examiners, or physical therapist assistant who is licensed by the Texas Board of Physical Therapy Examiners who assists and is supervised by

a licensed physical therapist;

(B) be for the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition;

(C) be expected to improve the recipient's [~~patient's~~] condition in a reasonable and generally predictable period of time, based on the physician's or allowed practitioner's assessment of the recipient's [~~patient's~~] restorative potential after any needed consultation with the physical therapist; and

(D) not be provided when the recipient [~~patient~~] has reached the maximum level of improvement. Repetitive services designed to maintain function once the maximum level of improvement has been reached are not a benefit. Services related to activities for the general good and welfare of a recipient [~~patients~~] such as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation are not reimbursable.

(6) Occupational therapy. To be payable as a home health benefit, occupational therapy services must be:

(A) provided by an occupational therapist [~~one~~] who is currently [~~registered and~~] licensed by the Texas Board of Occupational Therapy Examiners or by an occupational therapist assistant who is licensed by the Texas Board of Occupational Therapy Examiners to assist in the practice of occupational therapy and is supervised by an occupational therapist;

(B) for the evaluation and function-oriented treatment of a recipient [~~individuals~~] whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition; and

(C) specific goal-directed [~~goal directed~~] activities to achieve a functional level of mobility and communication and to prevent further dysfunction within a reasonable length of time based on the occupational therapist's evaluation and the physician's or allowed practitioner's assessment and plan of care.

(7) Insulin syringes and needles. Insulin syringes and needles must meet the following requirements to qualify for reimbursement under Medicaid home health services.

(A) Pharmacies enrolled in the Medicaid Vendor Drug Program may dispense insulin syringes and needles to an eligible Medicaid recipient [~~recipients~~] with a physician's or an allowed practitioner's prescription.

(B) Prior authorization is not required for an eligible recipient to obtain insulin syringes and needles.

(C) Insulin syringes and needles obtained in accordance with this section will be reimbursed through the Medicaid Vendor Drug Program.

(D) A physician's or an allowed practitioner's plan of care is not required for

an eligible recipient to obtain insulin syringes and needles under this section.

(8) Diabetic supplies and related testing equipment. Diabetic supplies and related testing equipment must meet the following requirements to qualify for reimbursement under Medicaid home health services.

(A) Diabetic supplies and related testing equipment must be prescribed by a physician or an allowed practitioner.

(B) Prior authorization is required unless otherwise specified by HHSC.

(b) Home health service limitations include the following.

(1) Recipient [~~Patient~~] supervision.

(A) A recipient [~~Patients~~] must be seen by the recipient's [~~their~~] physician or allowed practitioner, [~~if consistent with subparagraph (C) of this paragraph, a nurse practitioner, clinical nurse specialist, or physician assistant,~~] within 30 days prior to the start of home health services. This requirement [~~physician visit~~] may be waived when a diagnosis has already been established by the [~~attending~~] physician or allowed practitioner and the recipient [~~patient~~] is currently undergoing active medical care and treatment. Such a waiver is based on the physician's or allowed practitioner's statement that an additional evaluation visit is not medically necessary.

(B) A recipient [~~Patients~~] receiving home health care services must remain under the care and supervision of a physician or an allowed practitioner who reviews and revises the plan of care at least every 60 days or more frequently as the physician or allowed practitioner determines necessary.

[~~(C) If the face-to-face encounter is performed by a nurse practitioner, clinical nurse specialist, or physician assistant, the practitioner must communicate the clinical findings of that encounter to the ordering physician, and the physician ordering the services must:~~]

[~~(i) record the date of the face-to-face encounter and the practitioner who conducted the encounter;~~]

[~~(ii) affirm that the face-to-face encounter is related to the primary reason the patient requires home health services and that the encounter occurred within 30 days prior to the start of home health services; and~~]

[~~(iii) include the clinical findings of the encounter in the patient's medical record.~~]

(2) Time limited prior authorizations.

(A) Prior authorizations for payment of home health services may be issued by HHSC for a service period not to exceed 60 days on any given authorization. Specific authorizations may be limited to a time period less than the established maximum. When the need for home health services exceeds 60 days, or when

there is a change in the service plan, the provider must obtain prior approval and retain the physician's or allowed practitioner's signed and dated orders with the revised plan of care.

(B) The provider must [~~shall~~] be notified by HHSC in writing of the authorization or denial [~~(or denial)~~] of requested services.

(C) Prior authorization requests for covered Medicaid home health services must include the following information:

(i) the [~~The~~] Medicaid identification form with the following information about the recipient:

(I) full name, age, and address;

(II) Medical Assistance Program Identification number;

(III) health insurance claim number (where applicable); and

(IV) Medicare number;

(ii) the physician's or allowed practitioner's written, signed, and dated plan of care (submitted by the provider if requested);

(iii) the clinical record data (completed and submitted by the provider if requested);

(iv) a description of the home or living environment;

(v) a composition of the family/caregiver;

(vi) observations pertinent to the overall plan of care in the home; and

(vii) the type of service the recipient [~~patient~~] is receiving from other community or state agencies.

(D) If inadequate or incomplete information is provided, the provider will be requested to furnish additional documentation as required by HHSC to make a decision on the request.

(3) Medication administration. Nursing visits for the purpose of administering medications are not covered if:

(A) the medication is not considered medically necessary to the treatment of the recipient's [~~individual's~~] illness;

(B) the administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice;

(C) there is not a medical reason prohibiting the administration of the medication by mouth; or

(D) the recipient [~~patient~~], a primary caregiver, a family member, a legally

authorized representative (LAR), a court appointed guardian, or [~~and/or~~] a neighbor of the recipient has been taught or can be taught to administer intramuscular (IM) and intravenous (IV) injections.

(4) Prior approval. Services or supplies furnished without prior approval, unless otherwise specified by HHSC, are not covered home health services [~~benefits~~].

(5) Recipient residence. Services, equipment, or supplies furnished to a recipient who is a resident or patient in a hospital, skilled nursing facility, or intermediate care facility are not covered home health services [~~benefits~~].

(6) Non-billable services. Skilled nursing services that are considered administrative and are not billable include:

(A) nursing visits for the primary purpose of assessing a recipient's care needs to develop a plan of care; and

(B) RN visits for general supervision of nursing care provided by a home health aide or others over whom the RN is professionally responsible.

(c) Home health services are subject to utilization review, which includes the following:

(1) the physician or allowed practitioner is responsible for retaining in the recipient's [~~client's~~] record a copy of the plan of care or [~~and/or~~] a copy of the request form documenting the medical necessity of the home health care service, supply, or item of DME [~~equipment, or appliance~~] and how it meets the recipient's health care needs;

(2) the home health services provider is responsible for documenting the amount, duration, and scope of services in the recipient's plan of care, the DME and supply [~~equipment/supply~~] order request form, and the recipient's [~~client~~] record based on the physician's or allowed practitioner's orders[~~. This information is subject to retrospective review~~]; and

(3) HHSC may conduct retrospective [~~establish~~] random, and targeted reviews [~~utilization review processes~~] to ensure the appropriate utilization of home health services [~~benefits~~] and to monitor the cost effectiveness of home health services.

§354.1040. Requirements for Wheeled Mobility Systems.

(a) Purpose. This section details the requirements for receiving reimbursement for the provision of, or the performance of a major modification to, a wheeled mobility system. This section implements Texas Human Resources Code §32.0425 [~~§32.0424 of the Human Resources Code~~].

(b) Definitions. The following words and terms when used in this section [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) Occupational therapist (OT)--A person licensed by the Texas Board of Occupational Therapy Examiners to practice occupational therapy, as defined in

Texas Occupations Code §454.002(4)[~~, of the Texas Occupations Code~~] (relating to Definitions).

(2) Physical therapist (PT)--A person licensed by the Texas Board of Physical Therapy Examiners to practice physical therapy, as defined in §354.1121 of this subchapter [~~chapter~~] (relating to Definitions).

(3) Qualified rehabilitation professional (QRP)--A person who holds one or more of the following certifications:

(A) [~~Holds~~] a certification as an assistive technology professional or a rehabilitation engineering technologist issued by, and in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA);

(B) [~~Holds~~] a certification as a seating and mobility specialist issued by, and in good standing with, RESNA; or [~~and/or~~]

(C) [~~Holds~~] a certification as a certified rehabilitation technology supplier issued by, and in good standing with, the National Registry of Rehabilitation Technology Suppliers (NRRTS).

(4) Wheeled Mobility System--An item of durable medical equipment (DME) that is a customized powered or manual mobility device or a feature or component of the device, including [~~the following~~]:

(A) seated [~~Seated~~] positioning components;

(B) powered [~~Powered~~] or manual seating options;

(C) specialty [~~Specialty~~] driving controls;

(D) multiple [~~Multiple~~] adjustment frame;

(E) nonstandard [~~Nonstandard~~] performance options; and

(F) other [~~Other~~] complex or specialized components.

(c) Roles and responsibilities. The following persons, when referenced in this section, shall have the following roles in the provision of, or the performance of a major modification to, a wheeled mobility system, unless the context clearly indicates otherwise.

(1) [~~Occupational therapist (OT) --~~]The OT [~~occupational therapist~~] is responsible for completing the clinical assessment of a recipient required for obtaining a wheeled mobility system. The assessment must [~~shall~~] include detailed documentation of medical need for specific mobility or seating equipment and all necessary accessories.

(2) [~~Physical therapist (PT) --~~]The PT [~~physical therapist~~] is responsible for completing the clinical assessment of a recipient required for obtaining a wheeled mobility system. The assessment must [~~shall~~] include detailed documentation of

medical need for specific mobility or seating equipment and all necessary accessories.

(3) [~~Qualified rehabilitation professional (QRP) –~~]The QRP is required to:

(A) be [~~Be~~] present for and involved in the clinical assessment of the recipient;

(B) be [~~Be~~] present at the time of delivery of the wheeled mobility system to direct the fitting of the wheeled mobility system to ensure that the system is appropriate for the recipient; and

(C) verify [~~Verify~~] that the wheeled mobility system functions correctly relative to the recipient.

(4) A person that is licensed as an OT or [~~and/or~~] a PT, and is also certified as a QRP, may perform either the role of the therapist or the QRP during the clinical assessment of the recipient [~~client~~], but cannot serve in both roles at the same time.

(d) Benefit. Wheeled mobility systems are a covered home health services [~~Medicaid~~] benefit when the following criteria are met.

(1) All the requirements for DME, as detailed in §354.1039 of this division [~~chapter~~] (relating to Benefits and Limitations of Home Health Services [~~Benefits and Limitations~~]) are met.

(2) The wheeled [~~Wheeled~~] mobility system is [~~systems are~~] provided by an enrolled DME supplier that directly employs or contracts with a QRP.

(3) An enrolled DME supplier obtains prior authorization for a wheeled mobility system [~~systems~~] from HHSC [~~the Texas Health and Human Services Commission (HHSC) or its designee~~].

(e) Prior authorization requirements. The following documentation must be submitted in a manner approved by HHSC [~~or its designee~~] to obtain prior authorization for a wheeled mobility system.

(1) A signed and dated physician's or allowed practitioner's prescription, or other such documentation as directed by HHSC, that details a wheeled mobility system, including all necessary components[~~, needed by~~] the recipient needs.[~~;~~]

(2) A clinical assessment that includes detailed documentation of medical need for specific mobility or seating equipment and all necessary accessories, signed and dated by an OT or PT authorized to perform the assessment.[~~;~~]

(3) Documentation in a form or manner directed by HHSC [~~or its designee~~] attesting that a QRP was present for and involved in the clinical assessment of the recipient.[~~; and~~]

(4) Any other documentation deemed necessary by HHSC [~~or its designee~~] to

adequately explain the medical necessity of the requested equipment.

(f) Requirements for reimbursement. Reimbursement for the provision of, or the performance of a major modification to, a wheeled mobility system will be considered only when:

(1) the [~~The~~] system is delivered to a recipient by a Medicaid-enrolled DME provider that directly employs or contracts with, a QRP, and the QRP was present and involved in the clinical assessment of the recipient for the requested wheeled mobility system; and

(2) at [~~At~~] the time the wheeled mobility system is delivered to the recipient, the QRP is present and responsible for:

(A) directing the fitting to ensure that the system is appropriate for the recipient; and

(B) verifying that the system functions correctly relative to the recipient.

(g) Documentation requirements for reimbursement. The following documentation must be submitted by the enrolled DME supplier with the claim for consideration of reimbursement for a wheeled mobility system in a manner approved by HHSC [~~or its designee~~].

(1) A signed and dated HHSC DME Certification and Receipt Form as required in §354.1185 of this subchapter [~~chapter~~] (relating to Provider Compliance with Durable Medical Equipment (DME) Certification Requirements).[~~; and~~]

(2) Documentation in a form and manner as directed by HHSC [~~or its designee~~] attesting that a QRP was present at the time of delivery and:

(A) directed the fitting of the wheeled mobility system to ensure that the system was appropriate for the recipient; and

(B) verified that the wheeled mobility system functions correctly relative to the recipient.

(h) Effective dates for services provided. The provisions of this section apply to the following services:

(1) wheeled [~~Wheeled~~] mobility systems delivered on or after September 1, 2011;

(2) a [~~A~~] major modification to a wheeled mobility system provided on or after September 1, 2011; and

(3) QRP functions, including participating in a clinical assessment of a recipient [~~client~~] and directing the fitting of a wheeled mobility system, related to the provision of, or a major modification to, a wheeled mobility system when:

(A) the wheeled mobility system is delivered on or after September 1, 2011; and

(B) the QRP functions are performed after the effective date of the associated rates as determined by HHSC.

§354.1043. Competitive Procurement of Durable Medical Equipment (DME) and Supplies.

HHSC [~~The Texas Department of Health (department)~~] may establish a process for procuring DME and supplies that encourages competition and results in savings to HHSC [~~the department~~].

(1) The categories or individual types of DME and supplies that HHSC [~~which the department~~] may procure through a competitive process will be determined by HHSC [~~the department~~] using the following criteria:

(A) the DME or supplies are used by a recipient [~~recipients~~] in sufficient quantities to encourage the competitive process and be cost effective for HHSC [~~the department~~];

(B) the DME or supplies can be timely, safely, and effectively dispensed or provided by a prime vendor or contractor with a physician's or an allowed practitioner's prescription or order:

(i) without the necessity of fitting or instruction on its use; or

(ii) fitting and instruction can be provided by the prime vendor or contractor in compliance with HHSC [~~department~~] criteria;

(C) dispensing or providing the DME or supplies through a prime vendor or contractor will not limit or impair the accessibility and availability of the DME or supplies to the recipient [~~recipients~~] requiring the DME or supplies;

(D) dispensing or providing the DME or supplies through a prime vendor or contractor will not result in the recipient [~~recipients~~] receiving those DME or supplies in an unusable condition; and

(E) acquiring the DME or supplies through a prime vendor or contractor using a competitive process will result in cost savings to HHSC's [~~the department~~].

(2) HHSC [~~the department~~] may limit the number of providers with whom it will contract using the following criteria:

(A) all providers must submit a complete response to each section of HHSC's [~~the department's~~] procurement offer which will be used to evaluate provider qualifications, DME and supplies specifications, and accessibility and pricing provisions. Providers who fail to submit complete responses will be excluded from evaluation and consideration;

(B) the number of providers may be limited to only the number required to ensure statewide accessibility to the DME and supplies being procured; and

(C) the number of qualified providers will be limited to those providers who

submit competitive responses which will result in savings to HHSC [~~the department~~].