The Health and Human Services Commission (HHSC) proposes, on behalf of the Department of Aging and Disability Services (DADS), amendments to §19.101, concerning definitions; §19.1210, concerning certification and recertification requirements in Medicaid-certified facilities; §19.1911, concerning contents of the clinical record; §19.1926, concerning Medicaid hospice services; §19.2302, concerning requirements for a contracted Medicaid facility; §19.2326, concerning the Medicaid Swing Bed Program for rural hospitals; §19.2500, concerning preadmission screening and resident review (PASARR); and §19.2609, concerning payment of claims; proposes new §19.2401, concerning general qualifications for medical necessity determinations; §19.2403, concerning medical necessity determination; §19.2407, concerning denied medical necessity; §19.2413, concerning determination of payment rate based on the minimum data set (MDS) assessment submission; §19.2611, concerning retroactive vendor payments; and §19.2615, concerning resident transaction notices; and proposes the repeal of §19.1212, concerning physicians charging a fee to complete Medicaid forms; §19.2402, concerning the utilization review plan; §19.2403, concerning the utilization review process; §19.2404, concerning utilization review effective dates; §19.2407, concerning denied medical necessity; §19.2408, concerning retroactive medical necessity determinations; §19.2409, concerning general qualifications for at-risk assessments and medical necessity determinations; §19.2410, concerning criteria specific to a medical necessity determination; and §19.2413, concerning reconsideration of medical necessity determination and effective dates, in Chapter 19, Nursing Facility Requirements for Licensure and Medicaid Certification.

BACKGROUND AND PURPOSE

The purpose of the amendments, new sections, and repeal is to implement rule changes necessitated by a project under the direction of HHSC that will replace the state case-mix system for provider payments, which is based on the Texas Index for Level of Effort (TILE) model, with the federal case-mix system, which is based on the Resource Utilization Group (RUG) model. The TILE-to-RUG project implements Texas Health and Safety Code, §242.221 et seq., which requires DADS to use an automated system for nursing facility reimbursement and an assessment form designed by the United States Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). As a result, DADS is replacing its Client Assessment, Review and Evaluation (CARE) form (also known as Form 3652) with the federal MDS assessment for making medical necessity determinations and calculating the RUG.
The proposal also updates agency names, corrects rule cross-references, and updates statutory citations.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §19.101 adds definitions for "admission MDS assessment," "completion date," "MDS nurse reviewer," "RN assessment coordinator," "RUG," and "state Medicaid claims administrator;" and deletes definitions for "admission determination of medical necessity," "CARE form," "case mix," "facility nurse assessor," "medical necessity assessment," "Natural Death Act," "nurse reviewer," "preadmission medical necessity determination," "TDMHMR," "TILE," "TILE 202 restorative nursing," "TILE error," and "utilization review committee." The amendment to §19.101 revises the definition of "comprehensive assessment," "medical necessity," "NHIC," and "vendor payment" to conform to terminology used in the RUG model. Other amendments to definitions in §19.101 update the name of the Texas State Board of Medical Examiners to the Texas Medical Board, update the name of the Board of Nurse Examiners for the State of Texas to the Texas Board of Nursing, delete a reference to the Texas Board of Nursing Facility Administrators, and correct outdated citations to rules and statutes.

The proposed amendment to §19.1210 revises the section to reflect the procedure and time frame for the attending physician of an individual who is receiving Medicaid-funded nursing facility services in a Medicaid-certified nursing facility (hereinafter referred to as a recipient) to certify and recertify the recipient's need for nursing facility care under the RUG model.

The proposed amendment to §19.1911 adds a requirement for a nursing facility resident's clinical record to meet the documentation requirements in HHSC's rule at 1 TAC §371.214, concerning the RUG classification system, which is also being amended as part of the conversion from TILE to RUG. The amendment also adds requirements that a resident's clinical record contain a face sheet indicating the current mailing address and telephone numbers for the attending physician, that clinical documentation in the resident's record be signed and dated, and that each page of clinical documentation identify the name of the resident for whom the clinical care is intended. The amendment to §19.1911 also replaces a reference to the CARE form with a reference to the MDS assessment and replaces obsolete references to the Texas Department of Human Services (DHS) and the Texas Department of Mental Health and Mental Retardation (TDMHMR) with references to DADS.

The proposed amendment to §19.1926 replaces a reference to the TILE assessment with a reference to the MDS assessment.

The proposed amendment to §19.2302 revises the titles of sections in cross-references to HHSC's rules concerning MDS assessments and the RUG classification system to reflect the new titles of those sections, which are being amended as part of the conversion from TILE to RUG. The amendment to §19.2302 also changes references from DHS to DADS and updates subsection (f) to reflect current administrative hearing procedures for nursing
facilities for which DADS has suspended vendor payments or has proposed contract termination.

The proposed amendment to §19.2326 replaces a reference to TILE payment rates with a reference to RUG payment rates, replaces references to DHS with references to DADS, replaces references to the Texas Department of Health with references to the Department of State Health Services, and corrects rule cross-references.

The proposed amendment to §19.2500 updates agency names and responsibilities to reflect the consolidation of health and human services agencies in 2004, and removes a reference to §19.2410, which is being repealed as part of this proposal.

The amendment to §19.2609 specifies the time frames with which a nursing facility must comply when submitting claims and making adjustments to claims under the RUG model.

Proposed new §19.2401 contains the general qualifications for a medical necessity determination that currently are in §19.2409, which is proposed for repeal. The proposed new section is similar to the section proposed for repeal, except that the criteria for nursing facility risk in §19.2409(a) are not in the new rule. Because the MDS assessment includes the risk criteria and because DADS rules require that a medical necessity determination be made based on an evaluation of the needs shown on the MDS assessment, it is duplicative to have the risk criteria in rule.

Proposed new §19.2403 describes the purpose of a medical necessity determination in establishing an individual's eligibility for admission to the Texas Medicaid Nursing Facility Program and in securing a nursing facility's payment for services provided to a recipient. The new section describes the admission MDS assessment review process, the role of the state Medicaid claims administrator in making a medical necessity determination, and the effective period for a medical necessity determination. The new section governs the establishment of permanent medical necessity for a recipient, as well as the consequences a nursing facility faces if the facility fails to provide sufficient information on a recipient's MDS assessment for the state Medicaid claims administrator to make a medical necessity determination.

Proposed new §19.2407 governs the procedure the state Medicaid claims administrator must follow if the state Medicaid claims administrator finds that a Medicaid applicant or recipient does not meet the criteria for medical necessity. The procedure allows for the Medicaid applicant's or recipient's attending physician or a nursing facility physician to contest the finding of the state Medicaid claims administrator, and to provide additional information about the applicant's or recipient's medical need for nursing facility care. The proposed new section also describes the right of the applicant or recipient, or the applicant's or recipient's responsible party, to request a fair hearing if medical necessity is denied and sets forth the time frames in which the fair hearing must be requested.
Proposed new §19.2413 requires a nursing facility to complete an MDS assessment in accordance with instructions provided by the Centers for Medicare and Medicaid Services. A nursing facility must submit the MDS assessment and the Long-Term Care Medicaid Information Section in compliance with proposed new §19.2413 in order for the facility to be paid a calculated RUG rate for services provided, if the applicant or recipient is financially eligible for Medicaid and meets the medical necessity criteria for nursing facility care. The new section governs the payment consequences for a nursing facility if the facility submits an MDS assessment after the due date required by the federal MDS submission schedule or submits an MDS assessment outside the time period covered by the MDS assessment; it also governs how DADS determines the nursing facility payment rate when a facility submits a significant change in status assessment, a modification or significant correction to an MDS assessment, or an incomplete or erroneous MDS assessment.

Proposed new §19.2611 governs payments that DADS can make retroactively to a nursing facility for services the nursing facility provided to an individual who was eligible for, but had not yet applied for, Medicaid, for up to three months before the individual files an application for Medicaid eligibility. The proposed new section states that retroactive vendor payments are based on the individual's calculated RUG rate for the period covered by the retroactive vendor payment.

Proposed new §19.2615 requires a nursing facility to electronically submit to the state Medicaid claims administrator a resident transaction notice within 72 hours after a recipient's admission or discharge from the Medicaid nursing facility vendor payment system and requires the nursing facility administrator to sign the resident transaction notice.

The proposed repeal of §19.1212 eliminates an obsolete rule from DADS' rule base concerning a physician's charges for completing the CARE form.

The proposed repeal of §§19.2402-19.2404 and 19.2407 eliminates rules governing the procedures of the Utilization Review Committee, which will be obsolete under the RUG model. Under the RUG model, the state Medicaid claims administrator, rather than the Utilization Review Committee, will determine if an individual has a medical necessity for nursing facility care. The provisions of §19.2404 that govern resident transaction notices, are in proposed new §19.2615; and the provisions of §19.2407, governing denied medical necessity, are in proposed new §19.2407.

The proposed repeal of §19.2408 eliminates a rule governing retroactive medical necessity determinations that will no longer be valid under the RUG model. Provisions concerning retroactive vendor payments, which currently are in §19.2408, can be found in proposed new §19.2611.

Section 19.2409 is proposed for repeal, so that it can be proposed as new §19.2401 and be located in a more logical place in the subchapter.
The proposed repeal of §19.2410 eliminates a rule containing criteria for a medical necessity determination, because the criteria listed are not all-inclusive and only reference possible services or procedures that might qualify an individual for a medical necessity determination. The MDS assessment is the tool used to determine an individual's medical necessity for nursing facility care and, therefore, this rule is unnecessary.

The proposed repeal of §19.2413 eliminates a rule governing the reconsideration of medical necessity determinations and effective dates if a nursing facility provides services for a recipient during a period of time not covered by an effective medical necessity determination. The provisions of §19.2413 will not apply under the RUG model and, therefore, need to be repealed. Proposed new §19.2403(d) covers effective periods for medical necessity determinations under the RUG model.

FISCAL NOTE

Gordon Taylor, DADS Chief Financial Officer, has determined that, for the first five years the proposed amendments, new sections, and repeal are in effect, there are foreseeable implications relating to costs or revenues of state government. There are no foreseeable implications relating to costs or revenues of local governments.

The effect on state government for the first five years the proposed amendments, new sections, and repeal are in effect is an estimated additional cost of $5,935,500 in FY 2009; $0 in FY 2010; $0 in FY 2011; $0 in FY 2012; and $0 in FY 2013. The cost in FY 2009 is related to a one-year rate adjustment for providers who will lose revenue as a result of the TILE to RUG conversion to allow time for this group of providers to adjust to the RUG payment methodology.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

DADS has determined that the proposed amendments, new sections, and repeal will not have an adverse economic effect on small businesses or micro-businesses, because elimination of the requirement for nursing facilities to complete both the MDS assessment and the CARE form will reduce costs for nursing facilities. To minimize the impact on providers who may lose revenue as a result of the new reimbursement methodology, DADS is planning a one-year rate adjustment to assist that group of providers.

PUBLIC BENEFIT AND COSTS

Barry Waller, DADS Assistant Commissioner for Provider Services, has determined that, for each year of the first five years the amendments, new sections, and repeal are in effect, the public benefit expected as a result of enforcing the amendments, new sections, and repeal is a streamlined and simplified Medicaid form submission process and more accurate MDS assessment completion, because the MDS assessment will determine the nursing facility's payment rate. The elimination of the CARE form will mean nursing
facility staff can spend less time on form completion and more time on individual direct care, which ultimately will benefit the health and safety of nursing facility residents.

Mr. Waller anticipates that there will not be an economic cost to persons who are required to comply with the amendments, new sections, and repeal. The amendments, new sections, and repeal will not affect a local economy.

TAKINGS IMPACT ASSESSMENT

DADS has determined that this 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

Questions about the content of this proposal may be directed to Larry North at (512) 438-3922. Written comments on the proposal may be submitted to Texas Register Liaison, Legal Services-008, Department of Aging and Disability Services W-615, P.O. Box 149030, Austin, Texas 78714-9030, or street address 701 West 51st St., Austin, TX 78751; faxed to (512) 438-5759; or e-mailed to rulescomments@dads.state.tx.us. To be considered, comments must be submitted no later than 30 days after the date of this issue of the Texas Register. The last day to submit comments falls on a Sunday; therefore, comments must be either (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered to DADS before 5:00 p.m. on DADS' last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 008" in the subject line.
TITLE 40    SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19   NURSING FACILITY REQUIREMENTS FOR LICENSURE
AND MEDICAID CERTIFICATION
SUBCHAPTER B  DEFINITIONS
RULE  §19.101

Proposed action:
X Amendment

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides that the HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.


The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise.
(1) Abuse--Any act, failure to act, or incitement to act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident. This includes verbal, sexual, mental/psychological, or physical abuse, including corporal punishment, involuntary seclusion, or any other actions within this definition.

(A) "Involuntary seclusion"--Separation of a resident from others or from his room against the resident's will or the will of the resident's legal representative. Temporary monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used as a therapeutic intervention as determined by professional staff and consistent with the resident's plan of care.

(B) "Mental/psychological abuse"--Mistreatment within the definition of "abuse" not resulting in physical harm, including, but not limited to, humiliation, harassment, threats of punishment, deprivation, or intimidation.

(C) "Physical abuse"--Physical action within the definition of "abuse," including, but not limited to, hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

(D) "Sexual abuse"--Any touching or exposure of the anus, breast, or any part of the genitals of a resident without the voluntary, informed consent of the resident and with the intent to arouse or gratify the sexual desire of any person and includes but is not limited to sexual harassment, sexual coercion, or sexual assault.

(E) "Verbal abuse"--The use of any oral, written, or gestured language that includes disparaging or derogatory terms to a resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability.


(3) Activities assessment--See Comprehensive Assessment and Comprehensive Care Plan [of Care].

(4) Activities director--The qualified individual appointed by the facility to direct the activities program as described in §19.702 of this title (relating to Activities).

(5) Addition--The addition of floor space to an institution.

(6) Administrator--Licensed nursing facility administrator.

[begin addition] (7) Admission MDS assessment--An MDS assessment that determines a recipient's initial determination of eligibility for medical necessity for admission into the Texas Medicaid Nursing Facility Program.[end addition]
(7) Admission determination of medical necessity—The state Medicaid claims administrator's decision regarding an individual's need for medical and nursing services upon the individual's entering his entry into a nursing facility or upon his becoming eligible for Medicaid. The admission determination of medical necessity is valid for up to 120 days from the effective date assigned by the Utilization Review Committee.

(8) Affiliate--With respect to a:

(A) partnership, each partner thereof;

(B) corporation, each officer, director, principal stockholder, and subsidiary; and each person with a disclosable interest;

(C) natural person, which includes each:

(i) person's spouse;

(ii) partnership and each partner thereof of which said person or any affiliate of said person is a partner; and

(iii) corporation in which said person is an officer, director, principal stockholder, or person with a disclosable interest.

(9) Agent--An adult to whom authority to make health care decisions is delegated under a durable power of attorney for health care.

(10) Applicant--A person or governmental unit, as those terms are defined in the Health and Safety Code, Chapter 242, applying for a license under that chapter.


(12) Attending physician--A physician, currently licensed by the Texas Medical State Board of Medical Examiners, who is designated by the resident or responsible party as having primary responsibility for the treatment and care of the resident.

(13) Authorized electronic monitoring--The placement of an electronic monitoring device in a resident's room and using the device to make tapes or recordings after making a request to the facility to allow electronic monitoring.

(14) Barrier precautions--Precautions including the use of gloves, masks, gowns, resuscitation equipment, eye protectors, aprons, faceshields, and protective clothing for purposes of infection control.
CARE form--The DADS Client Assessment, Review and Evaluation (CARE) form completed by Medicaid-certified nursing facilities which allows for determination of medical necessity, reimbursement rate, initial level of the Preadmission Screening and Resident Review (PASARR) and the initial medical care determination and reassessment of the 1915(c) waivers.

Care and treatment--Services required to maximize resident independence, personal choice, participation, health, self-care, psychosocial functioning and reasonable safety, all consistent with the preferences of the resident.

Case mix--A method of classifying recipients based upon resource and service needs and paying nursing facilities a per diem rate according to the recipient's classification.

Certification--The determination by DADS that a nursing facility meets all the requirements of the Medicaid and/or Medicare programs.


CMS--Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration (HCFA).

Complaint--Any allegation received by DADS other than an incident reported by the facility. Such allegations include, but are not limited to, abuse, neglect, exploitation, or violation of state or federal standards.

Completion date--The date an RN assessment coordinator signs an MDS assessment as complete.

Comprehensive assessment--An interdisciplinary description of a resident's needs and capabilities including daily life functions and significant impairments of functional capacity, as described in §19.801(2) of this chapter (relating to Resident Assessment).

Comprehensive care plan--A plan of care prepared by an interdisciplinary team that includes measurable short-term and long-term objectives and timetables to meet the resident's needs developed for each resident after admission. The plan addresses at least the following needs: medical, nursing, rehabilitative, psychosocial, dietary, activity, and resident's rights. The plan includes strategies developed by the team, as described in
§19.802(b)(2) of this title (relating to Comprehensive Care Plans), consistent with the physician's prescribed plan of care, to assist the resident in eliminating, managing, or alleviating health or psychosocial problems identified through assessment. Planning includes:

(A) goal setting;

(B) establishing priorities for management of care;

(C) making decisions about specific measures to be used to resolve the resident's problems; and/or

(D) assisting in the development of appropriate coping mechanisms.

Controlled substance--A drug, substance, or immediate precursor as defined in the Texas Controlled Substance Act, Texas Health and Safety Code, Chapter 481, and/or the Federal Controlled Substance Act of 1970, Public Law 91-513.

Controlling person--A person with the ability, acting alone or in concert with others, to directly or indirectly, influence, direct, or cause the direction of the management, expenditure of money, or policies of a nursing facility or other person. A controlling person does not include a person, such as an employee, lender, secured creditor, or landlord, who does not exercise any influence or control, whether formal or actual, over the operation of a facility. A controlling person includes:

(A) a management company, landlord, or other business entity that operates or contracts with others for the operation of a nursing facility;

(B) any person who is a controlling person of a management company or other business entity that operates a nursing facility or that contracts with another person for the operation of a nursing facility; and

(C) any other individual who, because of a personal, familial, or other relationship with the owner, manager, landlord, tenant, or provider of a nursing facility, is in a position of actual control or authority with respect to the nursing facility, without regard to whether the individual is formally named as an owner, manager, director, officer, provider, consultant, contractor, or employee of the facility.

Covert electronic monitoring--The placement and use of an electronic monitoring device that is not open and obvious, and the facility and DADS have not been informed about the device by the resident, by a person who placed the device in the room, or by a person who uses the device.
DADS--The Department of Aging and Disability Services.

Dangerous drugs--Any drug as defined in the Texas Health and Safety Code, Chapter 483.

Dentist--A practitioner licensed by the Texas State Board of Dental Examiners.

Department--Department of Aging and Disability Services.

DHS--Formerly, this term referred to the Texas Department of Human Services; it now refers to DADS, unless the context concerns an administrative hearing. Administrative hearings were formerly the responsibility of DHS; they now are the responsibility of the Texas Health and Human Services Commission (HHSC).

Dietitian--A qualified dietitian is one who is qualified based upon either:

(A) registration by the Commission on Dietetic Registration of the American Dietetic Association; or

(B) licensure, or provisional licensure, by the Texas State Board of Examiners of Dietitians. These individuals must have one year of supervisory experience in dietetic service of a health care facility.

Direct care by licensed nurses--Direct care consonant with the physician's planned regimen of total resident care includes:

(A) assessment of the resident's health care status;

(B) planning for the resident's care;

(C) assignment of duties to achieve the resident's care;

(D) nursing intervention; and

(E) evaluation and change of approaches as necessary.

Distinct part--That portion of a facility certified to participate in the Medicaid Nursing Facility program.
Drug (also referred to as medication)--Any of the following:

(A) any substance recognized as a drug in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them;

(B) any substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man;

(C) any substance (other than food) intended to affect the structure or any function of the body of man; and

(D) any substance intended for use as a component of any substance specified in subparagraphs (A)-(C) of this definition. It does not include devices or their components, parts, or accessories.

Electronic monitoring device--Video surveillance cameras and audio devices installed in a resident's room, designed to acquire communications or other sounds that occur in the room. An electronic, mechanical, or other device used specifically for the nonconsensual interception of wire or electronic communication is excluded from this definition.

Emergency--A sudden change in a resident's condition requiring immediate medical intervention

Exploitation--The illegal or improper act or process of a caretaker using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain.

Exposure (infections)--The direct contact of blood or other potentially infectious materials of one person with the skin or mucous membranes of another person. Other potentially infectious materials include the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and body fluid that is visibly contaminated with blood, and all body fluids when it is difficult or impossible to differentiate between body fluids.

Facility--Unless otherwise indicated, a facility is an institution that provides organized and structured nursing care and service and is subject to licensure under Health and Safety Code, Chapter 242.

(A) For Medicaid, a facility is a nursing facility which meets the requirements of §1919(a)-(d) of the Social Security Act. A facility may not include any institution that is for the care and treatment of mental diseases except for services furnished to individuals
age 65 and over and who are eligible as defined in §19.2500 of this title (relating to Preadmission Screening and Resident Review (PASARR)).

(B) For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity which participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution.

(C) "Facility" is also referred to as a nursing home or nursing facility. Depending on context, these terms are used to represent the management, administrator, or other persons or groups involved in the provision of care of the resident; or to represent the physical building, which may consist of one or more floors or one or more units, or which may be a distinct part of a licensed hospital.

[begin deletion] (41) Facility nurse assessor--The licensed nurse in the nursing facility, who completes the Client Assessment, Review and Evaluation (CARE) forms. [end deletion]

[begin addition] (40) [end addition] [begin deletion] (42) [end deletion] Family representative--An individual appointed by the resident to represent the resident and other family members, by formal or informal arrangement.

[begin addition] (41) [end addition] [begin deletion] (43) [end deletion] Fiduciary agent--An individual who holds in trust another's monies.

[begin addition] (42) [end addition] [begin deletion] (44) [end deletion] Free choice--Unrestricted right to choose a qualified provider of services.

[begin addition] (43) [end addition] [begin deletion] (45) [end deletion] Goals--Long-term: general statements of desired outcomes. Short-term: measurable time-limited, expected results that provide the means to evaluate the resident's progress toward achieving long-term goals.

[begin addition] (44) [end addition] [begin deletion] (46) [end deletion] Governmental unit--A state or a political subdivision of the state, including a county or municipality.

[begin addition] (45) [end addition] [begin deletion] (47) [end deletion] HCFA--Health Care Financing Administration, now the Centers for Medicare & Medicaid Services (CMS).

[begin addition] (46) [end addition] [begin deletion] (48) [end deletion] Health care provider--An individual, including a physician, or facility licensed, certified, or otherwise authorized to administer health care, in the ordinary course of business or professional practice.
Hearing--A contested case hearing held in accordance with the Administrative Procedure Act, Texas Government Code, Chapter 2001, and the formal hearing procedures in 1 TAC Chapter 357, Subchapter I.

HIV--Human Immunodeficiency Virus.

Incident--An abnormal event, including accidents or injury to staff or residents, which is documented in facility reports. An occurrence in which a resident may have been subject to abuse, neglect, or exploitation must also be reported to DADS.

Infection control--A program designed to prevent the transmission of disease and infection in order to provide a safe and sanitary environment.

Inspection--Any on-site visit to or survey of an institution by DADS for the purpose of licensing, monitoring, complaint investigation, architectural review, or similar purpose.

Interdisciplinary care plan--See the definition of "comprehensive care plan."

IV--Intravenous.

Legend drug or prescription drug--Any drug that requires a written or telephonic order of a practitioner before it may be dispensed by a pharmacist, or that may be delivered to a particular resident by a practitioner in the course of the practitioner's practice.

Licensed health professional--A physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; pharmacist; physical or occupational therapy assistant; registered professional nurse; licensed vocational nurse; licensed dietitian; or licensed social worker.

Licensed nursing home (facility) administrator--A person currently licensed by DADS in accordance with Chapter 18 of this title (relating to Nursing Facility Administrators) and the Texas Board of Nursing Facility Administrators.

Licensed vocational nurse (LVN)--A nurse who is currently licensed by the Texas Board of Nursing.
Board of Nursing Nurse Examiners for the State of Texas as a licensed vocational nurse.


(59) Life safety features—Fire safety components required by the Life Safety Code, including, but not limited to, building construction, fire alarm systems, smoke detection systems, interior finishes, sizes and thicknesses of doors, exits, emergency electrical systems, and sprinkler systems.

(60) Life support—Use of any technique, therapy, or device to assist in sustaining life. (See §19.419 of this title (relating to Advance Directives and Medical Powers of Attorney)).

(61) Local authorities—Persons, including, but not limited to, local health authority, fire marshal, and building inspector, who may be authorized by state law, county order, or municipal ordinance to perform certain inspections or certifications.

(62) Local health authority—The physician appointed by the governing body of a municipality or the commissioner's court of the county to administer state and local laws relating to public health in the municipality's or county's jurisdiction as defined in Health and Safety Code, §121.021.

(63) Long-term care-regulatory—DADS' Regulatory Services Division, which is responsible for surveying nursing facilities to determine compliance with regulations for licensure and certification for Title XIX participation.

(64) Manager—A person, other than a licensed nursing home administrator, having a contractual relationship to provide management services to a facility.

(65) Management services—Services provided under contract between the owner of a facility and a person to provide for the operation of a facility, including administration, staffing, maintenance, or delivery of resident services. Management services do not include contracts solely for maintenance, laundry, or food service.
(66) MDS--Minimum data set. See Resident Assessment Instrument (RAI).

(67) MDS nurse reviewer--A registered nurse employed by HHSC to monitor the accuracy of the MDS assessment submitted by a Medicaid-certified nursing facility.

(68) Medicaid applicant--A person who requests the determination of eligibility to become a Medicaid recipient.

(69) Medicaid nursing facility vendor payment system--Electronic billing and payment system for reimbursement to nursing facilities for services provided to eligible Medicaid recipients.

(70) Medicaid recipient--A person who meets the eligibility requirements of the Title XIX Medicaid program, is eligible for nursing facility services, and resides in a Medicaid-participating facility.

(71) Medical director--A physician licensed by the Texas Medical Board, who is engaged by the nursing home to assist in and advise regarding the provision of nursing and health care.

(72) Medical necessity (MN)--The determination that a recipient requires the services of licensed nurses in an institutional setting to carry out the physician's planned regimen for total care. A recipient's need for custodial care in a 24-hour institutional setting does not constitute a medical need. A group of health care professionals employed or contracted by the state Medicaid claims administrator contracted with HHSC makes individual determinations of medical necessity regarding nursing facility care. These health care professionals consist of physicians and registered nurses.

(73) Medical necessity assessment--The process by which the applicant's or recipient's medical condition is evaluated to determine the need for nursing facility care based upon information supplied by the nursing facility.

(74) Medical power of attorney--The legal document that designates an agent to make treatment decisions if the individual designator becomes incapable.

(75) Medical-social care plan--See Interdisciplinary Comprehensive Care Plan.
Medically related condition--An organic, debilitating disease or health disorder that requires services provided in a nursing facility, under the supervision of licensed nurses.

Medication aide--A person who holds a current permit issued under the Medication Aide Training Program as described in Chapter 95 of this title (relating to Medication Aides--Program Requirements) and acts under the authority of a person who holds a current license under state law which authorizes the licensee to administer medication.

Minimum data set (MDS)--See Resident Assessment Instrument (RAI).

Misappropriation of funds--The taking, secretion, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive any property, real or personal, or anything of value belonging to or under the legal control of a resident without the effective consent of the resident or other appropriate legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct relating to the custody or disposition of property of a resident.


Neglect--A deprivation of life's necessities of food, water, or shelter, or a failure of an individual to provide services, treatment, or care to a resident which causes or could cause mental or physical injury, or harm or death to the resident.

NHIC--Formerly, this term referred to the National Heritage Insurance Corporation. It which was the intermediary for the Texas Medicaid program; it now refers to the state Medicaid claims administrator. current intermediary for the Texas Medicaid program, the Texas Medicaid and Health Partnership.

Nonnursing personnel--Persons not assigned to give direct personal care to residents; including administrators, secretaries, activities directors, bookkeepers, cooks, janitors, maids, laundry workers, and yard maintenance workers.

Nurse aide--An individual who provides nursing or nursing-related services to residents in a facility under the supervision of a licensed nurse. This definition does not include an individual who is a licensed health professional, a registered dietitian, or someone who volunteers such services without pay. A nurse aide is not authorized to provide nursing and/or
nursing-related services for which a license or registration is required under state law. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants.

Nurse aide trainee--An individual who is attending a program teaching nurse aide skills.

Nurse practitioner--A person licensed by the Texas Board of Nursing as a registered professional nurse, authorized by the Texas Board of Nursing as an advanced practice nurse in the role of nurse practitioner.

Nurse reviewer--A registered professional nurse employed by HHSC to monitor the accuracy of the CARE form assessment data.

Nursing assessment--See definition of "comprehensive assessment" and "comprehensive care plan."

Nursing care--Services provided by nursing personnel which include, but are not limited to, observation; promotion and maintenance of health; prevention of illness and disability; management of health care during acute and chronic phases of illness; guidance and counseling of individuals and families; and referral to physicians, other health care providers, and community resources when appropriate.

Nursing facility/home--An institution that provides organized and structured nursing care and service, and is subject to licensure under Health and Safety Code, Chapter 242. The nursing facility may also be certified to participate in the Medicaid Title XIX program. Depending on context, these terms are used to represent the management, administrator, or other persons or groups involved in the provision of care to the residents; or to represent the physical building, which may consist of one or more floors or one or more units, or which may be a distinct part of a licensed hospital.

Nursing facility/home administrator--See the definition of "licensed nursing home (facility) administrator."

Nursing personnel--Persons assigned to give direct personal and nursing services to residents, including registered nurses, licensed vocational nurses, nurse aides, orderlies, and medication aides. Unlicensed personnel function under the authority of licensed personnel.
Objectives--See definition of "goals."

OBRA--Omnibus Budget Reconciliation Act of 1987, which includes provisions relating to nursing home reform, as amended.

Ombudsman--An advocate who is a certified representative, staff member, or volunteer of the DADS Office of the State Long Term Care Ombudsman.

Optometrist--An individual with the profession of examining the eyes for defects of refraction and prescribing lenses for correction who is licensed by the Texas Optometry Board.

Paid feeding assistant--An individual who meets the requirements of §19.1113 of this chapter (relating to Paid Feeding Assistants) and who is paid to feed residents by a facility or who is used under an arrangement with another agency or organization.

PASARR--Preadmission Screening and Resident Review.

Palliative Plan of Care--Appropriate medical and nursing care for residents with advanced and progressive diseases for whom the focus of care is controlling pain and symptoms while maintaining optimum quality of life.

Patient care-related electrical appliance--An electrical appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care area, as defined in Standard 99 of the National Fire Protection Association.

Person--An individual, firm, partnership, corporation, association, joint stock company, limited partnership, limited liability company, or any other legal entity, including a legal successor of those entities.

Person with a disclosable interest--A person with a disclosable interest is any person who owns at least a 5.0% interest in any corporation, partnership, or other business entity that is required to be licensed under Health and Safety Code, Chapter 242. A person with a disclosable interest does not include a bank, savings and loan, savings bank, trust company, building and loan association, credit union, individual loan and thrift company, investment banking firm, or insurance company, unless these entities participate in the management of the facility.
Pharmacist--An individual, licensed by the Texas State Board of Pharmacy to practice pharmacy, who prepares and dispenses medications prescribed by a physician, dentist, or podiatrist.

Physical restraint--See Restraints (physical).

Physician--A doctor of medicine or osteopathy currently licensed by the Texas Medical Board of Medical Examiners.

Physician assistant (PA)--

(A) A graduate of a physician assistant training program who is accredited by the Committee on Allied Health Education and Accreditation of the Council on Medical Education of the American Medical Association; or

(B) A person who has passed the examination given by the National Commission on Certification of Physician Assistants. According to federal requirements (42 CFR §491.2) a physician assistant is a person who meets the applicable state requirements governing the qualifications for assistant to primary care physicians, and who meets at least one of the following conditions:

(i) is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or

(ii) has satisfactorily completed a program for preparing physician assistants that:

(II) consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

(III) was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(C) A person who has satisfactorily completed a formal educational program for preparing physician assistants who does not meet the requirements of paragraph (d)(2), 42 CFR §491.2, and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding July 14, 1978.
Podiatrist--A practitioner whose profession encompasses the care and treatment of feet who is licensed by the Texas State Board of Podiatric Medical Examiners.

Poison--Any substance that federal or state regulations require the manufacturer to label as a poison and is to be used externally by the consumer from the original manufacturer's container. Drugs to be taken internally that contain the manufacturer's poison label, but are dispensed by a pharmacist only by or on the prescription order of a physician, are not considered a poison, unless regulations specifically require poison labeling by the pharmacist.

Practitioner--A physician, podiatrist, dentist, or an advanced practice nurse or physician assistant to whom a physician has delegated authority to sign a prescription order, when relating to pharmacy services.

Preadmission medical necessity determination--The determination of need for nursing facility care before the individual's admission into the nursing facility. This determination is valid until admission into a nursing facility or up to 30 days from the effective date.

PRN (pro re nata)--As needed.

Provider--The individual or legal business entity that is contractually responsible for providing Medicaid services under an agreement with DADS.

Psychoactive drugs--Drugs prescribed to control mood, mental status, or behavior.

Qualified surveyor--An employee of DADS who has completed state and federal training on the survey process and passed a federal standardized exam.

Quality assessment and assurance committee--A group of health care professionals in a facility who develop and implement appropriate action to identify and rectify substandard care and deficient facility practice.

Quality-of-care monitor--A registered nurse, pharmacist, or dietitian employed by DADS who is trained and experienced in long-term care facility regulation, standards of practice in long-term care, and evaluation of resident care, and functions independently of DADS' Regulatory Services Division.
Recipient--Any individual residing in a Medicaid certified facility or a Medicaid certified distinct part of a facility whose daily vendor rate is paid by Medicaid.

Registered nurse (RN)--An individual currently licensed by the Texas Board of Nursing as a Registered Nurse in the State of Texas.

Reimbursement methodology--The method by which HHSC determines nursing facility per diem rates.

Remodeling--The construction, removal, or relocation of walls and partitions, the construction of foundations, floors, or ceiling-roof assemblies, the expanding or altering of safety systems (including, but not limited to, sprinkler, fire alarm, and emergency systems) or the conversion of space in a facility to a different use.

Renovation--The restoration to a former better state by cleaning, repairing, or rebuilding, including, but not limited to, routine maintenance, repairs, equipment replacement, painting.

Representative payee--A person designated by the Social Security Administration to receive and disburse benefits, act in the best interest of the beneficiary, and ensure that benefits will be used according to the beneficiary's needs.

Resident--Any individual residing in a nursing facility.

Resident assessment instrument (RAI)--An assessment tool used to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity as specified by the Secretary of the U.S. Department of Health and Human Services. At a minimum, this instrument must consist of the Minimum Data Set (MDS) core elements as specified by the Centers for Medicare & Medicaid Services (CMS); utilization guidelines; and Resident Assessment Protocols (RAPS).

Responsible party--An individual authorized by the resident to act for him as an official delegate or agent. Responsible party is usually a family member or relative, but may be a legal guardian or other individual. Authorization may be in writing or may be given orally.
Restraint hold--

(A) A manual method, except for physical guidance or prompting of brief duration, used to restrict:

(i) free movement or normal functioning of all or a portion of a resident's body; or

(ii) normal access by a resident to a portion of the resident's body.

(B) Physical guidance or prompting of brief duration becomes a restraint if the resident resists the guidance or prompting.

Restraints (chemical)--Psychoactive drugs administered for the purposes of discipline, or convenience, and not required to treat the resident's medical symptoms.

Restraints (physical)--Any manual method, or physical or mechanical device, material or equipment attached, or adjacent to the resident's body, that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The term includes a restraint hold.

RN assessment coordinator--A registered nurse who signs and certifies a comprehensive assessment of a resident's needs, using the RAI, including the MDS, as specified by DADS.

RUG--Resource Utilization Group. A categorization method, consisting of 34 categories based on the MDS, that is used to determine a recipient's service and care requirements and to determine the daily rate DADS pays a nursing facility for services provided to the recipient.

Seclusion--See the definition of "involuntary seclusion" in paragraph (1)(A) of this section.

Secretary--Secretary of the U.S. Department of Health and Human Services.

Services required on a regular basis--Services which are provided at fixed or recurring intervals and are needed so frequently that it would be impractical to provide the services in a home or family setting. Services required on a regular basis include continuous or periodic nursing observation, assessment, and intervention in all areas of resident care.
SNF--A skilled nursing facility or distinct part of a facility that participates in the Medicare program. SNF requirements apply when a certified facility is billing Medicare for a resident's per diem rate.

Social Security Administration--Federal agency for administration of social security benefits. Local social security administration offices take applications for Medicare, assist beneficiaries file claims, and provide information about the Medicare program.

Social worker--A qualified social worker is an individual who is licensed, or provisionally licensed, by the Texas State Board of Social Work Examiners as prescribed by the Texas Occupations Code, Chapter 505, and who has at least:

(A) a bachelor's degree in social work; or
(B) similar professional qualifications, which include a minimum educational requirement of a bachelor's degree and one year experience met by employment providing social services in a health care setting.

Standards--The minimum conditions, requirements, and criteria established in this chapter with which an institution must comply to be licensed under this chapter.

State Medicaid claims administrator--The entity under contract with HHSC to process Medicaid claims in Texas.

State plan--A formal plan for the medical assistance program, submitted to CMS, in which the State of Texas agrees to administer the program in accordance with the provisions of the State Plan, the requirements of Titles XVIII and XIX, and all applicable federal regulations and other official issuances of the U.S. Department of Health and Human Services.

State survey agency--DADS is the agency, which through contractual agreement with CMS is responsible for Title XIX (Medicaid) survey and certification of nursing facilities.

Supervising physician--A physician who assumes responsibility and legal liability for services rendered by a physician assistant (PA) and has been approved by the Texas State Board of Medical Examiners to supervise services rendered by specific PAs. A supervising physician may also be a physician who provides general supervision of a nurse practitioner providing services in a nursing facility.
Supervision--General supervision, unless otherwise identified.

Supervision (direct)--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence. If the person being supervised does not meet assistant-level qualifications specified in this chapter and in federal regulations, the supervisor must be on the premises and directly supervising.

Supervision (general)--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence. The person being supervised must have access to the licensed and/or qualified person providing the supervision.

Supervision (intermittent)--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence, with initial direction and periodic inspection of the actual act of accomplishing the function or activity. The person being supervised must have access to the licensed and/or qualified person providing the supervision.

TDMHMR--Formerly, this term referred to the Texas Department of Mental Health and Mental Retardation; it now refers to DADS.

Texas Register--A publication of the Texas Register Publications Section of the Office of the Secretary of State that contains emergency, proposed, withdrawn, and adopted rules issued by Texas state agencies. The Texas Register was established by the Administrative Procedure and Texas Register Act of 1975.

Therapeutic diet--A diet ordered by a physician as part of treatment for a disease or clinical condition, in order to eliminate, decrease, or increase certain substances in the diet or to provide food which has been altered to make it easier for the resident to eat.

Therapy week--A seven-day period beginning the first day rehabilitation therapy or restorative nursing care is given. All subsequent therapy weeks for a particular individual will begin on that day of the week.

Threatened violation--A situation that, unless immediate steps are taken to correct, may cause injury or harm to a resident's health and safety.
Texas Index for Level of Effort; an index of 11 categories plus a default that consists of relative resource utilization groups. The index determines where a nursing facility client fits based upon service and care requirements. It determines the daily rate to be paid on behalf of the client.

202 restorative nursing—Nursing care and practices, based on a plan of care developed by the restorative team, designed to maintain or improve on goals achieved during physical or occupational therapy. Examples of TILE 202 restorative nursing include training and skill practice in self feeding, bed mobility, transfers, ambulation, dressing or grooming, and active range of motion.

TILE error—Inaccuracies in a CARE form assessment of a Medicaid recipient that result in an incorrect TILE classification.

Title II--Federal Old-Age, Survivors, and Disability Insurance Benefits of the Social Security Act.

Title XVI--Supplemental Security Income (SSI) of the Social Security Act.

Title XVIII--Medicare provisions of the Social Security Act.

Title XIX--Medicaid provisions of the Social Security Act.

Total health status--Includes functional status, medical care, nursing care, nutritional status, rehabilitation and restorative potential, activities potential, cognitive status, oral health status, psychosocial status, and sensory and physical impairments.

UAR--HHSC's Utilization and Assessment Review Section.

Uniform data set--See Resident Assessment Instrument (RAI).

Universal precautions--The use of barrier and other precautions by long-term care facility employees and/or contract agents to prevent the spread of blood-borne diseases.

Utilization review committee--The group of health care professionals contracted by HHSC to make individual determinations of medical necessity regarding nursing facility care. The Utilization Review Committee consists of physicians and registered nurses.
Vendor payment--Payment made by DADS on a daily-rate basis for services delivered to recipients in Medicaid-certified nursing facilities. Vendor payment is based on the nursing facility's approved-to-pay claim processed by the state Medicaid claims administrator. The Nursing Facility Billing Statement, subject to adjustments and corrections, is prepared from information submitted by the nursing facility, which is currently on file in the computer system as of the billing date. Vendor payment is made at periodic intervals, but not less than once per month for services rendered during the previous billing cycle.

Working day--Any 24-hour period, Monday through Friday, excluding state and federal holidays.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.

TITLE 40 SOCIAL SERVICES AND ASSISTANCE
PART 1 DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER M PHYSICIAN SERVICES
RULE §19.1210

Proposed action:
X Amendment

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.
The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

§19.1210. Certification and Recertification Requirements in Medicaid-Certified Facilities.

(a) [begin addition] A recipient's [end addition] The [end deletion] physician [begin addition] must certify and recertify the recipient's need for nursing facility care in accordance with this section [end addition] [begin deletion] participates in the utilization review process as specified in §19.2405 of this title (relating to Physicians' Certifications and Recertifications) [end deletion].

(b) [begin addition] A recipient's physician must certify the [end addition] [begin deletion] Physician's certification of a [end deletion] recipient's need for nursing facility care [begin deletion] is required [end deletion] no [begin addition] later [end addition] [begin deletion] more [end deletion] than 20 days after [begin addition] the recipient's [end addition] [begin deletion] or 30 days before [end deletion] admission to the facility [begin deletion] or before the Medicaid agency authorizes payment, whichever is later [end deletion].

(c) [begin addition] A recipient's physician must recertify the recipient's need for nursing facility care [end addition] [begin deletion] Physician's recertification of residents is required for admission and [end deletion] every 180 days [begin addition] that the recipient remains in the nursing facility after the first certification [end addition] [begin deletion] thereafter [end deletion].

(d) [begin addition] A nursing facility must: [end addition]

[begin addition] (1) ensure that each certification and recertification statement [end addition] [begin deletion] Physician's certification and recertification statements documenting the need for continued nursing facility services are placed in each resident's clinical record and reviewed on a regular basis by Texas Department of Human Services staff. The facility must ensure that each certification or recertification [end deletion] states: "I hereby certify that this resident requires/continues to require nursing facility care for 180 days [begin addition] ". [end addition]

[begin addition] (2) keep the physician's certification and recertification statements in the recipient's clinical record [end addition]

[begin deletion] (e) When the physician anticipates that the recipient will require less than a 180-day stay, the physician must specify the anticipated number of days in the certification statement [end deletion]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.
STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

§19.1212. Physicians Charging a Fee To Complete Medicaid Forms.

The Texas Nursing Facility Comprehensive Assessment, Review, and Evaluation (CARE) form for a resident assessment is completed in connection with required physician visits with the resident. The physician charges the National Heritage Insurance Company (NHIC) the allowable amount for the visit which includes his services for completing the form. This assumes that the physician actually filled out the form and, in these cases, he should show on the bill that the visit was for medical evaluation or reevaluation purposes. If a nursing facility administrator pays the physician for his
services of completing forms for a recipient, NHIC does not reimburse the physician for those same expenses. [end deletion]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.

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**STATUTORY AUTHORITY**

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

**§19.1911. Contents of the Clinical Record.**

[begin addition] (a) A resident's clinical record must meet all documentation requirements in the Texas Health and Human Services Commission rule at 1 TAC §371.214 (relating to Resource Utilization Group Classification System). [end addition]
The clinical record of each resident must contain:

1. A face sheet that contains the attending physician's current mailing address and telephone numbers;
2. Sufficient information to identify and care for the resident, to include at a minimum:
   A. Full name of resident;
   B. Full home/mailing address;
   C. Social security number;
   D. Health insurance claim numbers, if applicable;
   E. Date of birth; and
   F. Clinical record number, if applicable;
3. A record of the resident's assessments;
4. The comprehensive, interdisciplinary plan of care and services provided (see also §19.802 of this chapter relating to Comprehensive Care Plans), and the permanency plan for pediatric residents younger than 22 years of age;
5. The results of any Preadmission Screening and Resident Review conducted by DADS; The Texas Department of Human Services (DHS) or the Texas Department of Mental Health and Mental Retardation (TDMHMR);
6. Signed and dated clinical documentation from all health care practitioners involved in the resident's care, with each page identifying the name of the resident for whom the clinical care is intended;
Any directives or durable powers of attorney as described in §19.419 of this chapter (relating to Advance Directives and Medical Powers of Attorney) ; any medical discharge information in accordance with §19.803 of this chapter (relating to Discharge Summary (Discharge Plan of Care)) and a physician discharge summary, to include, at least, dates of admission and discharge, admitting and discharge diagnoses, condition on discharge, and prognosis, if applicable ; at admission or within 14 days after admission, documentation of an initial medical evaluation, including history, physical examination, diagnoses and an estimate of discharge potential and rehabilitation potential, and documentation of an annual medical examination ; the physician's signed and dated orders, including medication, treatment, diet, restorative and special medical procedures, and routine care to maintain or improve the resident's functional abilities (required for the safety and well-being of the resident), which must not be changed, either
on a handwritten or computerized physician's order sheet after the orders have been signed by the physician unless space allows for additional orders below the physician's signature, including space for the physician to sign and date again [begin addition]; [end addition] [begin deletion]. [end deletion]

[begin addition] (12) [end addition] [begin deletion] (11) [end deletion] [begin addition] arrangements [end addition] [begin deletion] Arrangements [end deletion] for the emergency care of the resident in accordance with §19.1204 of this [begin addition] chapter [end addition] [begin deletion] title [end deletion] (relating to Availability of Physician for Emergency Care) [begin addition]: [end addition] [begin deletion]. [end deletion]

[begin addition] (13) [end addition] [begin deletion] (12) [end deletion] [begin addition] observations [end addition] [begin deletion] Observations [end deletion] made by nursing personnel according to the time frames specified in §19.1010 of this [begin addition] chapter [end addition] [begin deletion] title [end deletion] (relating to Nursing Practices) [begin addition] and which facility [end addition] [begin deletion]. Facility [end deletion] staff must ensure [begin deletion] that the observations [end deletion] show at least the following:

(A) items as specified on the [begin addition] MDS assessment [end addition] [begin deletion] Resident Assessment Instrument and the Texas Nursing Facility Client Assessment Review and Evaluation (CARE) form [end deletion]; and

(B) current information, including:

(i) PRN medications and results;

(ii) treatments and any notable results;

(iii) physical complaints, changes in clinical signs and behavior, mental and behavioral status, and all incidents or accidents;

(iv) flow sheets which may include bathing, restraint observation and/or release documentation, elimination, fluid intake, vital signs, ambulation status, positioning, continency status and care, and weight;

(v) the resident's ability to participate in activities of daily living as defined in §19.1010(e)(1) of this [begin addition] chapter [end addition] [begin deletion] title [end deletion] (relating to Nursing Practices) [end deletion]; and

(vi) dietary intake to include deviations from normal diet, rejection of substitutions, and physician's ordered snacks and/or supplemental feedings [begin addition]; [end addition] [begin deletion]. [end deletion]
The date and hour all drugs and treatments are administered; and.

Documentation of special procedures performed for the safety and well-being of the resident must be included in the clinical record.


(a) When a nursing facility (NF) contracts for hospice services for residents, the nursing facility must:

(1) have a written contract for the provision of arranged services, which must be signed by authorized representatives of the NF and hospice. Authorized representatives of the NF and hospice must sign the contract. The contract must include the following:

(A) the services to be provided;

(B) a stipulation that hospice-related services performed by NF staff may be provided only with the express authorization of the hospice;

(C) how the contracted services are to be coordinated, supervised, and evaluated by the hospice and the NF;

(D) delineation of the roles of the hospice and the NF in the admission process, recipient and family assessment, and the interdisciplinary team case conferences;

(E) a requirement for documentation of services furnished; and

(F) the qualifications of the personnel providing the services;

(2) provide room and board services, which include the performance of personal care services, including assistance in the activities of daily living, administration of medication, socializing activities, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies;

(3) immediately notify the hospice of any significant changes in the hospice recipient's condition;
(4) have joint procedures with the hospice provider for ordering medications that ensure the proper payor is billed and for reconciling billing between NF and hospice, including:

(A) contacting the hospice prior to filling a new prescription; and

(B) ensuring that drugs unrelated to the terminal illness are ordered through the Vendor Drug program; and

(5) ensure that hospice documentation is a part of the current clinical record [begin addition], which, at [end addition] [begin deletion], At [end deletion] a minimum, [begin addition] must [end addition] [begin deletion] documentation will [end deletion] include the current and past:

(A) Texas Medicaid Hospice Recipient Election/Cancellation form;

(B) [begin addition] MDS assessment [end addition] [begin deletion] Texas Index for Level of Effort (TILE) Assessment [end deletion];

(C) Physician Certification of Terminal Illness form;

(D) Medicare Election Statement, if dually eligible;

(E) verification that the recipient does not have Medicare Part A;

(F) hospice interdisciplinary assessments;

(G) hospice plan of care; and

(H) current interdisciplinary notes, which include the following:

(i) nurses notes and summaries;

(ii) physician orders and progress notes; and

(iii) medication and treatment sheets during the hospice certification period.

(b) The NF and hospice must ensure that the coordinated plan of care reflects the participation of the hospice, the NF, the recipient, and the recipient's legal representative to the extent possible. The plan of care must include directives for managing pain and other uncomfortable symptoms, and must be revised and updated as necessary to reflect the [begin addition] recipient's [end addition] [begin deletion] individual's [end deletion] current status.
(c) The recipient has the right to refuse any services from the nursing facility and the hospice provider.

(d) The hospice retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions, which includes:

(1) designation of a hospice registered nurse to coordinate the implementation of the plan of care;

(2) provision of substantially all core services (physician, nursing, medical social work, and counseling services) that must be routinely provided directly by the hospice employees, and cannot be delegated to the NF, as outlined under 42 Code of Federal Regulations §418.80;

(3) provision of drugs and medical supplies as needed for palliation and management of the terminal illness and related conditions; and

(4) involvement of NF personnel in assisting with the administration of prescribed therapies in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family or caregiver in the home setting.

(e) The hospice may arrange to have non-core hospice services provided by the NF if the hospice assumes professional management responsibility for the services and assures these services are performed in accordance with the policies of the hospice and the recipient's plan of care.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.
STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

§19.2302. Requirements for a Contracted Medicaid Facility.

(a) This section applies to nursing facilities (NFs) that have been licensed and certified as eligible for participation under Title XIX.

(b) Each nursing facility (NF) must comply with the state requirements for participation and the facility's contract on a continuing basis.

(c) Each NF must comply with the Texas Health and Human Services Commission's (HHSC's) utilization review requirements as provided in 1 TAC §371.212 (relating to [begin addition] Minimum Data Set (MDS) Assessments [end addition] [begin deletion] Case Mix Classification System [end deletion]), §371.213 (relating to Utilization Review and Control Activities Performed by Texas Health and Human Services Commission (Commission)), and §371.214 (relating to [begin addition] Resource Utilization Group Classification System [end addition] [begin deletion] Texas Index for Level of Effort (TILE) Assessments [end deletion]).

(d) A facility may not participate in the Texas Medical Assistance Program if it has restrictive policies or practices, including:

(1) requiring the resident to make a will, with the facility named as legatee or devisee;

(2) requiring the resident to assign his life insurance to the facility;

(3) requiring the resident to transfer property to the facility;
(4) requiring the resident to pay a lump sum entrance fee or make any other payment or concession to the facility beyond the recognized rate for board, room, and care as a condition for entry, departure, or continued stay;

(5) controlling or restricting the resident, the resident's guardian, or responsible party in the use of the resident's personal needs allowance;

(6) restricting the resident from leaving the facility at will except as provided by state law;

(7) restricting the resident from applying for Medicaid for a specified period of time;

(8) denying appropriate care to an individual on the basis of his race, religion, color, national origin, sex, age, disability, marital status, or source of payment; and

(9) preventing terminally ill adult residents from exercising their will in making written or unwritten directives to reject life-sustaining procedures.

(e) If DADS has documentation showing good cause, it reserves the right to reject the facility's participation or to cancel an existing contract if the facility charges the Title XIX resident, any member of his family, or any other source for supplementation or for any item except as allowed within DHS policies and regulations.

(f) If DADS suspends a facility's vendor payments or proposes to terminate a facility's contract, the facility may request an administrative hearing to challenge the action. If a facility requests a hearing, the facility must make the request in accordance with HHSC rules at 1 TAC Chapter 357, Subchapter I. If the State statutes and Title XIX NF contracts provide for appeal procedures for aggrieved providers whose vendor payments may be or have been suspended or whose contracts have been canceled by DHS. A facility must submit a written request for a contract appeals hearing that is received by the department within 15 days of the facility's receipt of the letter notifying the facility of the proposed action. The facility must send the request for a hearing to the Texas Department of Human Services, P.O. Box 149030 (W-613), Austin, Texas 78714-9030. Hearings will be held in Austin, Texas.

(g) DADS' interpretations of the requirements for participation or the contract may not be appealed to DHS's policies and regulations department unless the interpretation has caused an adverse action for the facility.
(h) Facilities must allow representatives of [begin addition] DADS [end addition] [begin deletion] DHS [end deletion], the Medicaid Fraud Control Unit, and the Department of Health and Human Services to enter the premises at any time to make inspections or to privately interview the residents receiving assistance from [begin addition] DADS [end addition] [begin deletion] DHS [end deletion].

(i) Facilities must supply [begin addition] DADS [end addition] [begin deletion] DHS [end deletion] complete information according to federal and state requirements about the identity of:

1. each person who directly or indirectly owns interest of 5% or more in the facility;
2. each owner (in whole or in part) of any property, assets, mortgage, deed of trust, note, or other obligation secured by the facility;
3. each officer and director, if the facility is organized as a corporation;
4. each partner, if the facility is organized as a partnership (A copy of the partnership agreement is required, but the dollar amount of capital contributions of the partners may be omitted); and
5. any director, officer, agency, or managing employee of the institution, agency, or organization, who has ever been convicted of a criminal offense related to the person's involvement in programs established by Title XVIII, XIX, and XX. (Effective dates for disclosure of any convictions are July 1, 1966, for Medicare, and January 1, 1969, for Medicaid.)

(j) If a profit-making corporation operates the facility, a copy of the following material is required:

1. certificate of incorporation (for Texas corporations only);
2. certificate of authority to do business in Texas (for out-of-state corporations only);
3. a resolution from the board of directors authorizing a specific person or officer to sign contracts between [begin addition] DADS [end addition] [begin deletion] DHS [end deletion] and the corporation; and
4. any management contract for the facility. If no stockholder owns, directly or beneficially, 5.0% or more of the corporate stock, the president and secretary of the corporation should state this on the department form.
(k) If a nonprofit corporation operates the facility, a copy of the following material is required:

1. Certificate of incorporation (for Texas corporations only);
2. Certificate of authority to do business in Texas (for out-of-state corporations only);
3. A resolution from the board of directors authorizing a specific person or officer to sign contracts with DADS; and
4. A copy of any management contract for the facility.

(l) Facilities other than those described in subsections (j) and (k) of this section must furnish a copy of:

1. Charter or other legal basis for the organization which owns the facility;
2. Any management contract or agreement for the facility;
3. By-laws of the organization (if applicable); and
4. Other information required by DHS to determine the status of the legal entity that owns the facility.

(m) Facilities must disclose business transaction information. A facility must send to DHS, within 35 days after the date of a written request, complete information on:

1. The ownership of a subcontractor with whom the facility has had, during the previous 12 months, business transactions totaling more than $25,000; and
2. Any business transactions between the facility and any wholly owned supplier, or between the facility and any subcontractor during the five-year period ending on the date of the request.

(n) The facility must report changes in the required information promptly to DHS.

(o) Failure to provide this information may result in suspension, termination, or other contract action, including holding vendor funds. Payment to the facility is denied beginning on the day after the
date information was due, and ending on the day before the date the information is received by [begin addition] DADS [end addition] [begin deletion] DHS [end deletion].

(p) Each facility must comply with Government Code, §531.116. A facility that furnishes services under the Medicaid program is subject to Occupations Code, Chapter 102. The facility's compliance with that chapter is a condition of the facility's eligibility to participate as a facility under those programs.


(a) Program description. The Texas Department of Human Services (DHS) operates the Medicaid Swing Bed Program for rural hospitals located in counties with populations of 100,000 or less. The Medicaid Swing Bed Program is modeled on Medicare's Swing Bed Program. The Medicaid Swing Bed Program permits participating rural hospitals to use their beds interchangeably to furnish both acute hospital care and nursing facility care to Medicaid recipients, when no care beds are available in nursing facilities (NFs) in the area. When a participating rural hospital furnishes NF nursing care to Medicaid recipients, DHS makes payment to the hospital using the same procedures, the same case-mix methodology, and the same Resource Utilization Group daily Texas Index for Level of Effort (TILE) rates that the Texas Health and Human Services Commission authorizes for reimbursing NFs participating in the Texas Medicaid Nursing Home Program.

(b) Application to participate. Rural hospitals apply to DHS to participate in the Medicaid Swing Bed Program. Each applicant must be located in a county with a population of 100,000 or less and must meet the qualifying requirements of the Medicare Swing Bed Program. Hospitals approved for participation enter into swing bed provider agreements with DHS.

(c) Parallel participation in Medicare. A rural hospital participating in the Medicaid Swing Bed Program must:

1. have a Medicare hospital provider agreement; and
(2) be Medicare-certified by the [begin addition] Department of State Health Services (DSHS) [end addition] [begin deletion] Texas Department of Health (TDH) [end deletion] as a swing bed hospital in the Medicare Swing Bed Program.

(d) Applicability of Medicare requirements. Each participating rural hospital must satisfy all the requirements of the Medicare Swing Bed Program, except that Medicare's five-weekday transfer requirement, as stated in §482.66(b)(i)-(ii), 42 Code of Federal Regulations, and 15% payment limitation do not apply for Medicaid reimbursement purposes.

(e) Applicability of NF [begin addition] requirements [end addition] [begin deletion] Requirements [end deletion]. From day one of the resident's stay, [begin addition] a rural hospital participating in the Medicaid Swing Bed Program [end addition] [begin deletion] participating rural hospitals [end deletion] must meet the requirements set forth in §19.101 of this title (relating to Definitions); §19.2304(c) of this title (relating to [begin addition] Contract [end addition] [begin deletion] Federal [end deletion] Requirements); [begin addition] §§19.300-19.314 and 19.316 [end addition] [begin deletion] §§19.1701-19.1715 and 19.1717 [end deletion] of this title (relating to General Requirements; Applicable Codes and Standards; Waivers; Emergency Power; Space and Equipment; Resident Rooms; Toilet Facilities; Resident Call System; Dining and Resident Activities; Other Environmental Conditions; Site and Grounds; Fire Service and Access; Means of Egress; Interior Finishes - Walls, Ceilings, and Floors; Fire Alarms, Detection Systems, and Sprinkler Systems; and Subdivision of Building Spaces - Smoke Barriers); §§19.1901-19.1914 and 19.1917 of this title (relating to Administration; Governing Body; Required Training of Nurse Aides; Proficiency of Nurse Aides; Staff Qualifications; Use of Outside Resources; Medical Director; Laboratory Services; Radiology and Other Diagnostic Services; Clinical Records; Contents of the Clinical Record; Additional Clinical Record Service Requirements; Clinical Records Service Supervisor; Disaster and Emergency Preparedness; and Quality Assessment and Assurance); §§19.2601-19.2608 and 19.2610 of this title (relating to Subchapter AA, Vendor Payment); [begin addition] Subchapter Y of this title [end addition] [begin deletion] §§19.2402-19.2405, and 19.2407-19.2413 of this title [end deletion] (relating to [begin addition] Medical Necessity Determinations [end addition] [begin deletion] Subchapter Y, Medical Review and Re-evaluation [end deletion]); [begin deletion] §§19.1801 and 19.1902 of this title (relating to General Reimbursement Information and Cost Reporting Procedures) [end deletion]; and Appendix [begin addition] B. Cost Determination Process, and Appendix C. Reimbursement Methodology for Nursing Facilities [end addition] [begin deletion] A. General Reimbursement Methodology [end deletion], of [begin addition] DADS' Nursing Facility Requirements for Licensure and Medicaid Certification Handbook [end addition] [begin deletion] DHSS's Long-Term Care Nursing Facility Requirements for Licensure and Medicaid Certification [end deletion].

(f) Rural hospital (Medicaid swing bed facility) licensure and certification requirements. Pursuant to [begin addition] Texas [end addition] [begin deletion] the [end deletion] Health and Safety Code §§222.021, 222.024, and 222.025 concerning the duplication of health care inspections and licensing, a rural hospital participating in the
Medicaid [begin addition] Swing Bed Program [end addition] [begin deletion] swing bed program [end deletion] satisfies licensure and certification requirements referenced in this section when it is currently licensed and certified as a hospital by [begin addition] DSHS [end addition] [begin deletion] the Texas Department of Health [end deletion]. However, in accordance with [begin addition] Texas Human Resources Code, [end addition] §32.024 [begin deletion] of the Human Resources Code [end deletion], if the rural hospital's swing beds are used for more than one 30-day length of stay per year, per resident the hospital must comply with the full Nursing Facility Requirements.

(g) Rural hospital (Medicaid swing bed facility) administrator. The governing body of a rural hospital participating in the Medicaid Swing Bed Program satisfies the requirement to appoint a qualified full-time nursing facility administrator, found at §19.1902(b) of this title (relating to Governing Body), when it appoints a hospital administrator as its official representative and designates the administrator's responsibilities and authority, subject to the following exception. If the swing beds are used for more than one 30-day length of stay per year, per resident, the hospital's governing body must appoint a full-time licensed nursing [begin addition] facility [end addition] [begin deletion] home [end deletion] administrator.

(h) Rural hospital (Medicaid swing bed facility) staff development requirements. A rural hospital participating in the Medicaid Swing Bed Program satisfies the staff development requirements found at §19.1929 of this title (relating to Staff Development) if the swing beds are used for no more than one 30-day length of stay per year, per resident.

(i) Rural hospital (Medicaid swing bed facility) transfer agreement. A rural hospital participating in the Medicaid Swing Bed Program is not required to have a transfer agreement with another hospital, as required by §19.1915 of this title (relating to Transfer Agreement).

(j) Rural hospital geographic region. The phrase "a participating rural hospital's geographic region" refers to an area that includes nursing facilities with which the hospital normally arranges transfers and all other nursing facilities in similar proximity to the hospital. If a hospital has no previous transfer practices on which to base a determination, the phrase "geographic region" refers to an area that includes all nursing facilities within 50 miles of the hospital except for facilities that the hospital demonstrates to be inaccessible to its patients.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.
Proposed action:
X New

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.


Medical necessity is the prerequisite for participation in the Medicaid (Title XIX) Long-term Care program. This section contains the general qualifications for a medical necessity determination. To verify that medical necessity exists, an individual must meet the conditions described in paragraphs (1) and (2) of this section.

(1) The individual must demonstrate a medical condition that:

(A) is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and

(B) requires licensed nurses' supervision, assessment, planning, and intervention that are available only in an institution.
(2) The individual must require medical or nursing services that:

(A) are ordered by a physician;

(B) are dependent upon the individual's documented medical conditions;

(C) require the skills of a registered or licensed vocational nurse;

(D) are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and

(E) are required on a regular basis. [end addition]


(a) Purpose. A recipient must have a determination of medical necessity for nursing facility care to participate in the Texas Medicaid Nursing Facility Program.

(1) The state Medicaid claims administrator makes a medical necessity determination by evaluating a recipient's medical and nursing needs based on the MDS assessment required by DADS.

(2) A recipient must have a determination of medical necessity for nursing facility care before the nursing facility can be paid for services, except as provided in §19.2413 of this subchapter (relating to Determination of Payment Rate Based on the MDS Assessment Submission) and §19.2611 of this chapter (relating to Retroactive Vendor Payment).

(b) Admission MDS assessment review.

(1) The admission MDS assessment review process is initiated when the state Medicaid claims administrator receives an MDS assessment and the Long-Term Care Medicaid Information Section, in accordance with §19.2413 of this subchapter, indicating that a Medicaid applicant or recipient is requesting vendor payment for care in a contracted nursing facility. A registered nurse must sign and certify that the MDS assessment is completed in accordance with §19.801 of this chapter (relating to Resident Assessment).

(2) The admission MDS assessment review determines medical necessity and establishes the authorization for payment of a calculated RUG rate.

(c) Role of the state Medicaid claims administrator. The state Medicaid claims administrator reviews all MDS assessments, including significant change in status assessments, modifications, and significant corrections, and approves or denies medical
necessity in accordance with §19.2401 of this subchapter (relating to General Qualifications for Medical Necessity Determinations).

(d) Effective period.

(1) A determination of medical necessity based on the admission MDS assessment review remains in effect for the time period determined by the federal MDS submission schedule.

(2) If a nursing facility submits a recipient's MDS assessment after the due date established by the federal MDS submission schedule, the recipient's medical necessity remains in effect for the period between the due date and the date the state Medicaid claims administrator received the MDS assessment.

(3) If a nursing facility submits a recipient's MDS assessment after the due date established by the federal MDS submission schedule and, after reviewing the MDS assessment, the state Medicaid claims administrator determines that the recipient does not meet the criteria for medical necessity, the effective date of the denial of medical necessity is the date the state Medicaid claims administrator received the MDS assessment. A denial of medical necessity is conducted in accordance with §19.2407 of this subchapter (relating to Denied Medical Necessity).

(e) Permanent medical necessity.

(1) A recipient's permanent medical necessity status is established on the completion date of any MDS assessment approved for medical necessity no less than 184 calendar days after the recipient's admission to the Texas Medicaid Nursing Facility Program.

(2) A nursing facility must submit a recipient's MDS assessment in compliance with the federal MDS submission schedule even after the recipient achieves permanent medical necessity status.

(3) A recipient's permanent medical necessity status moves with the recipient, unless the recipient is discharged to home for more than 30 days.

(4) If a recipient who has permanent medical necessity status transfers to another Medicaid-certified nursing facility, the nursing facility to which the recipient transfers must complete a new MDS assessment in compliance with the federal MDS submission schedule.

(f) Insufficient information. If an MDS assessment does not have sufficient information for the state Medicaid claims administrator to make a medical necessity determination, the MDS assessment is put in suspense for 21 days with a message from the state Medicaid claims administrator informing the nursing facility that the MDS assessment has been put in suspense for 21 days. Unless the nursing facility provides
sufficient information on the MDS assessment to determine medical necessity within 21 days, medical necessity is denied. [end deletion]


(a) If the state Medicaid claims administrator determines that a Medicaid applicant or a recipient does not meet the criteria for medical necessity described in §19.2401 of this subchapter (relating to General Qualifications for Medical Necessity Determinations), the state Medicaid claims administrator notifies the attending physician and the nursing facility in writing and provides them an opportunity to present additional information about the applicant's or recipient's medical need for nursing facility care.

(1) If the attending physician or a nursing facility physician does not respond or contest the findings of the state Medicaid claims administrator within 10 working days after receipt of the written notice about the decision, the findings are final.

(2) If the attending physician or a nursing facility physician contests the findings of the state Medicaid claims administrator, at least one physician with the state Medicaid claims administrator must review the case. If the state Medicaid claims administrator's physician determines that the applicant's or recipient's admission or stay is not medically necessary, the determination becomes final.

(3) The state Medicaid claims administrator sends written notification of the final determination of denied medical necessity to the attending physician, the nursing facility, and the applicant or recipient (or responsible party).

(b) After an applicant receives written notice of a determination of denied medical necessity, the applicant or responsible party must request a fair hearing within 90 days after the date of denied medical necessity, or the applicant loses the right to a fair hearing.

(c) After a recipient receives written notice of a determination of denied medical necessity, the recipient or responsible party must request a fair hearing within 10 days after the date of the written notice in order to have nursing facility services paid for during the appeal.

(1) If the recipient requests a fair hearing within 10 days after the date of the written notice and the determination of denied medical necessity is upheld, the effective date of the denial is 10 days after the hearing officer's written decision.

(2) If the recipient does not request a fair hearing within 10 days after the date of the written notice, DADS makes vendor payments to the nursing facility at the previously established RUG rate for 15 days or until the recipient is discharged, whichever occurs first.
(3) If the recipient does not request a fair hearing within 10 days after the date of the written notice, the recipient must request a fair hearing within 90 days after the date of denied medical necessity, or the recipient loses the right to a fair hearing.

(d) Fair hearings are conducted by the Texas Health and Human Services Commission (HHSC) in accordance with HHSC rules at 1 TAC Chapter 357. [end addition]

[begin addition] §19.2413. Determination of Payment Rate Based on the MDS Assessment Submission.

(a) Definitions. In this section, the following words and terms have the following meanings unless the context clearly indicates otherwise.

(1) All conditions of eligibility--A recipient meets all conditions of eligibility when the state Medicaid claims administrator approves the recipient for medical necessity and the recipient meets financial eligibility for Medicaid.

(2) On-time MDS assessment--An MDS assessment that is submitted in accordance with the federal MDS submission schedule and is received by the state Medicaid claims administrator within 31 days after the completion date.

(3) Missed MDS assessment--An MDS assessment that is received by the state Medicaid claims administrator outside the time period that the MDS assessment covers.

(b) MDS submission requirement. A nursing facility must:

(1) complete all MDS assessments according to CMS' instructions;

(2) submit a recipient's MDS assessment, including an admission MDS assessment, a quarterly MDS assessment, and a significant change in status assessment, to the state MDS database in compliance with the federal MDS submission schedule;

(3) submit the Long-Term Care Medicaid Information Section to the state Medicaid claims administrator; and

(4) submit the recipient's MDS assessment in compliance with the federal MDS submission schedule even after the recipient has permanent medical necessity as described in §19.2403(e) of this subchapter (relating to Medical Necessity Determination).

(c) Admission MDS assessments.
(1) If a nursing facility discharges a recipient with a status of return not anticipated, and the recipient returns to the facility, the nursing facility must complete an admission MDS assessment for a determination of medical necessity and establishment of a RUG rate, regardless of the amount of time between the recipient's discharge and return.

(2) A nursing facility must complete and submit an admission MDS assessment to receive payment for a recipient's period of stay in the nursing facility, even if the recipient leaves the nursing facility before the MDS assessment is completed and never returns long enough for the MDS assessment to be completed. See subsection (i) of this section for completion of an admission MDS assessment in the event of a recipient's death.

(3) DADS pays a calculated RUG rate for an admission MDS assessment from the date the recipient was admitted to the nursing facility, except as provided in §19.2611 of this chapter (relating to Retroactive Vendor Payments).

(d) Payment of a calculated RUG rate. If a recipient meets all conditions of eligibility, DADS pays a calculated RUG rate for an MDS assessment if it is received by the state Medicaid claims administrator during the time period that the MDS assessment covers.

(e) On-time MDS assessment. If a recipient meets all conditions of eligibility, DADS pays a calculated RUG rate from the completion date of the required MDS assessment, except for an admission MDS assessment as described in subsection (c)(3) of this section.

(f) MDS assessments that are not on time. The state Medicaid claims administrator stops payment for services if the state Medicaid claims administrator does not receive an on-time MDS assessment. Payment for services resumes when the state Medicaid claims administrator receives all MDS assessments that are due as required by the federal MDS submission schedule.

(g) Missed MDS assessments. When the state Medicaid claims administrator receives a missed MDS assessment, DADS pays the nursing facility a default RUG rate for the entire period of the missed MDS assessment if the recipient meets financial eligibility for Medicaid, except as provided in paragraph (2) of this subsection.

(1) If an MDS assessment is missed for the purpose of calculating a RUG rate, the nursing facility must still submit the MDS assessment to comply with §19.801 of this chapter (relating to Resident Assessment).

(2) For a newly contracted nursing facility and a nursing facility that undergoes a change of ownership, DADS pays the calculated RUG rate for any missed MDS assessments that occur while the nursing facility is unable to submit MDS assessments to the state MDS database.
(h) Significant change in status assessment, modification, or significant correction. If a recipient meets all conditions of eligibility, DADS pays the calculated RUG rate from the completion date of a significant change in status assessment, modification, or significant correction.

(i) Incomplete or erroneous MDS assessments. If an applicant meets all conditions of eligibility, DADS pays a default rate for an MDS assessment that is incomplete or has errors.

(j) Prohibition against recourse. A nursing facility must not charge and must not take any other recourse against a recipient, the recipient's family members, the recipient's estate or the recipient's representative for a claim that is reduced because the facility failed to comply with a DADS rule or procedure pertaining to reimbursement. [end addition]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.

TITLE 40    SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19   NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER Y  MEDICAL REVIEW AND RE-EVALUATION

Proposed action:
X  Repeal

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules
necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

(a) The Texas Department of Human Services (DHS) contracts with the Utilization Review Committee of the National Heritage Insurance Company (NHIC) to perform utilization review functions for the purpose of determining medical necessity. Professionally developed written criteria are used to evaluate the medical necessity for admission and continued stay of Medicaid recipients.
(b) The Utilization Review Committee consists of physicians, registered nurses, and other staff as needed.

The Utilization Review Committee determines the need for nursing facility care by evaluating the recipient's medical and/or nursing needs based on facility documentation required by the Texas Department of Human Services (DHS). The medical necessity determination must be made before receiving vendor payment for service delivery, except as provided in §19.2408 of this title (relating to Retroactive Medical Necessity Determinations) and §19.2413 of this title (relating to Reconsideration of Medical Necessity Determination (MN) and Effective Dates).
(1) Documentation and utilization requirements are based on each recipient's need for care, under daily supervision of licensed nurses. All forms must contain the signature and license number of the director of nurses and the nurse assessor.
(2) The review process is initiated when the Utilization Review Committee receives a Texas Nursing Facility Client Assessment, Review, and Evaluation (CARE) form indicating that a Medicaid applicant or recipient is requesting vendor payment for care in a contracted nursing facility.
(A) A preadmission screening for PASARR is necessary when an individual is being admitted to any nursing facility in which he has not recently resided and to which he cannot qualify as a readmission (see §19.2500 of this title (relating to Preadmission Screening and Annual Resident Review (PASARR))).
(B) A preadmission review of a CARE form may be submitted on any individual seeking admission to a Medicaid facility. The optional preadmission review allows a facility to determine whether the individual would meet the medical necessity requirements for the Medicaid Nursing Facility Program. A preadmission review does not establish medical necessity, an authorization for reimbursement, or a level of reimbursement.
(C) An admission review of a CARE form determines the medical necessity and establishes an authorization for reimbursement and a level of reimbursement. A valid medical necessity determination is an eligibility requirement for Medicaid participation,
and vendor payments cannot be made on behalf of recipients who do not have established medical necessity determinations.

(i) If a facility is receiving Medicare copayment from DHS for a recipient, that recipient is not considered to be in the Medicaid vendor payment system.

(ii) The CARE form must be received by the Utilization Review Committee in accordance with §19.2404 of this title (relating to Utilization Review Effective Dates). The admission review and determination of medical necessity (MN) remains valid for up to 180 days from date of admission or the stamp-in date when not received by the Utilization Review Committee within 20 days of admission.

(iii) An admission Texas Nursing Facility CARE form must include a current certification by a physician.

(iv) Admission reviews must be done on all new Medicaid admissions who do not have a permanent medical necessity.

(D) The medical necessity review (MNR) is due 180 days after the effective date of the admission MN determination. If the MNR indicates an MN for nursing facility care, the MN will become permanent. If a CARE form is not received by the day after the expiration date of the current MN determination, the current MN determination ceases to exist. To reinstate an expired MN determination:

(i) if more than 30 days have elapsed, facility staff must submit an admission CARE form assessment, signed by the physician, to the Utilization Review Committee.

(ii) if 30 days or less have elapsed, an MN review is submitted. The date of receipt of these CARE forms is the new effective date of the MN.

(E) Texas Index for Level of Effort (TILE) review is done 180 days after the effective date of the MNR and every 180 days thereafter, except for recipients with a TILE level of 211. For TILE level 211, no additional assessment forms are required, and payment will continue at that level, unless the facility submits a form indicating a change in condition.

(3) To ensure that payments continue, the facility must submit all forms in a timely manner so that they are received by the Utilization Review Committee no later than the day after the expiration of the current form.

(A) When submitting forms by mail, the stamp-in date (effective date) will be considered to be the date mailed only if sent by certified mail.

(i) When utilizing certified mail, the facility must enclose an original and photocopy of an alphabetized list of assessment forms being submitted with each envelope/package as well as a self-addressed, stamped envelope. The assessment forms must also be in alphabetical order. The facility is responsible for the content of each envelope/package including the accuracy and completeness of the forms and list.

(ii) The lists submitted by the facility will be compared to the envelope/package contents. Verification of content will be made and the assessment forms stamped in. Any discrepancies will be noted on the photocopy list. Each photocopy list will be returned to the facility in the envelope provided. The Utilization Review Committee must retain the alphabetized list for two years as part of the facility records.

(iii) Facilities must retain the photocopy of the alphabetized list with the certified mail receipt attached at least until all accounts are satisfied for the time periods involved, or two years, whichever is longest.
Texas Nursing Facility Client Assessment, Review, and Evaluation (CARE) forms should be submitted in the following manner:

(i) The Utilization Review Committee accepts CARE forms from facilities up to 45 days before the expiration of the recipient's current assessment, and

(ii) The CARE forms submitted for TILE reviews must be completed no more than 60 days prior to the expiration date of the current assessment.

(C) All forms must be fully completed and contain all current information. To ensure that payments continue, any forms that are returned for proper completion must be received by the Utilization Review Committee no later than the day after expiration of the current form.

(D) If a CARE form is not received by the day after the expiration date of the current form, payment ceases.

(E) The Texas Department of Human Services (DHS) does not pay for the period of time between an expired form and the new effective date, unless the facility has requested and been granted a reconsideration of effective dates. See §19.2413 of this title (relating to Reconsideration of Medical Necessity Determination (MN) and Effective Dates).

(i) DHS recoups any inadvertent payments made to facilities.

(ii) If the facility does not receive payment and there has been no reconsideration of effective dates granted, then restrictions apply as described in §19.2608 of this title (relating to Limitations on Provider Charges) when the reason for no payment is facility error.

When the recipient is admitted to or discharged from the Medicaid Nursing Facility vendor payment system, the facility must submit a Resident Transaction Notice form within 72 hours. Failure to submit forms regarding discharges may result in the withholding of vendor payment until the documentation is obtained.

(1) The administrator of the facility must submit to the Utilization Review Committee an admission Texas Nursing Facility Client Assessment, Review, and Evaluation (CARE) form within 20 calendar days following admission to the Medicaid Nursing Facility vendor payment system.

(A) The CARE form must be completed and signed by the physician within 20 calendar days following admission to the Nursing Facility vendor payment system.

(B) The CARE form submitted within 20 calendar days of the date of admission will be effective on the date of the admission.

(C) The effective date of a Texas Nursing Facility CARE form not submitted within 20 calendar days following admission to the Nursing Facility vendor payment system will be the stamp in date at the Utilization Review Committee.

(2) If a recipient who has not achieved a permanent medical necessity determination is out of the Medicaid nursing facility vendor payment system for more than 30 days, existing medical necessity determinations are no longer in effect and a new admission medical necessity determination must be done, as described in §19.2403(2)(B) of this title (relating to Utilization Review Process) for a TILE rate to be established.
The Texas Department of Human Services (DHS) does not make vendor payment when a CARE form expires. See §19.2413 of this title (relating to Reconsideration of Medical Necessity (MN) Determination and Effective Dates).

(A) A provider is not entitled to payment for services rendered from the expiration date to the new effective date of a recipient's CARE form unless a reconsideration of effective dates has been granted.

(B) Vendor payment made by the Texas Department of Human Services (DHS) for any period not within CARE form effective dates is subject to recoupment.

If more than 30 days elapse between the effective dates of a facility's contract cancellation and new contract, the facility must submit new documentation for recipients who have remained in the facility during the noncontracted period. Recipients with permanent medical necessity determinations keep their permanent medical necessity status.

If the Utilization Review Committee determines that the written criteria for admission or continued stay are not met, the attending physician is notified in writing within two working days and allowed an opportunity to present additional information about the recipient's medical need for nursing facility placement.

(1) If the attending physician does not respond or contest the findings of the Utilization Review Committee within five working days of receipt of the decision, the findings are final.

(2) If the attending physician contests the findings of the Utilization Review Committee, at least one additional physician in the Utilization Review Department must review the case. If the additional physician determines that the recipient's admission or stay is not medically necessary, the determination becomes final.

(3) Written notification of the final determination of a denied medical necessity must be sent to the attending physician, recipient (or responsible party), facility administrator, and the state office of the Texas Department of Human Services (DHS) no later than two days after the decision.

(4) A physician must make the final determination that a recipient's stay is not medically necessary.

(5) Recipients' appeals will be processed as a fair hearing according to Texas Department of Human Services' fair hearings rules in Chapter 79 of this title (relating to Legal Services). The recipient should contact the Utilization Review Committee to request a hearing. When the recipient does not appeal the denied medical necessity decision within ten days of the decision, vendor payments to the facility will be made at the rate for the previously established Texas Index for Level of Effort (TILE) for a period of 15 days or until the recipient is transferred, whichever occurs first. If the recipient does appeal within ten days of the decision and the denied medical necessity is upheld, the effective date will be ten days after the hearing officer's written decision.

Private pay individuals living in Medicaid-certified nursing facilities, or distinct parts, who do not receive SSI cash benefits and who make application for Medicaid may be eligible for "three months prior" vendor payments. To ensure that vendor payments begin
on the date that an individual's financial resources are exhausted, the potential recipient must have a valid medical necessity (MN) determination.

— (1) If a recipient is found to be otherwise eligible for vendor payments for all or part of the three months prior to the date of his application for Medicaid assistance, Texas Department of Human Services (DHS) Medicaid eligibility staff will notify facility staff. Facility staff should submit a request for MN determination form (CARE) for the retroactive period.

— (2) If an applicant meets all other eligibility criteria for three months prior coverage, DHS makes retroactive vendor payments according to the assigned Texas Index for Level of Effort (TILE) level for the period indicated on the CARE form submitted for retroactive coverage.

— (3) DHS makes retroactive vendor payments for only that period of time during which physician certification, plan of care, and medical necessity requirements are met. After establishment of any retroactive medical necessity, verification may be done to show that the applicant's record includes the physician's certification, recertification, and plans of care, and that the plans were reviewed as required during the applicable period(s). The effective date of the new MN determination for the retroactive period of eligibility is the first day of the earliest month in which the applicant qualified for a medical necessity determination. If the recipient has paid for the retroactive time period, the facility must reimburse him the vendor portion that DHS paid.

§19.2409. General Qualifications for At-Risk Assessments and Medical Necessity Determinations.

(a) To be eligible for the Medicaid (Title XIX) Long-term Care program, an individual must meet two or more of the following criteria for nursing facility risk, as specified in the Resident Assessment Instrument Home Care Assessment for Nursing Home Risk, as revised in April 1996 and summarized as follows:

(1) needs assistance with one or more of the activities of dressing, personal hygiene, eating, toilet use, or bathing;

(2) has a functional decline in the past 90 days;

(3) has a history of a fall two or more times in past 180 days;

(4) has a neurological diagnosis of Alzheimer's, head trauma, multiple sclerosis, Parkinsonism, or dementia;

(5) has a history of nursing facility placement within the last five years;

(6) has multiple episodes of urine incontinence daily; or

(7) goes out of one's residence one or fewer days a week.

(b) Medical necessity (MN) is the prerequisite for participation in the Medicaid (Title XIX) Long-term Care program. This section contains the general qualifications for an MN determination. To verify that medical necessity exists, an individual must meet the conditions described in paragraphs (1) and (2) of this subsection.

(1) The individual must demonstrate a medical disorder or disease or both, with a related impairment that:

(A) limits his ability to recognize problems, changes in his condition, and the need for or side effects of prescribed medications;

(B) is of sufficient seriousness that his needs exceed the routine care which may be given by an untrained person; and
(C) requires nurses' supervision, assessment, planning, and intervention that are available only in an institution.

(2) The individual must require medical/nursing services that:

(A) are ordered by and remain under the supervision of a physician;

(B) are dependent upon the individual's documented medical, physical, and/or functional disorders, conditions, or impairments;

(C) require the skills of registered or licensed vocational nurses;

(D) are provided either directly by or under the supervision of licensed nurses in an institutional setting; and

(E) are required on a regular basis.

§19.2410. Criteria Specific to a Medical Necessity Determination.

(a) Specific criteria are also used to determine if the individual has medical necessity requiring nursing-facility care. The Texas Department of Human Services (DHS) recognizes, however, that these criteria are not all inclusive. The applicant's or the recipient's condition may be so complex that only the professional medical judgment of Utilization Review Committee physicians will be the deciding factor.

(b) For an applicant or a recipient to qualify for nursing-facility care, the recipient's medical problems and health care needs are, at a minimum, such that he requires institutional care under the supervision of a physician. An applicant or a recipient must need services for which a registered nurse's or licensed vocational nurse's supervision is required on a daily and/or routine basis. Services which could qualify an individual for a medical necessity determination include but are not limited to:

(1) routine monitoring of an individual in stable condition to determine responses to the treatment plan and to detect problems requiring the physician's attention and/or a change in the plan of care;

(2) administration of intramuscular (IM) medications and observation of the individual's response and side effects;

(3) administration and adjustment of medication for pain and monitoring of result and side effects;

(4) administration of insulin to a diabetic individual whose condition is stable but who is unable to self-administer insulin because of physical, medical, or mental reasons;

(5) routine oxygen administration after a regimen of therapy has been established and/or therapy can be done by the individual with nursing supervision;

(6) routine oral suctioning;

(7) tracheostomy care when a individual's condition is stable, but he is unable to care for his tracheostomy;

(8) routine IPPB therapy after a regimen of therapy has been established and/or therapy can be done by the individual with nursing supervision;

(9) routine maintenance of an indwelling catheter system;

(10) routine care of stoma and surrounding skin in the presence of a colostomy or ileostomy and routine care of a suprapubic catheter;

(11) decubitus care involving superficial, noninfected lesions and preventive measures when an individual has a physical illness which makes him susceptible to decubiti formation.
bowel and bladder control training and maintenance after a successful program has been established;

care of an individual with an amputation or a fracture requiring routine care of a stylized condition and reinforcement of an established rehabilitation plan; and

rehabilitative/restorative care, passive range-of-motion (ROM) exercises and positioning, care and assistance in application of braces/prosthetic devices or reinforcement of maintenance rehabilitative procedures.

§19.2413. Reconsideration of Medical Necessity (MN) Determination and Effective Dates.

When a facility provides care for a recipient for a period of time not covered by an effective medical necessity determination at admission or completion of Texas Nursing Facility Client Assessment, Review, and Evaluation (CARE) forms between reviews, the Texas Department of Human Services (DHS) will reconsider the effective dates.

(1) Recipients eligible for reconsideration of effective dates must have the following, prior to the submission of a request for reconsideration:

(A) financial eligibility established;
(B) admission to the Medicaid Nursing Facility Vendor Payment System on DHS's Resident Transaction Notice form; and
(C) a medical necessity determination using a CARE form with a Purpose Code 2.

(2) Requests for reconsideration require the completion of a CARE form based on the recipient's status in the facility during the four weeks immediately preceding the first date for which payment is to be recovered, with the exception of the instances noted in §19.1812 (1) of this title (relating to Case Mix Classification System).

(3) Requests for reconsideration for periods of time already denied a medical necessity determination by the Utilization Review Committee (URC) will not be accepted.

(4) The URC will only accept a request up to 12 months following the last day that service was provided.

(5) The URC will notify the facility of the results of the reconsideration within 45 days. The facility may initiate an appeal, when reconsideration is denied, by submitting a request in writing as outlined in Chapter 79 of this title (relating to Legal Services). The facility must initiate the appeal within ten workdays of receipt of notification that a reconsideration was denied.

(6) The facility may neither charge nor take any other recourse against Medicaid recipients, their family members, or their representatives for any claim denied or reduced because of the facility's failure to comply with any DHS rule, regulation, or procedure pertaining to reimbursement.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.
Proposed action:
X Amendment

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

§19.2500. Preadmission Screening and Resident Review (PASARR).

(a) Definitions. The following words and terms, when used in this section, [begin deletion] shall [end deletion] have the following meanings, unless the context clearly indicates otherwise:

(1) Acute inpatient care - An acute institutional setting that provides medical care, such as a hospital, but does not include inpatient psychiatric care.

(2) Alzheimer's disease - A degenerative disease of the central nervous system as diagnosed by a physician in accordance with the International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM).
(3) **Amyotrophic lateral sclerosis** - A degenerative motor neuron disease as diagnosed by a physician in accordance with International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM).

(4) **Anencephaly** - A developmental anomaly with absence of neural tissue in the cranium.

(5) **Chronic obstructive pulmonary disease** - A disease of the respiratory system as diagnosed by a physician in accordance with the International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM).

(6) **Comatose** - A state of unconsciousness characterized by the inability to respond to sensory stimuli as certified by a physician.

(7) **Congestive heart failure** - A disease of the circulatory system as diagnosed by a physician in accordance with International Classification of Diseases, 9th Revision Clinical Modification (ICD-9-CM).

(8) **Convalescent care** - Care provided after a person's release from an acute care hospital that is part of a medically prescribed period of recovery which does not exceed 120 days.

(9) **Dementia** - A degenerative disease of the central nervous system as diagnosed by a physician in accordance with the International Classification of Diseases 9th revision Clinical Modification (ICD-9-CM).

(10) **Functioning at the brain stem level** - A significantly impaired state of consciousness characterized by normal respirations and minimal (mostly reflexive) response to environmental stimuli as certified by a physician.

(11) **Huntington's disease** - A disease of the central nervous system diagnosed by a physician in accordance with the International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM).

(12) **Legal representative** - The parent of a minor child, the legal guardian, or the surrogate decision maker of the applicant or the resident of a nursing facility.

(13) **Level I - identification screening** - The process of identifying individuals with an indication of mental illness, mental retardation and/or a related condition, who require a Level II PASARR assessment.

(14) **Level II - PASARR assessment** - Preadmission Screening and Resident Review assessment of persons with mental illness, mental retardation, and/or a related condition conducted in accordance with 42 United States Code Annotated, §1396r.
(15) Medical staff - Any staff licensed to practice medicine, such as a physician, registered nurse, or a licensed vocational nurse.

(16) Mental illness - A mental disorder is a schizophrenic, mood, paranoid, panic, or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder). The disorder results in functional limitations in major life activities within the past three to six months that would be appropriate for the individual's developmental stage. The individual typically has at least one of the following characteristics on a continuing or intermittent basis: serious difficulty in the areas of interpersonal functioning; and/or concentration, persistence, and/or pace; and/or adaptation to change. Within the past two years, the disorder has required psychiatric treatment more than one time and more intensive than outpatient care and/or the individual has experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment or which resulted in intervention by housing or law enforcement officials.

(17) Mental retardation - A diagnosis of mental retardation (mild, moderate, severe, and profound) and significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(18) New admission - An individual who is admitted to any nursing facility in which he has not recently resided and to which he cannot qualify as a readmission.

(19) Nursing facility - A Texas Medicaid-certified institution, except for a facility certified as an intermediate care facility for persons with mental retardation or related conditions (ICF/MR/RC), providing nursing services to nursing facility residents.

(20) Nursing facility applicant - An individual seeking admission to a Texas Medicaid-certified nursing facility.

(21) Nursing facility resident - An individual who resides in a Texas Medicaid-certified nursing facility and receives services provided by professional medical nursing personnel of the facility.

(22) QMHP - Qualified Mental Health Professional. An individual who has at least one year of experience working with persons with mental illness.

(23) QMRP - Qualified Mental Retardation Professional. An individual who has at least one year experience working with persons with mental retardation and/or a related condition.
(24) Parkinson's Disease - A degenerative disease of the central nervous system as diagnosed by a physician in accordance with the Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM).

(25) PASARR - Preadmission screening and resident review.

(26) PASARR determination - A decision made by [begin addition] DADS or its designee [end addition] [begin deletion] Texas Department of Human Services (DHS) PASARR Determination Program professional staff [end deletion] to establish if an individual requires the level of services provided in a nursing facility, as defined by medical necessity, if the individual has the need for specialized services for mental illness, mental retardation, and/or a related condition. The decisions are based on information included in the Level II PASARR Assessment.

(27) Readmission - An individual who is readmitted to a nursing facility from a hospital to which he or she was transferred for the purpose of receiving care.

(28) Related condition - A severe, chronic disability as defined in 42 Code of Federal Regulations §435.1009, in the definition of persons with related conditions, that meets all of the following conditions:

(A) it is attributable to:

   (i) cerebral palsy or epilepsy; or

   (ii) any other condition including autism, but excluding mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons.

(B) it is manifested before the person reaches age 22.

(C) it is likely to continue indefinitely.

(D) it results in substantial functional limitations in three or more of the following areas of major life activity:

   (i) self-care;

   (ii) understanding and use of language;

   (iii) learning;

   (iv) mobility;
(v) self-direction; and

(vi) capacity for independent living.

(29) Specialized services for individuals with mental illness - The implementation of an individualized plan of care developed under and supervised by an Interdisciplinary Team, which includes a physician, and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health personnel.

(30) Specialized services for individuals with mental retardation or a related condition - A continuous program for each [begin addition] resident [end addition] [begin deletion] client [end deletion], which includes aggressive, consistent implementation of specialized and generic training, treatment, health services and related services that is directed toward:

(A) the acquisition of the behaviors necessary for the [begin addition] resident [end addition] [begin deletion] client [end deletion] to function with as much self-determination and independence as possible; and

(B) the prevention or deceleration of regression or loss of current optimal functional status. Specialized services do not include services to maintain generally independent [begin addition] residents [end addition] [begin deletion] clients [end deletion] who are able to function with little supervision or in the absence of a continuous specialized services program.

(31) Substantial risk of serious harm to self and/or others - Harm which may be demonstrated either by a person's behavior or by evidence of severe emotional distress and deterioration in his mental condition to the extent that the person cannot remain at liberty, as determined by a court of law.

(32) Terminal illness - As defined for hospice purposes in 42 Code of Federal Regulations §418.3 in the definition of terminally ill.

(33) Ventilator dependent - Reliance upon a respirator or respiratory ventilator as a life support system to assist with breathing.

(b) Preadmission screenings.

(1) Purpose. All new admissions (private pay, Medicare beneficiaries, and Medicaid recipients) must be screened prior to admission to a nursing facility to determine if:

(A) the individual has mental illness (MI), mental retardation (MR), and/or a related condition (RC);
(B) the individual needs nursing facility services, as defined by medical necessity; and

(C) the individual requires specialized services.

(2) Readmissions. The following individuals are not subject to preadmission screenings:

(A) readmissions following hospitalizations;

(B) individuals who:

(i) are admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital,

(ii) require nursing facility services for the condition for which the individual received care in the hospital, and

(iii) have been certified by their attending physician prior to admission to the nursing facility that they are likely to require less than 30 days of nursing facility services;

(C) individuals who have a terminal illness as defined for hospice purposes in 42 Code of Federal Regulations §418.3, in the definition of terminally ill; and

(D) residents who:

(i) transfer from their current nursing facility residence to a new nursing facility residence;

(ii) have not had any interruption in continuous nursing facility residence other than for acute care hospitalization; and

(iii) have not had any change in their mental condition. For residents who transfer from one nursing facility to another, the transferring nursing facility is responsible for ensuring copies of the most recent PASARR assessment accompany the transferring resident.

(3) Level I Identification Screening. Individuals who are suspected of having mental illness, mental retardation, or a related condition (MI/MR/RC) are identified through the medical necessity screening process.

(A) Medical staff document for the presence of MI if the individual meets the following criteria:
(i) has a diagnosis of MI (excluding a primary diagnosis of Alzheimer's disease or dementia);

(ii) has a level of impairment that results in functional limitations in major life activities within the past three to six months in the areas of interpersonal functioning, concentration, persistence, pace and/or adaptation to change; and

(iii) within the last two years, due to the mental disorder, has had psychiatric treatment more intensive than outpatient care more than once and/or experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

(B) Medical staff document for the presence of MR and/or RC if the individual:

(i) has a diagnosis of MR and/or RC,

(ii) has any history of MR and/or RC identified in the past; or

(iii) presents any evidence (cognitive or behavioral functioning) that may indicate the presence of MR and/or a RC.

(C) Identification of MI, MR, or RC requires that an individual receive a Level II assessment prior to admission to a nursing facility.

(D) An individual, who has medical necessity, may be immediately admitted to or continue residing in a nursing facility if:

(i) MI, MR, or RC was substantiated in writing;

(ii) an individual is in the nursing facility for convalescent care;

(iii) an individual is comatose, functioning at the brain stem level, ventilator dependent, terminally ill, or has a serious medical condition such as chronic obstructive pulmonary disease, anencephaly, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure which result in an impairment so severe that the individual could not be expected to benefit from specialized services;

(iv) an individual has a primary diagnosis of dementia and is not MR and/or RC;

(vi) an individual is determined by [begin addition] DADS or its designee [end addition] [begin deletion] DHS [end deletion] during the Level II Assessment process not to have MI/MR/RC.
(4) Level II - PASARR assessment [end addition] [begin deletion] Level II Assessment [end deletion], [begin addition] DADS or its designee assesses [end addition] [begin deletion] DHS staff assess [end deletion] the need for nursing facility and specialized services.

(A) The assessment process consists of a:

(i) PASARR [begin addition] preadmission [end addition] [begin deletion] nursing facility [end deletion] assessment; [begin addition] and [end addition]

(ii) [begin addition] Level II - PASARR assessment, [end addition] [begin deletion] PASARR mental illness assessment (as appropriate); and [end deletion]

(begin deletion) (iii) PASARR mental retardation and related conditions assessment (as appropriate). [end deletion]

(B) Depending on the mental and/or physical condition, an assessment is conducted by one or more of the following:

(i) a registered nurse who is a qualified mental health professional;

(ii) a registered nurse who is a qualified mental retardation professional;

and

(iii) a psychologist who is a qualified mental retardation professional with at least a Master's degree; and

(iv) other qualified mental health professionals.

(C) It is the responsibility of the nursing facility to [begin addition] submit the required PASARR assessment to DADS or its designee [end addition] [begin deletion] contact the PASARR unit of DHS [end deletion] and request screening of any resident suspected of having MI, MR, or RC.

(c) Change in condition.

(1) The nursing facility will promptly notify [begin addition] DADS or its designee [end addition] [begin deletion] the mental health mental retardation authority, and PASARR unit of DHS [end deletion] after a significant change in the physical or mental condition of a resident that relates to the MI, MR, or RC diagnosis.

(2) [begin addition] DADS or its designee conducts [end addition] [begin deletion] The PASARR unit of DHS will conduct [end deletion] a review, as described in subsection (b)(4) of this section, and [begin addition] makes [end addition] [begin deletion] make [end deletion] a determination, as described in subsection (d) of this section.
(3) DADS or its designee must evaluate and contact the attending physician when there is a question regarding a resident's capacity to understand and meaningfully participate in the decisions regarding his eligibility to remain in the nursing facility, be alternately placed, receive specialized services, and/or initiate appeals.

(A) A surrogate decision maker will be assigned by the attending physician if there is a question regarding capacity and the individual meets the criteria in the Consent to Medical Treatment Act, Health and Safety Code, Chapter 313, as referenced in §19.420(a)(3) of this chapter (relating to Documentation for the Delegation of Long-Term Care Resident's Rights).

(B) A resident An individual will be referred to probate or county court for the assignment of a legal guardian if:

(i) no surrogate decision maker is available; or

(ii) there is a question regarding capacity, but the individual does not meet the criteria for a surrogate decision maker under §19.420(a)(3) of this chapter (relating to Documentation for the Delegation of Long-Term Care Resident's Rights).

(d) Determination process.

(1) The assessment data is analyzed by a qualified mental health and/or mental retardation professional in order to determine whether:

(A) Nursing facility services are needed, as described in §§19.2401 and 19.2410 of this chapter (relating to General Qualifications for Medical Necessity Determinations and Criteria Specific to a Medical Necessity Determination).

(B) An individual requires specialized services for mental illness. The presence of verbalizations or behaviors which indicate a person may pose a substantial risk of serious harm to self or others is evidence that the person requires specialized services.

(C) An individual requires specialized services for mental retardation or a related condition. A response by a person to the environment is evidence that the person requires specialized services.
(2) One of the following determinations is made:

(A) Nursing facility services are needed, but specialized services are not needed. Those individuals may be admitted to or continue residing in a nursing facility.

(B) Nursing facility services are needed and specialized services are needed. Those individuals may be admitted to or continue residing in a nursing facility and receive specialized services within the facility.

(C) Nursing facility services are not needed but specialized services are needed. Those individuals may not be admitted to or continue residing in a nursing facility except as described in paragraph (d)(3) of this subsection. Those individuals who are current nursing facility residents must be alternately placed as described in subsection (e) of this section.

(D) Nursing facility services are not needed and specialized services are not needed. Those individuals may not be admitted to or continue residing in a nursing facility. Those individuals who are current nursing facility residents must be alternately placed, according to discharge procedures stated under §19.502 of this chapter (relating to Transfer and Discharge in Medicaid-certified Facilities).

(3) If a nursing facility resident has 30 or more months of continuous residence in a nursing facility preceding the PASARR determination, the resident may choose to remain and receive specialized services in the nursing facility, or seek alternate placement.

(4) If during the determination process DADS or its designee ascertains that a person does not have MI/MR/RC, the PASARR determination process will be discontinued and the individual may be admitted to the nursing facility.

(5) DADS or its designee notifies all individuals and their legal representative or surrogate decision maker (SDM) of the results of their PASARR determination through a letter sent to them, the nursing facility administrator, the attending physician, and the local mental retardation authority (MRA) or local mental health authority (MHA) as applicable, the Office of the State Long-Term Care Ombudsman, Texas Department of Mental Health and Mental Retardation authorities, the Texas Department on Aging (TDoA), and Texas Health and Human Services Commission (HHSC).
Individuals who have undergone a preadmission screening or change in condition are [begin addition] will be [end addition] notified within 10 calendar days of the determination.

(6) Any individual, or his legal representative or responsible party or SDM, not in agreement with the PASARR determination may file an appeal with [begin addition] HHSC [end addition] DHS [begin deletion] to receive a [begin deletion] fair hearing according to [begin addition] 1 TAC Chapter 357 [end addition] Chapter 79 of this title (relating to Legal Services) [begin deletion].

(A) [begin addition] If [end addition] the hearing officer reverses [begin addition] DADS' or its designee's [end addition] determination regarding nursing facility admission, the individual seeking entry into the nursing facility may be admitted immediately; and as long as the individual meets all other eligibility requirements, the facility may receive vendor payments. Current residents who have met all eligibility criteria may continue to reside in the facility and receive Medicaid reimbursement retroactive to the date when medical and financial eligibility were in effect.

(B) [begin addition] If [end addition] the hearing officer sustains [begin addition] DADS' or its designee's [end addition] determination regarding nursing facility admission, the individual seeking entry into the nursing facility may not enter the facility and may not be Medicaid-certified for nursing facility placement. Current residents who have met all eligibility criteria may be alternately placed.

(e) Specialized services and alternate placement.

(1) [begin addition] DADS requests [end addition] The Texas Department of Mental Health and Mental Retardation (TDMHMR) contracts with [end deletion] the local MRA to provide service coordination, [begin addition] MHMR authority to purchase case management, specialized services, and procure alternate placement services for persons determined by [begin addition] DADS or its designee [end addition] to require specialized services and/or request alternate placement. [begin addition] The Department of State Health Services requests the local MHA to provide service coordination, case management, specialized services, and alternate placement services for persons with mental illness determined to require specialized services, alternate placement, or both.

(2) A [begin addition] service coordinator must [end addition] [begin deletion] case manager will [end deletion] be assigned for those residents who require specialized services and/or request alternate placement.
(3) [begin addition] DADS [end addition] [begin deletion] DHS [end deletion] provides specialized rehabilitative services, as stated under §19.1303(a) of this [begin addition] chapter [end addition] [begin deletion] title [end deletion] (relating to Specialized Services in [begin addition] Medicaid-certified [end addition] [begin deletion] Medicaid-Certified [end deletion] Facilities).

(4) An interdisciplinary team [begin addition] is [end addition] [begin deletion] will be [end deletion] constituted by the physician, mental health/mental retardation professional, Director of Nurses, or other professionals as appropriate, the resident and legal representative, responsible party or SDM to develop a plan for specialized services and/or alternate placement. This team will identify those additional services required for specialized services that are not already being provided by the nursing facility and covered in the nursing facility daily vendor rate.

(5) The [begin addition] service coordinator must [end addition] [begin deletion] case manager will [end deletion] provide a [begin addition] monthly [end addition] written report [begin deletion] monthly [end deletion] to the primary or attending physician and to the nursing facility regarding the delivery of specialized services and alternate placement activities. The report will be retained in the resident's clinical record.

(6) The nursing facility must allow [begin addition] Office of the State Long-Term Care Ombudsman [end addition] [begin deletion] Tdoa [end deletion] staff or representatives from Advocacy, Inc., to counsel and inform affected residents of their rights and options under PASARR.

(7) Specialized services and nursing facility services [begin addition] must [end addition] [begin deletion] are to [end deletion] be coordinated and integrated for maximum benefit to the resident. A nursing facility must allow for the [begin addition] MRA or MHA, as applicable, [end addition] [begin deletion] MHMR authority [end deletion] or a subcontracted provider to provide specialized services within the facility. If a nursing facility accepts individuals or has individuals who require specialized services for their mental condition, it must establish and maintain a written cooperative agreement with the local [begin addition] MRA or MHA [end addition] [begin deletion] MHMR authority [end deletion] that includes:

(A) general responsibilities of the facility and the provider for delivering the appropriate and mutually supportive services to those residents requiring specialized services for their MI/MR/RC;

(B) a provision allowing the [begin addition] MRA staff or MHA [end addition] [begin deletion] MHMR authority [end deletion] staff to access the resident's clinical record and assessment information to avoid unnecessary duplication of services, with appropriate consent of the eligible resident, legal representative, responsible party or SDM;
(C) a provision allowing the [begin addition] MRA staff or MHA [end addition] [begin deletion] MHMR authority [end deletion] staff an opportunity to participate in or provide information for the facility's admission, programmatic, and discharge-planning meetings when the specialized services needs of an eligible resident are being considered; and

(D) a provision allowing the nursing facility staff to participate in or provide information to the [begin addition] service coordinator [end addition] [begin deletion] MHMR authority case manager [end deletion] during each resident's specialized services planning.

(8) The [begin addition] service coordinator [end addition] [begin deletion] case manager [end deletion] must provide and the nursing facility must maintain, as a separate document in the resident's record, a copy of the original Individual Specialized Services Plan developed by the interdisciplinary team, and any subsequent changes.

(9) The [begin addition] service coordinator [end addition] [begin deletion] case manager [end deletion] must provide to the facility and the facility must document in the comprehensive care plan the following information from the specialized services plan, the designated provider, the [begin addition] service coordinator [end addition] [begin deletion] case manager [end deletion], other written report, and documented telephone contacts:

(A) efforts to resolve the differences between the specialized services plan and the comprehensive care plan;

(B) specialized services objectives;

(C) the resident's adjustment to the specialized services program; and

(D) changes and modification to the plan.

(10) The facility must ensure that all residents who may benefit from specialized services are identified.

(11) If [begin addition] a resident [end addition] [begin deletion] the individual [end deletion] requires specialized rehabilitation services, the facility must cooperate in obtaining the screening or evaluation.

(12) For those residents who have been determined to be appropriately placed in a nursing facility and to need specialized services and who desire alternate placement, the following alternate placement activities occur:

(A) The [begin addition] MRA or MHA, as applicable, [end addition] [begin deletion] MHMR authority [end deletion] shall locate alternate placement in consultation with the resident or his legal representative.
(B) The resident, his legal representative, or SDM must approve the alternate placement.

(C) If the resident, the legal representative, or SDM refuse all alternate placement options, the resident may remain in the nursing facility and receive specialized services there until an acceptable option is found.

(13) For those residents who have been determined to not need nursing facility services and to need specialized services and who have 30 continuous months of nursing facility residence, a choice will be offered to either seek alternate placement or remain in the nursing facility. If the resident, legal representative, or SDM chooses alternate placement, the following alternate placement activities occur:

(A) The MRA or MHA, as applicable, shall locate alternate placement in consultation with the resident, his legal representative, or SDM.

(B) The resident, his legal representative, or SDM must approve the alternate placement.

(C) Until the resident, his legal representative, or SDM approves an alternate placement, the resident may remain in the nursing facility and receive specialized services.

(14) For those residents determined not to need nursing facility services and to need specialized services but who do not have 30 months continuous residence, the resident will be discharged according to procedures stated under §19.502 of this chapter (relating to Transfer and Discharge).

(f) Limitations on provider charges. Nursing facilities that admit or retain individuals with a diagnosis of mental illness, mental retardation, or a related condition who have not been screened by DADS or its designee shall not be reimbursed for that individual, as described in §19.2608 of this chapter (relating to Limitations on Provider Charges).

(g) Discharge planning. Nursing facilities must provide discharge planning services to all residents who are to be alternately placed as described in this section and provide residents those rights described in §19.502 of this chapter (relating to Transfer and Discharge).
This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.

TITLE 40    SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19    NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER AA    VENDOR PAYMENT
RULE    §§19.2609, 19.2611, 19.2615

Proposed action:
X Amendment
X New

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

§19.2609. Payment of Claims.

[begin addition] To [end addition] [begin deletion] In order to [end deletion] receive payment for [begin addition] a service, a nursing facility must submit a [end addition] [begin deletion] services provided, the nursing facility's [end deletion] complete and accurate claim [begin addition] to the state Medicaid claims administrator so that it is received [end addition] [begin deletion] for services for which the nursing facility is
entitled to payment must be received by the Texas Department of Human Services' (DHS's) claims processor within 12 months after the date of service. In this section, For purposes of this section, the date of service is defined as the last day of the month in which the service was provided. Claims for services delivered before the effective date of this section must be submitted within 12 months of the effective date of this section.

(1) All payments are subject to availability of funds as provided by law.

(2) A nursing facility must submit claims and adjustments rejected or denied to the state Medicaid claims administrator within 12 months after the date of service. DADS may pay for claims and adjustments rejected or denied during the 12-month period through no fault of the nursing facility. Adjustments to claims must be received by DHS's claims processor during the applicable 12-month period. Claims and adjustments rejected or denied during the 12-month period through no fault of the nursing facility may be paid upon approval by DHS.

(3) If a recipient's Medicaid eligibility is established after provision of services, the nursing facility must submit the claim for service to the state Medicaid claims administrator within 12 months after the date eligibility is established.

(4) A nursing facility may resubmit a claim after the 12-month period in the case of state-generated retroactive payments. The requirement to submit claims within 12 months of the date of service does not prohibit a provider from re-billing in the case of state-generated retroactive adjustments.

(5) The provisions of procedures outlined in §19.2413 of this chapter (relating to Determination of Payment Rate Based on the MDS Assessment Submission and Reconsideration of Medical Necessity (MN) Determination and Effective Dates) are not affected by this section.

(6) DADS recoups any inadvertent payments made to a facility.
§19.2611. Retroactive Vendor Payment.

(a) In this section, retroactive vendor payment is payment DADS makes retroactively to a nursing facility for services the nursing facility provided to an individual who was eligible for, but had not yet applied for, Medicaid. A nursing facility is eligible for up to three months retroactive vendor payment for services it provided, if:

1. the individual resided in a Medicaid-certified nursing facility, or a distinct part, during the time services were provided;
2. the individual did not receive Supplemental Security Income cash benefits;
3. the individual met Medicaid financial eligibility requirements;
4. the state Medicaid claims administrator has a current MDS assessment for the individual that the facility submitted in compliance with the federal MDS submission requirements; and
5. the nursing facility met physician certification and plan of care requirements during the time services were provided.

(b) After receipt of an application for Medicaid, Texas Health and Human Services Commission (HHSC) Medicaid eligibility staff notify the applicant whether the applicant meets financial eligibility. The state Medicaid claims administrator uses the applicant's current MDS assessment to make the MN determination and determine the effective date of the MN determination. For the purpose of establishing three months prior eligibility, the effective date of the MN determination for a new recipient is the first day of the month in which the recipient qualified for MN.

(c) If the requirements in subsection (a) of this section are met, DADS makes a retroactive vendor payment based on the recipient's calculated RUG rate for the period covered by the retroactive vendor payment.

(d) DADS or HHSC may verify that the recipient's record includes the required physician's certification, recertification, and plans of care, and that the plans were reviewed as required during the applicable periods.

(e) If a recipient paid the nursing facility for services for which the facility later receives retroactive vendor payment, the facility must reimburse the recipient the full amount the recipient paid, beginning with the effective date of Medicaid eligibility, minus any applied income or co-payment as determined by HHSC Medicaid eligibility staff. [end addition]

A nursing facility must electronically submit to the state Medicaid claims administrator a resident transaction notice within 72 hours after a recipient's admission or discharge from the Medicaid nursing facility vendor payment system. The nursing facility administrator must sign the resident transaction notice.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.