TO: Health and Human Services Commission Executive Council

DATE: February 24, 2017

FROM: Sharon Wallace, DADS Regulatory

AGENDA ITEM: 3.j

SUBJECT: Nursing Facility Specialized Services

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

The purpose of the proposed rules is to clarify the difference between rehabilitative services, which may be provided to any resident in a nursing facility, and nursing facility specialized services, which may be provided only to a nursing facility resident who is a Medicaid recipient with an intellectual or developmental disability over 21 years of age, also referred to as a “designated resident.” The proposal removes all references to specialized services in Chapter 19, Subchapter N, which governs rehabilitative services, and adds requirements for nursing facility specialized services in Subchapter BB, which governs nursing facility responsibilities related to preadmission screening and resident reviews.

ISSUES AND ALTERNATIVES:

There are no outstanding issues or concerns with implementation of the proposed amendments, new sections, and repeal.

STAKEHOLDER INVOLVEMENT:

A public meeting was held on August 8, 2016, at the John H. Winters Building to provide an opportunity for external stakeholders to comment and ask questions regarding the proposal. In addition, external stakeholders were provided a copy of the proposal via email on August 3, 2016, and Gov-delivery on August 4, 2016.

The proposed rules were presented to the Medical Care Advisory Committee on November 10, 2016. In response to stakeholder comments made at the meeting, DADS amended the proposed rules to clarify that an assessment of a designated resident for therapy services, durable medical equipment, or a customized manual wheelchair can be completed any time but HHSC will pay for only one assessment every 180 days. In addition, the requirement that an individual be physically and cognitively capable of independently managing a manual wheelchair or have the orientation and ability to participate therapy services was eliminated, to ensure that a resident receives appropriate services.
FISCAL IMPACT:

☑️ None ☐ Yes

SERVICES IMPACT STATEMENT:

Persons served by the agency will benefit from proposed amendments, new sections, and repeal that will make nursing facilities better informed about the processes to request appropriate services for residents.

RULE DEVELOPMENT SCHEDULE:

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 10, 2016</td>
<td>Present to Medical Care Advisory Committee</td>
</tr>
<tr>
<td>February 24, 2017</td>
<td>Present to HHSC Executive Council</td>
</tr>
<tr>
<td>March 2017</td>
<td>Publish proposed rules in <em>Texas Register</em></td>
</tr>
<tr>
<td>June 2017</td>
<td>Publish adopted rules in <em>Texas Register</em></td>
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<tr>
<td>June 2017</td>
<td>Effective date</td>
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BACKGROUND AND PURPOSE

The purpose of the proposed rules is to clarify the difference between rehabilitative services, which may be provided to any resident in a nursing facility, and nursing facility specialized services, which may be provided only to a nursing facility resident who is a Medicaid recipient with an intellectual or developmental disability over 21 years of age, also referred to as a “designated resident.” The proposal removes all references to specialized services in Chapter 19, Subchapter N, which governs rehabilitative services, and adds requirements for nursing facility specialized services in Subchapter BB, which governs nursing facility responsibilities related to preadmission screening and resident reviews.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §19.101 adds definitions of “qualified mental health professional - community services,” and “rehabilitative services.” These are terms used in Subchapter N that require definitions. The proposed amendment adds “or the Health and Human Services Commission, as its successor agency” to the definition of “DADS” and “Department” to reflect the transfer of functions from DADS to HHSC. The proposed amendment also reorganizes the definitions of “medical necessity (MN),” “registered nurse (RN),” and “residential assessment instrument (RAI)” to reflect the correct alphabetical order according to the acronym.

The proposed new §19.1300 states that Subchapter N contains the requirements related to rehabilitative services provided to a resident in a nursing facility and that Subchapter BB contains the requirements related to nursing facility specialized services provided to a designated resident. This change is being made to clarify the scope of Subchapters N and BB.

The proposed amendment to §19.1301 makes editorial changes for clarity and consistency with terminology used in Chapter 19.

The proposed amendment to §19.1302 sets forth the requirements a person must meet to provide rehabilitative services to a resident.
The proposed repeal of §19.1303 removes the rule regarding specialized services in Medicaid-certified facilities from Subchapter N. Requirements for nursing facilities related to specialized services are in proposed new §§19.2750 - 19.2756 in Subchapter BB.

The proposed amendment to §19.1304 states that rehabilitative services covered by Medicaid include physical therapy, occupational therapy, and speech therapy, and requires a nursing facility to provide these services with the expectation that the resident's functioning will improve measurably in 30 days.

The proposed amendment to §19.1306 sets forth the requirements of a nursing facility related to the submission and payment of claims for rehabilitative services provided by the nursing facility and the requirements to request a fair hearing regarding any decision related to the provision of rehabilitative services.

The proposed amendment to §19.2701 explains that Subchapter BB includes the requirements a nursing facility must meet when providing nursing facility specialized services to a designated resident.

The proposed amendment to §19.2703 adds definitions of “CMWC” (customized manual wheelchair), “DME” (durable medical equipment), “HHSC,” and “therapy services.” The proposed amendment adds “or HHSC, as its successor agency” to the definition of “DADS” to reflect the transfer of functions from DADS to HHSC. In addition, the definition of “DADS” is amended to state that, for purposes of PASRR, HHSC is the state authority for intellectual and developmental disabilities. The amendment also makes editorial changes to the section for clarity and consistency.

The proposed amendment to §19.2704 adds the word “designated” to 19.2704(i)(8) to clarify that the facility must document annually in the Long-Term Care Online Portal (LTC Online Portal) all nursing facility specialized services, local intellectual and developmental disabilities authority specialized services, and local mental health authority (LMHA) specialized services for a designated resident.

The proposed amendment to §19.2706 makes editorial changes to the section for clarity and consistency.

The proposed amendment to §19.2709 requires a nursing facility to notify the LMHA representative of an incident or complaint involving a designated resident receiving LMHA specialized services.

The proposed new §19.2750 requires a nursing facility to request authorization from HHSC to provide a nursing facility specialized service if the service is agreed to by a designated resident’s IDT or SPT. The proposed new section also requires a nursing facility to request and receive authorization from HHSC before providing a nursing facility specialized service.

The proposed new §19.2751 contains the requirements a nursing facility must ensure are met before providing specialized therapy services to a designated resident. The new section also
permits a designated resident to request a fair hearing if HHSC denies authorization for a specialized therapy service.

The proposed new §19.2752 sets forth the qualifications for a person who provides nursing facility specialized therapy services to designated residents.

The proposed new §19.2753 sets forth the requirements a nursing facility must meet related to the submission and payment of claims for nursing facility specialized therapy services provided by the nursing facility.

The proposed new §19.2754 sets forth the requirements a nursing facility must meet to request prior authorization and purchase durable medical equipment or a customized manual wheelchair for a designated resident.

The proposed new §19.2755 sets forth the requirements a nursing facility must meet related to the submission and payment of claims for durable medical equipment and a customized manual wheelchair.

The proposed new §19.2756 sets forth the administrative requirements a nursing facility must meet related to the use, maintenance, and disposition of durable medical equipment or a customized manual wheelchair for a designated resident.

FISCAL NOTE

David Cook, Deputy Chief Financial Officer, has determined that, for the first five years the proposed amendments, new sections, and repeal are in effect, enforcing or administering the amendments, new sections, and repeal does not have foreseeable implications relating to costs or revenues of state or local governments.

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 these rules do not impose any new costs on nursing facilities.

PUBLIC BENEFIT AND COSTS

Mary T. Henderson, DADS Associate Commissioner for Regulatory 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 that nursing facilities will be better informed about the processes to request appropriate services for residents.

Ms. Henderson 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 Sharon Wallace at (210) 619-8292 in DADS Regulatory Services. Written comments on the proposal may be submitted to:
DADS Regulatory Service
Policy, Rules and Curriculum Unit
Department of Aging and Disability Services E-370
P.O. Box 149030
Austin, Texas 78714-9030

Written comments may also be sent to street address 701 West 51st St., Mail Code E-370, Austin, Texas 78751; faxed to (512) 438-4171; or emailed to sharon.wallace@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: (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 emailed by midnight on the last day of the comment period. When faxing or emailing comments, please indicate “Comments on Proposed Rule 16R02” in the subject line.

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 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 Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program.

The amendment affects Texas Government Code, §531.0055 and §531.021, and Texas Human Resources Code, §32.021.

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

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Abuse—Negligent or willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical or emotional harm or pain to a resident; or sexual abuse, including involuntary or nonconsensual sexual conduct that would constitute an offense under Penal Code §21.08 (indecent exposure) or Penal Code Chapter 22 (assaultive offenses), sexual harassment, sexual coercion, or sexual assault.

(2) Act—Chapter 242 of the Texas Health and Safety Code.

(3) Activities assessment—See Comprehensive Assessment and Comprehensive Care Plan.

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

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

(6) Administrator—Licensed nursing facility administrator.

(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.

(8) Advanced practice registered nurse—A person licensed by the Texas Board of Nursing as an advanced practice registered nurse.

(9) 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.

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

(11) Alzheimer's disease and related disorders--Alzheimer’s disease and any other irreversible dementia described by the Centers for Disease Control and Prevention or the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

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


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

(15) 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.

(16) Barrier precautions--Precautions including the use of gloves, masks, gowns, resuscitation equipment, eye protectors, aprons, face shields, and protective clothing for purposes of infection control.

(17) 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.

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

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

(21) 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.

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

(23) 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).

(24) 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 chapter (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

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


(26) 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;

(C) an officer or director of a publicly traded corporation that is, or that controls, a facility, management company, or other business entity described in subparagraph (A) of this paragraph but does not include a shareholder or lender of the publicly traded corporation; and

(D) 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.

(27) 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.

(28) DADS--The Department of Aging and Disability Services or the Health and Human Services Commission, as its successor agency.

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

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

(31) Department--The Department of Aging and Disability Services or the Health and Human Services Commission, as its successor agency.

(32) DHS--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).

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

   (A) registration by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics; 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.

(34) 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.

(35) Distinct part--That portion of a facility certified to participate in the Medicaid Nursing Facility program.

(36) 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 paragraph. It does not include devices or their components, parts, or accessories.

(37) 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.

(38) Emergency--A sudden change in a resident's condition requiring immediate medical intervention.

(39) Executive Commissioner--The executive commissioner of the Health and Human Services Commission.

(40) Exploitation--The illegal or improper act or process of a caregiver, family member, or other individual who has an ongoing relationship with a resident using the resources of the resident for monetary or personal benefit, profit, or gain without the informed consent of the resident.
(41) 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.

(42) Facility--Unless otherwise indicated, a facility is an institution that provides organized and structured nursing care and service and is subject to licensure under Texas 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 Chapter 17 of this title (relating to Preadmission Screening and Resident Review (PASRR)).

(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.

(43) Family council--A group of family members, friends, or legal guardians of residents, who organize and meet privately or openly.

(44) Family representative--An individual appointed by the resident to represent the resident and other family members, by formal or informal arrangement.

(45) Fiduciary agent--An individual who holds in trust another's monies.

(46) Free choice--Unrestricted right to choose a qualified provider of services.

(47) 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.

(48) Governmental unit--A state or a political subdivision of the state, including a county or municipality.

(49) HCFA--Health Care Financing Administration, now the Centers for Medicare & Medicaid Services (CMS).
(50) 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.

(51) 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 (relating to Hearings Under the Administrative Procedure Act) and Chapter 91 of this title (relating to Hearings Under the Administrative Procedure Act).

(52) HIV--Human Immunodeficiency Virus.

(53) 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.

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

(55) 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.

(56) Interdisciplinary care plan--See the definition of "comprehensive care plan."

(57) Involuntary seclusion--Separation of a resident from others or from the resident's room or confinement to the resident's room, against the resident's will or the will of a person who is legally authorized to act on behalf of the resident. Monitored separation from other residents is not involuntary seclusion if the separation is a therapeutic intervention that uses the least restrictive approach for the minimum amount of time, not exceed to 24 hours, until professional staff can develop a plan of care to meet the resident's needs.

(58) IV--Intravenous.

(59) 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.

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

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

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

(64) 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.

(65) Life support—Use of any technique, therapy, or device to assist in sustaining life. (See §19.419 of this chapter (relating to Advance Directives)).

(66) 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.

(67) 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 Texas Health and Safety Code, §121.021.

(68) 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.

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

(70) 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.


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

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

(74) Medicaid nursing facility vendor payment system—Electronic billing and payment system for reimbursement to nursing facilities for services provided to eligible Medicaid recipients.
(75) 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.

(76) 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.

(77) 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 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.

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

(78) Medical-social care plan--See Interdisciplinary Care Plan.

(79) Medically related condition--An organic, debilitating disease or health disorder that requires services provided in a nursing facility, under the supervision of licensed nurses.

(80) 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.

(81) 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.

(82) MN--Medical necessity. A determination, made by physicians and registered nurses who are employed by or contract with the state Medicaid claims administrator, that a recipient requires the services of a licensed nurse in an institutional setting to carry out a physician's planned regimen for total care. A recipient's need for custodial care in a 24-hour institutional setting does not constitute medical necessity.

(83) Neglect--The failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness.

(84) NHIC--This term referred to the National Heritage Insurance Corporation. It now refers to the state Medicaid claims administrator.
(85) 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.

(86) 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 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.

(87) Nurse aide trainee—An individual who is attending a program teaching nurse aide skills.

(88) Nurse practitioner—An advanced practice registered nurse.

(89) Nursing assessment—See definition of "comprehensive assessment" and "comprehensive care plan."

(90) 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.

(91) Nursing facility/home—An institution that provides organized and structured nursing care and service, and is subject to licensure under Texas 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.

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

(93) Nursing personnel—Persons assigned to give direct personal and nursing services to residents, including registered nurses, licensed vocational nurses, nurse aides, and medication aides. Unlicensed personnel function under the authority of licensed personnel.

(94) Objectives—See definition of "goals."

(95) OBRA—Omnibus Budget Reconciliation Act of 1987, which includes provisions relating to nursing home reform, as amended.
(96) Ombudsman--An advocate who is a certified representative, staff member, or volunteer of the DADS Office of the State Long Term Care Ombudsman.

(97) 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.

(98) 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.

(99) PASARR or PASRR--Preadmission Screening and Resident Review.

(100) 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.

(101) 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.

(102) 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.

(103) Person with a disclosable interest--A person with a disclosable interest is any person who owns at least a 5.0 percent interest in any corporation, partnership, or other business entity that is required to be licensed under Texas 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.

(104) Pharmacist--An individual, licensed by the Texas State Board of Pharmacy to practice pharmacy, who prepares and dispenses medications prescribed by a practitioner.

(105) Physical restraint--See Restraints (physical).

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

(107) 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;
(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:

(I) was at least one academic year in length;

(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.

(108) Podiatrist--A practitioner whose profession encompasses the care and treatment of feet who is licensed by the Texas State Board of Podiatric Medical Examiners.

(109) 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 practitioner, are not considered a poison, unless regulations specifically require poison labeling by the pharmacist.

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

(111) PRN (pro re nata)--As needed.

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

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

(114) Qualified mental health professional - community services--Has the meaning given in 25 TAC §412.303 (relating to Definitions).
(115) [444] Qualified surveyor--An employee of DADS who has completed state and federal training on the survey process and passed a federal standardized exam.

(116) [445] 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.

(117) [446] 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.

(118) RAI--Resident assessment instrument. 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 MDS core elements specified by CMS, utilization guidelines, and Care Area Assessment process.

(119) [447] 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.

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

(120) Rehabilitative services--Rehabilitative therapies and devices provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition. The term includes physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services.

(121) [449] Reimbursement methodology--The method by which HHSC determines nursing facility per diem rates.

(122) [420] 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.

(123) [421] Renovation--The restoration to a former better state by cleaning, repairing, or rebuilding, including, but not limited to, routine maintenance, repairs, equipment replacement, painting.

(124) [422] 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.

(125) [423] 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 Care Area Assessment (CAA) process.

Resident group -- A group or council of residents who meet regularly to:

(A) discuss and offer suggestions about the facility policies and procedures affecting residents' care, treatment, and quality of life;

(B) plan resident activities;

(C) participate in educational activities; or

(D) for any other purpose.

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.

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

Restrains (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 -- Registered nurse. An individual currently licensed by the Texas Board of Nursing as a registered nurse.
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.

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.
(142) [440] 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.

(143) [441] 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 Medical Board to supervise services rendered by specific PAs. A supervising physician may also be a physician who provides general supervision of an advanced practice registered nurse providing services in a nursing facility.

(144) [442] Supervision--General supervision, unless otherwise identified.

(145) [443] 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.

(146) [444] 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 qualified person providing the supervision.

(147) [445] 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 qualified person providing the supervision.

(148) [446] 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.

(149) [447] 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.

(150) [448] 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.

(151) [449] Threatened violation--A situation that, unless immediate steps are taken to correct, may cause injury or harm to a resident's health and safety.

(152) [450] Title II--Federal Old-Age, Survivors, and Disability Insurance Benefits of the Social Security Act.

(154) Title XVIII--Medicare provisions of the Social Security Act.

(155) Title XIX--Medicaid provisions of the Social Security Act.

(156) 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.

(157) UAR--HHSC's Utilization and Assessment Review Section.

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

(159) Universal precautions--The use of barrier and other precautions to prevent the spread of blood-borne diseases.

(160) Unreasonable confinement--Involuntary seclusion.

(161) Vaccine preventable diseases--The diseases included in the most current recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(162) 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.

(163) Working day--Any 24-hour period, Monday through Friday, excluding state and federal holidays.
§19.1300. Purpose.

(a) This subchapter contains the requirements a facility must comply with to provide rehabilitative services to a resident.

(b) Subchapter BB (relating to Nursing Facility Responsibilities Related to Preadmission Screening and Resident Review (PASRR) contains the requirements a facility must comply with to provide nursing facility specialized services to a designated resident, as defined in §19.2703 of this chapter (relating to Definitions).


(a) [Provision of services.] If rehabilitative services, such as, but not limited to, physical therapy, speech/language pathology, occupational therapy, mental health rehabilitative services for mental illness and mental retardation] are required in a resident's comprehensive care plan, the facility must:

(1) provide the required services; or

(2) obtain the required services from an outside resource, in accordance with §19.1906 of this chapter (relating to Use of Outside Resources), from a provider of specialized rehabilitative services.

(b) A facility must ensure that rehabilitative services:

(1) are provided to a resident under a comprehensive care plan based on the physician's diagnosis and orders; and

(2) are documented in the resident's clinical record.

§19.1302 Qualifications.

A facility must ensure that rehabilitative services are provided under the written order of a physician by qualified personnel.

(1) A qualified therapist is:

(1) an individual who:...
(A) [(i)] is a [Texas licensed] speech-language pathologist licensed by the Texas Department of Licensing and Regulation; or

(B) [(ii)] meets the educational requirements [for license] and has accumulated, or is in the process of accumulating, the supervised professional experience [(the internship)] required to be licensed as a speech-language pathologist [for license];

(2) [(B)] an individual [audiologist] who:

(A) [(i)] is an [Texas licensed] audiologist licensed by the Texas Department of Licensing and Regulation; or

(B) [(ii)] meets the educational requirements [for license] and has accumulated, or is in the process of accumulating, the supervised professional experience [(the internship)] required to be licensed as an audiologist [for license];

(3) [(C)] an occupational therapist [(a qualified consultant) who is currently] licensed by the Texas Board of Occupational Therapy Examiners;

(4) [(D)] an occupational therapy assistant [who is currently] licensed by the Texas [State] Board of Occupational Therapy Examiners;

(5) [(E)] a physical therapist [who is currently] licensed [as a physical therapist] by the Texas [State] Board of Physical Therapy Examiners; [or]

(6) [(F)] a physical therapist assistant [who is] licensed [as a physical therapist assistant] by the Texas [State] Board of Physical Therapy Examiners; or

(7) a qualified mental health professional – community services.

(2) A physical therapy aide is a person who assists in the practice of physical therapy and whose activities require on-the-job training and on-site supervision by a physical therapist or physical therapist assistant. A physical therapy aide is not a certified corrective therapist or an adaptive or corrective physical education specialist.

§19.1304. Rehabilitative Services in Medicaid-certified Facilities.

(a) Rehabilitative services covered by Medicaid [Services] are physical therapy services, occupational therapy services, and speech therapy services [for Medicaid nursing facility residents who are not eligible for Medicare or other insurance. The cost of therapy services for residents with Medicare or other insurance coverage or both must be billed to Medicare or other insurance or both].

(b) A facility must ensure that rehabilitative services covered by Medicaid are provided to a resident to evaluate or treat a function that has been impaired by illness or injury. [Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and
treatment of functions that have been impaired by illness.] Rehabilitative services must be provided with the expectation that the resident's functioning will improve measurably in 30 days.

§19.1306. Fee-for-Service Payment for [Specialized and] Rehabilitative Services.

(a) HHSC pays [DADS reimburses] a [nursing] facility for [specialized and] rehabilitative services provided to a Medicaid eligible resident based on fees determined [by the Health and Human Services Commission] in accordance with Title 1, Texas Administrative Code (TAC) §355.313 (relating to Reimbursement Methodology for Rehabilitative and Specialized [and Rehabilitative] Services).

(b) A facility [The services] must ensure that rehabilitative services provided to a resident eligible for Medicaid are:

(1) [be] ordered by the resident's attending physician; and

(2) except as provided in subsection (c)(1) of this section, [be] pre-certified by DADS.

(c) A session is one physical, occupational, or speech therapy service provided to [performed for] one resident. HHSC pays for an [An] evaluation [is reimbursed] at the same rate as a session.

(1) HHSC pays for one [One] evaluation that is not [reimbursed without being] pre-certified by DADS.

(2) To have an additional evaluation pre-certified by DADS, a facility must submit documentation [An additional evaluation must be supported] by the attending physician [physician's documentation] that indicates the resident has a new illness or injury, or a substantive change in a pre-existing condition.

(d) A facility must submit a complete and accurate claim for services that is [must be] received by DADS within 12 months after the last day services are provided in accordance with a single pre-certification by DADS.

[(e) A claim rejected during the 12-month period through no fault of the provider may be reimbursed upon approval by DADS.]

(e) [[(f)] A resident whose request for pre-certification of Medicaid rehabilitative [or specialized] services is denied may request [is entitled to] a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules) [rules of HHSC regarding Medicaid fair hearings]. A request for a fair hearing must be made to: Texas Department of Aging and Disability Services, Attn: Rehabilitative Services, P.O. Box 149030 (MC W 400), Austin, Texas 78714-9030. The request must be received by DADS within 90 days after the date the notice of action is mailed to the resident].
§19.1303. Specialized Services in Medicaid-certified Facilities.

Specialized Services are physical, occupational, and speech therapy evaluations and services provided to eligible Medicaid recipients identified by the Preadmission Screening and Resident Review (PASARR) team.
§19.2701. Purpose.

The purpose of this subchapter is to:

(1) describe the requirements of a nursing facility related to preadmission screening and resident review (PASRR), which is a federal requirement in Code of Federal Regulations, Title 42, Part 483, Subpart C to ensure that:

(A) an individual seeking admission to a Medicaid-certified nursing facility or a resident of a nursing facility receives a PASRR Level I screening (PL1) to identify whether the individual or resident is suspected of having mental illness (MI), an intellectual disability (ID), or a developmental disability (DD); and

(B) an individual or resident suspected of having MI, ID, or DD receives a PASRR Level II evaluation (PE) to confirm MI, ID, or DD and, if confirmed, to evaluate whether the individual or resident needs nursing facility care and specialized services; and

(2) describe the requirements of a nursing facility related to a designated resident who receives service planning and transition planning; and

(3) describe the requirements of a nursing facility related to nursing facility specialized services.


The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise:

(1) Alternate placement assistance--Assistance provided to a resident to locate and secure services chosen by the resident or LAR that meet the resident's basic needs in a setting other than a nursing facility. Assistance includes the identification of specific services and supports available through alternate resources for which the resident may be eligible and an explanation of the possible benefits and consequences of selecting a setting other than a nursing facility.

(2) Coma--A state of unconsciousness characterized by the inability to respond to sensory stimuli as documented by a physician.
(3) Comprehensive care plan--A plan, defined in §19.101 of this chapter (relating to Definitions), that includes, for a designated resident, nursing facility specialized services and nursing facility PASRR support activities.

(4) Convalescent care--A type of care provided after an individual's release from an acute care hospital that is part of a medically prescribed period of recovery.

(5) CMWC--Customized manual wheelchair. A wheelchair that consists of a manual mobility base and customized seating system and is adapted and fabricated to meet the individualized needs of a designated resident.

(6) DADS--Department of Aging and Disability Services or HHSC, as its successor agency. For purposes of the PASRR process, HHSC [DADS] is the state authority for intellectual and developmental disabilities.

(7) DD--Developmental disability. A disability that meets the criteria described in the definition of "persons with related conditions" in Code of Federal Regulations (CFR) Title 42, §435.1010.

(8) Delirium--A serious disturbance in an individual's mental abilities that results in a decreased awareness of the individual's environment and confused thinking.

(9) Designated resident--A Medicaid recipient with ID or DD who is 21 years of age or older and who is a resident.

(10) DME--Durable medical equipment. The following items, including any accessories and adaptations needed to operate or access the item:

(A) a gait trainer;

(B) a standing board;

(C) a special needs car seat or travel restraint;

(D) a specialized or treated pressure-reducing support surface mattress;

(E) a positioning wedge;

(F) a prosthetic device; and

(G) an orthotic device.

(11) DSHS--Department of State Health Services. For purposes of the PASRR process, DSHS is the state mental health authority.
(12) [49] Emergency protective services--Services that are furnished by the Department of Family and Protective Services to an elderly or disabled individual who has been determined to be in a state of abuse, neglect, or exploitation.

(13) [44] Exempted hospital discharge--A category of nursing facility admission that occurs when a physician has certified that an individual who is being discharged from a hospital is likely to require less than 30 days of nursing facility services for the condition for which the individual was hospitalized.

(14) [42] Expedited admission--A category of nursing facility admission that occurs when an individual meets the criteria for one of the following categories: convalescent care, terminal illness, severe physical illness, delirium, emergency protective services, respite, or coma.

(15) HHSC--Health and Human Services Commission or its designee.

(16) [43] ID--Intellectual disability. Mental retardation, as described in CFR Title 42, §483.102(b)(3)(i).

(17) [44] IDT--Interdisciplinary team. A team consisting of:

(A) a resident with MI, ID, or DD;

(B) the resident's LAR, if any;

(C) a registered nurse from the nursing facility with responsibility for the resident;

(D) a representative of a LIDDA or LMHA, or if the resident has MI and DD or MI and ID, a representative of the LIDDA and LMHA; and

(E) other persons, as follows:

(i) a concerned person whose inclusion is requested by the resident or LAR;

(ii) a person specified by the resident or LAR, nursing facility, or LIDDA or LMHA, as applicable, who is professionally qualified or certified or licensed with special training and experience in the diagnosis, management, needs and treatment of people with MI, ID, or DD; and

(iii) a representative of the appropriate school district if the resident is school age and inclusion of the district representative is requested by the resident or LAR.

(18) [45] Individual--A person seeking admission to a nursing facility.

(19) [46] ISP--Individual service plan. A service plan developed by the service planning team for a designated resident in accordance with §17.502(2) of this title (relating to Service Planning Team (SPT) Responsibilities for a Designated [Designed] Resident).
(20) [479] LAR--Legally authorized representative. A person authorized by law to act on behalf of an individual or resident with regard to a matter described by this subchapter, and who may be the parent of a minor child, the legal guardian, or the surrogate decision maker.

(21) [489] LIDDA--Local intellectual and developmental disabilities authority. An entity designated by the executive commissioner of HHSC [the Texas Health and Human Services Commission], in accordance with Texas Health and Safety Code §533A.035 [§533.035].

(22) [499] LIDDA specialized services--Support services, other than nursing facility services, that are identified through the PE or resident review and may be provided to a resident who has ID or DD. LIDDA specialized services are:

(A) service coordination, which includes alternate placement assistance;

(B) employment assistance;

(C) supported employment;

(D) day habilitation;

(E) independent living skills training; and

(F) behavioral support.

(23) [209] LMHA--Local mental health authority. An entity designated by the executive commissioner of HHSC [the Texas Health and Human Services Commission], in accordance with Texas Health and Safety Code §533.035. For the purposes of this subchapter, LMHA includes an entity designated by DSHS [the Department of State Health Services] as the entity to perform PASRR functions.

(24) [219] LMHA specialized services--Support services, other than nursing facility services, that are identified through the PE or resident review and may be provided to a resident who has MI. LMHA specialized services are defined in Title 25, Texas Administrative Code (TAC), Chapter 412, Subchapter I (relating to MH Case Management), including alternate placement, and 25 TAC Chapter 416, Subchapter A (relating to Mental Health Rehabilitative Services).

(25) [229] LTC Online Portal--Long Term Care Online Portal. A web-based application used by Medicaid providers to submit forms, screenings, evaluations, and the long term services and support Medicaid identification section of the MDS assessment.

(26) [239] MDS assessment--Minimum data set assessment. A standardized collection of demographic and clinical information that describes a resident's overall condition, which a licensed nursing facility in Texas is required to submit for a resident of admitted into the facility.

(27) [249] MI--Mental illness. Serious mental illness, as defined in 42 CFR §483.102(b)(1).
(28) Nursing facility--A Medicaid-certified facility that is licensed in accordance with Texas Health and Safety Code, Chapter 242.

(29) Nursing facility PASRR support activities--Actions a nursing facility takes in coordination with a LIDDA or LMHA to facilitate the successful provision of LIDDA specialized services or LMHA specialized services, including:

(A) arranging transportation for a designated resident to participate in a LIDDA specialized service or a LMHA specialized service outside the nursing facility;

(B) sending a resident to a scheduled LIDDA specialized service or a LMHA specialized service with food and medications required by the resident; and

(C) including in the comprehensive care plan an agreement to avoid, when possible, scheduling nursing facility services at times that conflict with LIDDA specialized services or LMHA specialized services.

(30) Nursing facility specialized services--Support services, other than nursing facility services, that are identified through the PE and may be provided to a designated resident who has ID or DD. Nursing facility specialized services are:

(A) physical therapy, occupational therapy, and speech therapy services;

(B) CMWC [customized manual wheelchair]; and

(C) DME [durable medical equipment, which consists of:]

   [(i) a gait trainer;]

   [(ii) a standing board;]

   [(iii) a special needs car seat or travel restraint;]

   [(iv) a specialized or treated pressure-reducing support surface mattress;]

   [(v) a positioning wedge;]

   [(vi) a prosthetic device; and]

   [(vii) an orthotic device].

(31) PASRR--Preadmission screening and resident review.

(32) PASRR determination--A decision made by DADS, DSHS, or their designee regarding an individual's need for nursing facility specialized services, LIDDA specialized services, and LMHA specialized services, based on information in the PE; and, in accordance
with Subchapter Y of this chapter (relating to Medical Necessity Determinations), whether the individual requires the level of care provided in a nursing facility. A report documenting the determination is sent to the individual and LAR.

(33) [30] PE--PASRR Level II evaluation. A face-to-face evaluation of an individual suspected of having MI, ID, or DD performed by a LIDDA or an LMHA to determine if the individual has MI, ID, or DD, and if so to:

(A) assess the individual's need for care in a nursing facility;

(B) assess the individual's need for nursing facility specialized services, LIDDA specialized services and LMHA specialized services; and

(C) identify alternate placement options.

(34) [31] PL1--PASRR Level I screening. The process of screening an individual to identify whether the individual is suspected of having MI, ID, or DD.

(35) [32] Pre-admission--A category of nursing facility admission from a community setting that is not an expedited admission or an exempted hospital discharge.

(36) [33] Referring entity--The entity that refers an individual to a nursing facility, such as a hospital, attending physician, LAR or other personal representative selected by the individual, a family member of the individual, or a representative from an emergency placement source, such as law enforcement.

(37) [34] Resident--An individual who resides in a Medicaid-certified nursing facility and receives services provided by professional nursing personnel of the facility.

(38) [35] Resident review--A face-to-face evaluation of a resident performed by a LIDDA or LMHA:

(A) for a resident with MI, ID, or DD who experienced a significant change in status, to:

(i) assess the resident's need for continued care in a nursing facility;

(ii) assess the resident's need for nursing facility specialized services, LIDDA specialized services and LMHA specialized services; and

(iii) identify alternate placement options; and

(B) for a resident suspected of having MI, ID, or DD, to determine whether the resident has MI, ID, or DD and, if so:

(i) assess the resident's need for continued care in a nursing facility;
(ii) assess the resident's need for nursing facility specialized services, LIDDA specialized services, and LMHA specialized services; and

(iii) identify alternate placement options.

(39) [36]) Respite--Services provided on a short-term basis to an individual because of the absence of or the need for relief by the individual's unpaid caregiver for a period not to exceed 14 days.

(40) [37]) Service coordination--As defined in §2.553 of this title (relating to Definitions), assistance in accessing medical, social, educational, and other appropriate services and supports that will help an individual achieve a quality of life and community participation acceptable to the person and LAR on the individual's behalf.

(41) [38]) Service coordinator--An employee of a LIDDA who provides service coordination.

(42) [39]) Severe physical illness--An illness resulting in ventilator dependence or diagnosis such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, or congestive heart failure, that results in a level of impairment so severe that the individual could not be expected to benefit from nursing facility specialized services, LIDDA specialized services or [and] LMHA specialized services.

(43) [40]) SPT--Service planning team. A team that develops, reviews, and revises the ISP for a designated resident.

(A) The SPT always includes:

(i) the designated resident;

(ii) the designated resident's LAR, if any;

(iii) the service coordinator;

(iv) nursing facility staff familiar with the designated resident's needs;

(v) persons providing nursing facility specialized services and LIDDA specialized services for the designated resident;

(vi) a representative from a community provider, if one has been selected; and

(vii) a representative from the LMHA, if the designated resident has MI.

(B) Other participants on the SPT may include:
(i) a concerned person whose inclusion is requested by the designated resident or the LAR; and

(ii) at the discretion of the LIDDA, a person who is directly involved in the delivery of services to people with ID or DD.

(44) Surrogate decision maker--An actively involved family member of a resident who has been identified by an IDT in accordance with Texas Health and Safety Code §313.004 and who is available and willing to consent on behalf of the resident.

(45) Terminal illness--A medical prognosis that an individual's life expectancy is six months or less if the illness runs its normal course, which is documented by a physician's certification in the individual's medical record maintained by a nursing facility.

(46) Therapy services--Assessment and treatment to help a designated resident learn, keep, or improve skills and functioning of daily living affected by a disabling condition. Therapy services are referred to as habilitative therapy services. Therapy services are limited to:

(A) physical therapy;

(B) occupational therapy; and

(C) speech therapy.

(47) Transition plan--A plan developed by the SPT that describes the activities, timetable, responsibilities, services, and supports involved in assisting a designated resident to transition from the nursing facility to the community.
§19.2704. Nursing Facility Responsibilities Related to PASRR.

(a) If an individual seeks admission to a nursing facility, the nursing facility:

(1) must coordinate with the referring entity to ensure the referring entity conducts a PL1; and

(2) may provide assistance in completing the PL1, if the referring entity is a family member, LAR, other personal representative selected by the individual, or a representative from an emergency placement source and requests assistance in completing the PL1.

(b) A nursing facility must not admit an individual who has not had a PL1 conducted before the individual is admitted to the facility.

(c) If an individual's PL1 indicates the individual is not suspected of having MI, ID, or DD, a nursing facility must enter the PL1 from the referring entity into the LTC Online Portal. The nursing facility may admit the individual into the facility through the routine admission process.

(d) For an individual whose PL1 indicates the individual is suspected of having MI, ID, or DD, a nursing facility:

(1) must enter the PL1 into the LTC Online Portal if the individual's admission category is:

(A) expedited admission; or

(B) exempted hospital discharge; and

(2) must not enter the PL1 into the LTC Online Portal if the individual's admission category is pre-admission.

(e) Except as provided by subsection (f) of this section, a nursing facility must not admit an individual whose PL1 indicates a suspicion of MI, ID, or DD without a complete PE and PASRR determination.

(f) A nursing facility may admit an individual whose PL1 indicates a suspicion of MI, ID, or DD without a complete PE and PASRR determination only if the individual:
(1) is admitted as an expedited admission;

(2) is admitted as an exempted hospital discharge; or

(3) has not had an interruption in continuous nursing facility residence other than for acute care lasting fewer than 30 days and is returning to the same nursing facility.

(g) A nursing facility must check the LTC Online Portal daily for messages related to admissions and directives related to the PASRR process.

(h) Within seven calendar days after the LIDDA or LMHA has entered a PE or resident review into the LTC Online Portal for an individual or resident who has MI, ID, or DD, a nursing facility must:

(1) review the recommended list of nursing facility specialized services, LIDDA specialized services, and LMHA specialized services; and

(2) certify in the LTC Online Portal whether the individual's or resident's needs can be met in the nursing facility.

(i) After an individual or resident who is determined to have MI, ID, or DD from a PE or resident review has been admitted to a nursing facility, the facility must:

(1) contact the LIDDA or LMHA within two calendar days after the individual's admission or, for a resident, within two calendar days after the LTC Online Portal generated an automated notification to the LIDDA or LMHA, to schedule an IDT meeting to discuss nursing facility specialized services, LIDDA specialized services, and LMHA specialized services;

(2) convene the IDT meeting within 14 calendar days after admission or, for a resident review, within 14 calendar days after the LTC Online Portal generated an automated notification to the LIDDA or LMHA;

(3) participate in the IDT meeting to:

   (A) identify which of the nursing facility specialized services, LIDDA specialized services, and LMHA specialized services recommended for the resident that the resident, or LAR on the resident's behalf, wants to receive; and

   (B) determine whether the resident is best served in a facility or community setting.

(4) provide staff from the LIDDA and LMHA access to the resident and the resident's clinical facility records upon request from the LIDDA or LMHA;

(5) enter into the LTC Online Portal within 3 business days after the IDT meeting for a resident:
(A) the date of the IDT meeting;

(B) the name of the persons who participated in the IDT meeting;

(C) the nursing facility specialized services, LIDDA specialized services, and LMHA specialized services that were agreed to in the IDT meeting; and

(D) the determination of whether the resident is best served in a facility or community setting;

(6) include in the comprehensive care plan:

(A) the nursing facility specialized services agreed to by the resident or LAR; and

(B) the nursing facility PASRR support activities;

(7) if Medicaid or other funding is available:

(A) initiate nursing facility specialized services within 30 days after the date that the services are agreed to in the IDT meeting; and

(B) provide nursing facility specialized services agreed to in the IDT meeting to the resident; and

(8) for a designated resident [who is a Medicaid recipient], annually document in the LTC Online Portal all nursing facility specialized services, LIDDA specialized services, and LMHA specialized services [currently] being provided to the designated [a] resident.

§19.2706. Nursing Facility Responsibilities Related to a Designated Resident.

(a) A nursing facility employee, nursing facility contractor, or nursing facility specialized services provider must report to the LIDDA the identity of any designated resident who expresses an interest in transitioning to the community.

(b) For a designated resident, a nursing facility must designate staff and necessary contractors to be members of the resident's SPT.

(c) A nursing facility must ensure its staff and contractors who are members of a designated resident's SPT:

(1) attend and participate in the [a] designated resident's SPT meetings as scheduled and convened by the service coordinator;

(2) contribute to the development of the [a] designated resident's ISP; and

(3) assist the SPT by:
(A) monitoring all nursing facility specialized services, LIDDA specialized services and LMHA specialized services, if applicable, provided to the designated resident to ensure the designated resident's needs are being met;

(B) making timely referrals, service changes, and amendments to the ISP as needed;

(C) ensuring that the designated resident's ISP, including nursing facility specialized services, nursing facility PASRR support activities, and LIDDA specialized services, is coordinated with the nursing facility's comprehensive care plan;

(D) if the designated resident has expressed interest in community living: [developing a transition plan for a resident who has expressed interest in community living and, if no transition plan is recommended due to identified barriers, participating to identify the action the SPT will take to address concerns and remove the barriers; and]

(i) developing a transition plan for the designated resident to live in the community; or

(ii) identifying the action the SPT will take to address concerns and remove barriers to the designated resident living in the community; and

(E) reviewing and discussing the information included in the ISP and transition plan with key nursing facility staff who work with the resident.

(d) A nursing facility must allow a service coordinator access to:

(1) a designated resident on a monthly basis, or more frequently if needed; and

(2) the designated resident's clinical facility records.

§19.2709. Incident and Complaint Reporting.

In addition to reporting incidents and complaints, including abuse and neglect, to DADS as required by §19.602 of this chapter (relating to Incidents of Abuse and Neglect Reportable to the Texas Department of Aging and Disability Services (DADS) and Law Enforcement Agencies by Facilities) and §19.2006 of this chapter (relating to Reporting Incidents and Complaints), a nursing facility must report the information by making a telephone report immediately after learning of the incident or complaint:

(1) to the service coordinator, if it involves a designated resident; and

(2) to the LMHA representative, if it involves a designated resident with MI receiving LMHA specialized services.
§19.2750. Nursing Facility Specialized Services for Designated Residents.

(a) A nursing facility must request authorization from HHSC to provide a nursing facility specialized service to a designated resident if the service is agreed to by the designated resident’s IDT in accordance with §19.2704 of this subchapter (relating to Nursing Facility Responsibilities Related to PASRR) or the designated resident’s SPT in accordance with §17.502(2) of this title (relating to Service Planning Team (SPT) Responsibilities for a Designated Resident).

(b) Before providing a nursing facility specialized service, a nursing facility must request and receive authorization from HHSC through the LTC Online Portal to provide the service.


(a) Before requesting authorization to provide a therapy service to a designated resident, a nursing facility must ensure that:

(1) the therapy service is required by the designated resident’s comprehensive care plan;

(2) the designated resident has a diagnosis relevant to the need for the therapy service;

(3) the therapy service is ordered by the designated resident’s attending physician; and

(4) a therapy provider who meets the qualifications in §19.2752 of this division (relating to Qualifications of a Provider of Therapy Services) completes an assessment within 30 days before the nursing facility request for authorization to provide the therapy service.

(b) After a nursing facility submits a request for authorization to provide a therapy service to a designated resident:

(1) the nursing facility receives a written approval or denial of its request through the LTC Online Portal; and

(2) HHSC notifies the designated resident or the designated resident’s LAR that the request has been approved or denied.
(c) If HHSC denies a request for authorization to provide therapy services to a designated resident, the designated resident may request a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules), to appeal the denial.

§19.2752. Qualifications of a Provider of Therapy Services.

A nursing facility must ensure that therapy services are provided to a designated resident by:

(1) a person who:

   (A) is a speech-language pathologist licensed by the Texas Department of Licensing and Regulation; or

   (B) meets the educational requirements and has accumulated, or is in the process of accumulating, the supervised professional experience required to be licensed as a speech-language pathologist;

(2) an occupational therapist licensed by the Texas Board of Occupational Therapy Examiners;

(3) an occupational therapy assistant licensed by the Texas Board of Occupational Therapy Examiners;

(4) a physical therapist licensed by the Texas Board of Physical Therapy Examiners; or

(5) a physical therapist assistant licensed by the Texas Board of Physical Therapy Examiners.

§19.2753. Payment for Therapy Services.

(a) HHSC pays a nursing facility for therapy services provided to a designated resident based on fees determined in accordance with 1 TAC §355.313 (relating to Reimbursement Methodology for Rehabilitative and Specialized Services).

(b) A therapy session is one hour of therapy provided to one resident.

(c) An assessment is reimbursed at the same rate as a therapy session.

(d) An occupational therapist or physical therapist may assess a designated resident at any time to evaluate the needs of the designated resident for a therapy service, but HHSC does not pay for an assessment of a designated resident conducted within 180 days after the previous assessment of the designated resident.

(e) A nursing facility must submit a complete and accurate claim for a therapy service within 12 months after the last day of an authorization from HHSC to provide the service.

(a) To request authorization to provide DME or a CMWC to a designated resident, a nursing facility must ensure that a physical therapist or occupational therapist licensed in Texas assesses the designated resident for the DME or CMWC. If, based on the assessment, the physical or occupational therapist recommends DME or a CMWC, the nursing facility must request authorization to provide the DME or CMWC through the LTC Online Portal. The assessment required by this subsection must be completed within 30 days before the nursing facility requests authorization through the LTC Online Portal.

(b) The request for authorization to provide DME or a CMWC made through the LTC Online Portal must include:

(1) the assessment of the designated resident described in subsection (a) of this section;

(2) a statement signed by the designated resident’s attending physician that the DME or CMWC is medically necessary; and

(3) detailed specifications of the DME or CMWC from a DME supplier.

(c) The documentation of the physical or occupational therapy assessment required by subsection (a) of this section must include:

(1) a diagnosis of the designated resident relevant to the need for DME or a CMWC;

(2) the specific DME or CMWC, including any adaptations recommended for the designated resident; and

(3) a description of how the DME or CMWC will meet the specific needs of the designated resident.

(d) After a nursing facility submits a request for authorization to provide DME or a CMWC to a designated resident:

(1) the nursing facility receives a written approval or denial of its request through the LTC Online Portal; and

(2) HHSC notifies the designated resident or the designated resident’s LAR that the request has been approved or denied.

(e) If HHSC approves a request to provide DME or a CMWC to a designated resident, the nursing facility must order the DME or CMWC from a DME supplier within 5 business days after receiving notification of the approval through the LTC Online Portal.
(f) If HHSC denies a request to provide DME or a CMWC to a designated resident, the designated resident may request a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules), to appeal the denial.


(a) A nursing facility must fully explore and use other sources to pay for DME or a CMWC before requesting payment from HHSC. If another funding source is available, HHSC pays no more than the remaining balance after other sources have paid.

(b) HHSC pays a nursing facility for an assessment for DME or a CMWC for a designated resident based on fees determined in accordance with 1 TAC §355.313 (relating to Reimbursement Methodology for Rehabilitative and Specialized Services).

(1) HHSC pays for a DME or CMWC assessment at the same rate as a therapy session.

(2) An occupational therapist or physical therapist may assess a designated resident at any time to evaluate the needs of the designated resident for DME or a CMWC, but HHSC does not pay for an assessment of a designated resident conducted within 180 days after the previous assessment of the designated resident.

(c) A complete and accurate claim for DME or a CMWC must be received by HHSC within 12 months after the day the DME or CMWC is purchased.

(d) A nursing facility must not submit a claim for payment for DME or a CMWC to HHSC before:

(1) an occupational therapist or physical therapist licensed in Texas verifies that the DME or CMWC meets the original specifications and the needs of the designated resident; and

(2) the nursing facility documents the verification in the LTC Online Portal.

(e) If HHSC denies a request for payment for DME or a CMWC because a nursing facility did not obtain authorization before purchasing the DME or CMWC or did not submit necessary documentation to HHSC, the facility may not charge the designated resident or family for the DME or CMWC.


(a) A nursing facility must ensure that only the designated resident to whom DME or a CMWC belongs uses the DME or CMWC. A nursing facility must identify the DME or CMWC as the personal property of the designated resident.

(b) If the designated resident who was provided DME or a CMWC is discharged from a nursing facility, the designated resident retains the DME or CMWC.
(c) If a designated resident who was provided DME or a CMWC dies, the DME or CMWC becomes property of the designated resident's estate. As part of the estate, the DME or CMWC is subject to the Medicaid Estate Recovery Program requirements in 1 TAC Chapter 373 (relating to Medicaid Estate Recovery Program).

(d) If DME or a CMWC is donated or sold to a nursing facility by a designated resident or the personal representative of a designated resident's estate, the transaction must be documented in accordance with §19.416 of this chapter (relating to Personal Property).

(e) A modification, adjustment, or repair to DME or a CMWC required within the first six months after delivery of the DME or CMWC is the responsibility of the DME supplier. More than six months after delivery of DME or a CMWC, a nursing facility must maintain and repair all medically necessary equipment for a designated resident, including DME or a CMWC obtained under this division, as required by §19.2601(b)(8)(C) of this chapter (relating to Vendor Payment (Items and Services Included)).

(f) A nursing facility must submit a request to replace DME or a CMWC of a designated resident in the same manner as a request for the authorization to provide DME or a CMWC to a designated resident. HHSC does not approve a request to replace a CMWC made within five years after a CMWC was purchased for the designated resident, unless the request includes:

(1) an order from the designated resident's attending physician; and

(2) an assessment by an occupational therapist or physical therapist licensed in Texas, with documentation explaining why the designated resident's current CMWC no longer meets the designated resident's needs.