



Home and Community- Based Service Adult Mental Health

Billing Guidelines

**Texas Health and Human Services
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TEXAS
Health and Human
Services

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1000 HCBS-AMH Billing Guidelines Definitions

Term	Definition
Activities of Daily Living (ADLs)	Routine daily activities. These activities include performing personal hygiene activities, dressing, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, navigating public transportation, participating in the community and other activities as defined by the department.
Billable Activity	An activity for which a service claim may be submitted for services.
Clinical Management for Behavioral Health Services (CMBHS)	An electronic health record created and maintained by HHSC for the use of contracted Mental Health and Substance Abuse Services. Contracted HCBS-AMH Provider Agencies and Recovery Management Entities shall utilize CMBHS as directed by HHSC.
Credentialing	A process to review and approve a staff member's educational status, experience, licensure and certification status (as applicable) to ensure that the staff member meets the departmental requirements for service provision. The process includes primary source verification of credentials, establishing and applying specific criteria and prerequisites to determine the staff member's initial and ongoing competency and assessing and validating the staff member's qualification to deliver care. Re-credentialing is the periodic process of reevaluating the staff's competency and qualifications.
Calendar Month	The first day of a month through the last day of that month.
Calendar Week	Sunday through Saturday.
Calendar Year	January through December.

Term	Definition
Claims Administrator	Contracted entity responsible for conducting certain Medicaid administrative activities on behalf of the single state Medicaid agency.
Clean Claim	In accordance with the Title 42, Code of Federal Regulations (CFR), §447.45(b), defined as a service claim submitted by a program provider for a service delivered to an individual that can be processed without obtaining additional information from the provider of the service or from a third party.
Competitive Employment	Employment that pays an individual at or above the greater of: (a) the applicable minimum wage; (b) or the prevailing wage paid to persons without disabilities performing the same or similar work.
Co-Payment	A fixed fee an individual pays for a service at the time the service is provided. Co-Payments are determined in accordance with Title 25, Texas Administrative Code (TAC), Chapter 412 Subchapter C (relating to Charges for Community Services).
Court-Appointed Guardian	<p>A Guardian who is given the legal authority by court order to care for the personal and property interests of another person, who is referred to as a ward of the state. A guardian who has been given responsibility by the court for both the personal well-being and financial interests of a person is known as a general guardian.</p> <p>A person can have two separate court-appointed guardians. For example, the court can choose to appoint one person as guardian of the person and a different person as the guardian of the person's estate.</p> <p>Guardian is a distinction from Legally Authorized Representatives, because the guardian is considered legally responsible for the person.</p>

Term	Definition
Deductible	Payment made by an individual in a specified amount for a service received before coverage begins for that service under the insurance policy.
Direct Service Provider Agency	An employee or a contractor of a HCBS-AMH Provider Agency or Recovery Management Entity who provides HCBS-AMH Service(s) directly to a person.
Disenrollment Date	The date of which a person exits the program.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit	Comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid
Enrollment Date	Delineation of time in relation to the person's enrollment into the program.
Encounter Data	Details related to the HCBS-AMH services rendered by provider to the person enrolled in HCBS-AMH.
Existing Clinical Relationship	Occurs when a person has received at least one in-person or synchronous audiovisual HCBS-AMH service from the same provider type within the IRP period prior to the initial service delivered by synchronous telephone (audio-only) technology. The IRP period requirement for at least one in-person or synchronous audiovisual service of the same type prior to the initial synchronous telephone (audio-only) service may not be waived.
Extended Shift	During a 24-hour period, a combined period of time of more than 16 hours.
Face-to-face	Within the physical presence of another person who is not asleep.

Term	Definition
Focused Assessment	<p>An appraisal of a person's current health status that:</p> <ul style="list-style-type: none"> (a) contributes to a comprehensive assessment conducted by a registered nurse; (b) collects information regarding the person's health status; and (c) determines the appropriate health care professionals or other persons who need the information and when the information should be provided.
HCBS-AMH Services	Home and Community-based Services provided under the HCBS-AMH Program.
HCBS-AMH Pre-Engagement	<p>Services provided by the LMHA/LBHA to perform the referral and enrollment process for persons seeking enrollment as an HCBS- AMH participant (Participant) who reside in the community of the LMHA/LBHA service area. Pre-engagement services include completing the HCBS-AMH Uniform Assessment, obtaining and completing referral documentation required to determine program eligibility, completing enrollment forms, and working to obtain necessary documents for determining Medicaid eligibility.</p>
Individual	<p>A person who is currently enrolled in the HCBS- AMH Program and receiving services or is involved in the enrollment process for HCBS- AMH.</p>

Term	Definition
Individual Recovery Plan (IRP)	<p>A written, individualized plan, developed in consultation with the individual and LAR, if applicable; person's treatment team and providers; and other persons according to the needs and desire of the person, which identifies the necessary HCBS to be provided to the person. The IRP must be approved by the department before a provider may deliver HCBS-AMH services.</p> <p>The IRP also serves as the treatment plan or recovery plan and is developed in accordance with 26 TAC, Part 1, Chapter 306, Subchapter D (relating to Mental Health Services--Admission, Continuity, and Discharge) and 26 TAC, §301.353 (relating to Provider Responsibilities for Treatment Planning and Service Authorization).</p> <p>The IRP must be approved by the department before a provider may deliver HCBS-AMH.</p>
Integrated Employment	<p>Employment at a work site at which a person routinely interacts with people without disabilities other than the person's work site supervisor or direct service providers.</p>
Interdisciplinary Team (IDT)	<p>A group of individual entities that help design, manage, facilitate and implement an integrated approach to a person's system of care that utilizes inclusion, policy and practice to best serve the person's behavioral and mental health needs.</p>
Invoice	<p>The file that a HCBS-AMH Provider will submit to HHSC as evidence of HCBS-AMH services provided. This file is generated by encounter data.</p>
Legally Authorized Representative (LAR)	<p>A LAR is an individual or judicial or other body authorized by law to act on behalf of a person with regard to a particular matter. The term may include a parent, guardian, or managing conservator of a minor.</p>

Term	Definition
Licensed Practitioner of the Healing Arts (LPHA)	A person who is a physician, a licensed professional counselor, a licensed clinical social worker, a licensed psychologist, an advanced practice nurse, or a licensed marriage and family therapist.
Licensed Vocational Nurse (LVN)	A person licensed to practice vocational nursing in accordance with Texas Occupations Code, Chapter 301.
Local Mental Health Authority / Local Behavioral Health Authority (LMHA/LBHA)	An entity designated as the local mental health authority by the department in accordance with the Texas Health and Safety Code, §533.035(a). For purposes of this subchapter, the term includes an entity designated as a local behavioral health authority.
Non-HCBS-AMH Services	Services provided by any funding source other than HCBS-AMH. Examples include but are not limited to other State Plan Services, Temporary Assistance for Needy Families (TANF), and Personal Care Services (PCS).
Preauthorization	The authorization a Recovery Manager will obtain, for billing purposes, prior to assisting a participant in dis-enrolling from another HCBS program and enrolling HCBS-AMH.
Prior Approval	Assurance from HHSC, prior to a program provider purchasing a requested adaptive aid or minor home modification, that the program provider will be paid for the adaptive aid or minor home modification if the provider complies with HCBS-AMH Billing Guidelines.

Term	Definition
Provider Agency	An agency, organization, or individual that meets credentialing standards defined by HHSC and enters into a Provider Agreement for HCBS-AMH. The HCBS-AMH Provider must ensure provision of all HCBS-AMH services directly and /or indirectly by establishing and managing a network of Subcontractors. The HCBS-AMH Provider has the ultimate responsibility to comply with the Provider Agreement and Manual regardless of service provision arrangement (directly or through Subcontractors).
Provider	An HCBS-AMH Provider Agency or Recovery Management Entity who has entered into a Provider Agreement with HHSC for the provision of HCBS-AMH.
Provider Agreement	A document which is required as a condition of enrollment or participation as an HCBS- AMH Provider. Also called a "contract," a written agreement referring to promises or agreements for which the law establishes enforceable duties and remedies between an HCBS-AMH Provider and HHSC.
Quality Management	A program developed and implemented by the provider by which organizational performance and services are assessed and evaluated to ensure the existence of those structures and processes necessary for the achievement of individual outcomes and continuous quality improvement.

Term	Definition
Qualified Mental Health Professional – Community Services (QMHP-CS)	<p>A staff member who is credentialed as a QMHP- CS who has demonstrated and documented competency in the work to be performed and:</p> <p>Has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA or Managed Care Organization (MCO) in accordance with 26 TAC, §301.331 (relating to Competency and Credentialing)) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;) – A person authorized by law to act on behalf of a child or adolescent with regard to a matter described in this subchapter, including, but not limited to, a parent, guardian, or managing conservator.</p> <p>Is a registered nurse; or</p> <p>Completes an alternative credentialing process identified by the HHSC.</p>
Recovery	A process of change through which persons improve their health and wellness, live a self- directed life, and strive to reach their full potential.
Recovery Manager (RM)	Recovery management entity contracted with HHSC to provide recovery management services.
Recovery Management Entity	An entity that employs individual recovery management providers.
Recovery Management Transitional Services	Recovery Management services provided to a person who is residing at a psychiatric hospital at the time of their enrollment in HCBS-AMH.

Term	Definition
Recovery Management Conversion Services	<p>Work conducted by the Recovery Manager when a participant is enrolled in another HCBS program and decides to discontinue services in the program and enroll in HCBS- AMH. The RM coordinates the disenrollment/enrollment process for the participant.</p> <p>Work conducted by the Recovery Manager when a participant is in a nursing facility. The RM coordinates with staff and providers to prepare the participant for discharge.</p> <p>RM must receive preauthorization of services before providing conversion services.</p>
Referring Entity	The entity that initiates the referral process of the person to HCBS-AMH.
Registered Nurse	A person licensed to practice professional nursing in accordance with Texas Occupations Code, Chapter 301
Residence	A place of bona fide and continuous habitation that is a structure with a common roof and common walls, except if the structure contains more than one dwelling such as an apartment complex or duplex, "residence" means a dwelling within the structure. A person may have only one residence.
RN Clinical Supervision	The monitoring for changes in health needs of the person, overseeing the nursing care provided and offering clinical guidance as indicated, to ensure that nursing care is safe and effective and provided in accordance with the nursing service plan for the person.

Term	Definition
RN Nursing Assessment	<p>An extensive evaluation of a person's health status that:</p> <ul style="list-style-type: none"> addresses anticipated changes in the conditions of the person as well as emergent changes in the person's health status; recognizes changes to previous conditions of the person; synthesizes the biological, psychological, spiritual and social aspects of the person's condition; collects information regarding the person's health status; analyzes information collected about the person's health status to make nursing diagnoses and independent decisions regarding nursing services provided to the person; plans nursing interventions and evaluates the need for different interventions; and determines the need to communicate and consult with other direct service providers or other persons who provide supports to the person.
Service Claim	A request submitted by a program provider to be paid by HHSC for a service
State Plan Services	Services that are offered under the Medicaid State Plan service array, which may be provided by any credentialed Medicaid State Plan direct service provider.
Status Definitions	The language that describes the status of the person in relation to the enrollment process. HCBS-AMH service definitions and descriptions are located in the HCBS-AMH Provider Manual.
Subcontractor	A single person, organization, or agency that enters an agreement with a HCBS-AMH Provider Agency to provide one or more HCBS-AMH services. A subcontractor must meet minimum qualifications defined by HHSC.

Term	Definition
Supervision	The process of directing, guiding and influencing the outcome of an unlicensed staff's performance.
Suspended Status	Enrollment status of a person who is not discharged from HCBS-AMH but whose services have been suspended, except as otherwise allowed by HHSC.
Telehealth Delivery of Services	<p>Synchronous audio-visual technology means an interactive, two-way audio and video telecommunications platform that meets the privacy requirements of the Health Insurance Portability and Accountability Act.</p> <p>Synchronous, audio-only, including telephone technology, means an interactive, two-way audio telecommunications platform that uses only sound and meets the privacy requirements of the Health Insurance Portability and Accountability Act.</p> <p>Audio-visual or audio-only options are not to be used 100% of the time. See the HCBS-AMH Provider Manual for more information on telehealth delivery of services.</p>
Uniform Assessment	<p>A standardized assessment identified by HHSC to determine HCBS-AMH program eligibility and clinical needs of the person. To be determined eligible to participate in this program, each person must receive a uniform assessment as defined by the department, based on the needs and strengths of the person. The uniform assessment will be the basis for the IRP.</p> <p>The assessor must consult with the person; the person's LAR, treatment team, providers; and other persons according to the needs and desire of the person to conduct the uniform assessment. The uniform assessment must be conducted face- to- face; take into account the ability of the person to perform two or more activities of daily living; and assess the person's need for HCBS-AMH.</p>

Term	Definition
Volunteer Work	Work performed by an individual without compensation that is for the benefit of an entity or person other than the individual and is performed in a location other than the individual's residence.

2000 Introduction

2100 HCBS-AMH Services and Codes

HCBS-AMH Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Unit	Unit Rate
Adaptive Aids	T599	HK	HE	N/A	Per encounter	cost
Assisted Living Services	T2031	HK	HE	N/A	Per day	\$33.40
Community Psychiatric Supports and Treatment*	H0036	HK	HE	FQ or 95	Per hour	\$79.53
Employment Assistance*	H2025	HK	HE	FQ or 95	Per hour	\$26.07
Supported Employment*	H2023	HK	HE	FQ or 95	Per hour	\$26.07
Flexible Funds	H2038	HK	HW	N/A	Per encounter	cost
Flexible Funds for technology*	H2038	HK	HW	U1	Per encounter	cost
Pre-Engagement	T2038	HK	HB	N/A	Per 15 minutes/m ax 64 units	\$3.97
HCBS-AMH Recovery Management*	H2015	HK	HE	FQ or 95	Per 15 minutes	\$31.69
Recovery Management Conversion Services Fee	H2015	HK	U1	N/A	Per encounter	\$614.29
Recovery Management Transitional Day Rate	H2015	HK	TU	N/A	Per day	\$19.28

HCBS-AMH Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Unit	Unit Rate
Recovery Management Transitional fee	H2015	HK	HW	N/A	Per enrollment	\$1,842.87
HCBS Psychosocial Rehabilitation Services Group*	H2019	HK	HQ	UN(2), UP(3), UQ(4), UR(5), US(6), 95	Per 15 minutes	\$5.39
HCBS Psychosocial Rehabilitation Services Individual*	H2019	HK	HE	FQ or 95	Per 15 minutes	\$26.93
Home Delivered Meals Medicaid	S5170	HK	HE	N/A	Per meal	\$6.93
Home Delivered Meals non-Medicaid	S5170	HK	HW	N/A	Per meal	\$6.46
Host Home/ Companion Care	S5136	HK	HE	N/A	Per day	\$82.40
Minor Home Modifications	S5165	HK	HE	N/A	Per encounter	cost
Nursing Licensed Vocational Nurse (LVN)*	S9124	HK	HE	FQ or 95	Per hour	\$29.69
Nursing registered Nurse (RN)*	S9123	HK	HE	FQ or 95	Per hour	\$43.39
Peer Support*	H0038	HK	HE	FQ or 95	Per 15 minutes	\$11.25
Respite Care In-Home	T1005	HK	HE	N/A	Per 15 minutes	\$3.40
Respite Care out-of-home 24-hour Residential Habilitation Home	T2033	HK	HE	N/A	Per day	\$147.12
Respite Care out-of-home Adult Foster Care home	S5140	HK	HE	N/A	Per day	\$33.28
Respite Care out-of-home Licensed Assisted Living Facility	S5151	HK	HE	N/A	Per day	\$52.55

HCBS-AMH Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Unit	Unit Rate
Respite Care out-of-home Nursing Facility	H0045	HK	HE	N/A	Per day	\$82.56
Substance Use Disorder Services Assessment*	H0001	HK	HH	95	Per assessment	\$41.35
Substance Use Disorder Services Group*	H0005	HQ	HH	UN(2), UP(3), UQ(4), UR(5), US(6), 95	Per hour	\$16.00
Substance Use Disorder Services Individual*	H0004	HK	HE	FQ or 95	Per 15 minutes	\$11.75
Supervised Living Services	H2013	HK	HE	N/A	Per day	\$147.12
Supported Home Living	S5130	HK	HE	N/A	Per 15 minutes	\$5.60
Transition Assistance Services	T2038	HK	HE	N/A	Per event	cost
Transition Assistance Services Requisition fee	T2038	HK	CG	N/A	Per event	\$158.28
Transportation	A0080	HK	HE	N/A	Per mile	Per Texas Comptroller of Public Accounts

***NOTES:**

More information on Flexible Funding requests for technology can be found in Section 3310.

HCBS-AMH services provided by synchronous audiovisual technology must be billed using modifier 95.

HCBS-AMH services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

2110 HCBS-AMH Service Utilization

HCBS-AMH Service	Standard Anticipated Units	High Need Utilization
Adaptive Aids	\$500	\$1,000
Assisted Living Services	Daily	N/A
Community Psychiatric Supports and Treatment	4 to 5 units/month	6 to 8 units/month
Employment Services Employment Assistance	8 to 13 units/month	14 to 17 units/month
Employment Services Supported Employment	10 to 21 units/month	22 to 38 units/month
Flexible Funds	As Authorized	As Authorized
HCBS-AMH Pre-Engagement	1 to 32 unit/per participant	33 to 64 unit/per participant
HCBS-AMH Recovery Management	24 to 48 units/week or max of 192 units/month	49 to 64 units/week or max of 256 units/month
HCBS Psychosocial Rehabilitation Services Group	20 to 40 units/month	41 to 65 units/month
HCBS Psychosocial Rehabilitation Services Individual	20 to 40 units/month	41 to 65 units/month
Home Delivered Meals Medicaid	20 to 45 units/month	46 to 62 units/month
Home Delivered Meals Non- Medicaid	20 to 45 units/month	46 to 62 units/month
Host Home/Companion Care	Daily	N/A
Minor Home Modifications	\$500	\$1,000
Nursing Licensed Vocational Nurse (LVN)	12 to 24 units/month	25 to 56 units/month
Nursing Registered Nurse (RN)	12 to 24 units/month	25 to 56 units/month
Peer Support	10 to 20 units/month	21 to 30 units/month
Recovery Management Conversion Services Fee	1	1
Recovery Management Transitional Day Rate	90	90
Recovery Management Transitional Fee	1	1
Respite Care In-Home	1 to 96 units/month	97 to 288 units/month

HCBS-AMH Service	Standard Anticipated Units	High Need Utilization
Respite Care Out-of-Home 24 Hour Residential Habilitation Home	1 unit/month	3 unit/month
Respite Care Out-of-Home Adult Foster Care Home	1 unit/month	3 unit/month
Respite Care Out-of-Home Licensed Assisted Living Facility	1 unit/month	3 unit/month
Respite Care Out-of-Home Nursing Facility	1 unit/month	3 unit/month
Substance Use Disorder Services Assessment	1	1
Substance Use Disorder Services Group	10 to 20 units/month	21 to 39 units/month
HCBS-AMH Pre-Engagement	1 to 32 unit/per participant	33 to 64 unit/per participant
HCBS-AMH Recovery Management	24 to 48 units/week or max of 192 units/month	49 to 64 units/week or max of 256 units/month
HCBS Psychosocial Rehabilitation Services Group	20 to 40 units/month	41 to 65 units/month
HCBS Psychosocial Rehabilitation Services Individual	20 to 40 units/month	41 to 65 units/month
Home Delivered Meals Medicaid	20 to 45 units/month	46 to 62 units/month
Home Delivered Meals Non-Medicaid	20 to 45 units/month	46 to 62 units/month
Host Home/Companion Care	Daily	N/A
Minor Home Modifications	\$500	\$1,000
Nursing Licensed Vocational Nurse (LVN)	12 to 24 units/month	25 to 56 units/month
Nursing Registered Nurse (RN)	12 to 24 units/month	25 to 56 units/month
Peer Support	10 to 20 units/month	21 to 30 units/month
Recovery Management Conversion Services Fee	1	1
Recovery Management Transitional Day Rate	90	90
Recovery Management Transitional Fee	1	1

HCBS-AMH Service	Standard Anticipated Units	High Need Utilization
Respite Care In-Home	1 to 96 units/month	97 to 288 units/month
Respite Care Out-of-Home 24 Hour Residential Habilitation Home	1 unit/month	3 unit/month
Respite Care Out-of-Home Adult Foster Care Home	1 unit/month	3 unit/month
Respite Care Out-of-Home Licensed Assisted Living Facility	1 unit/month	3 unit/month
Respite Care Out-of-Home Nursing Facility	1 unit/month	3 unit/month
Substance Use Disorder Services Assessment	1	1
Substance Use Disorder Services Group	10 to 20 units/month	21 to 39 units/month

NOTES:

Adaptive Aids, Minor Home Modifications, Transition Assistance Services and Flexible Funds do not have rates assigned to them.

When completing invoices, on the Encounter Data Tab, document the actual cost of the service in the Unit Rate column.

If Minor Home Modifications, and Adaptive Aids cost is over \$500.00, three bids must be obtained and submitted for review prior to purchase.

Room and board, normal household expenses and items not related to amelioration of the person's disability are not included.

There is a \$2,000 cost cap per participant for the transition event into their residence (including, but not limited, to supported home living and Host Home/Companion Care).

There is a \$1,000 cost cap per participant for the transition event into a host home, supervised living or assisted living arrangement.

Persons are responsible for their room and board costs.

There are not modifiers for blank cells under the Modifier 3 and Modifier 4 columns at this time. Providers will be notified of any service code and modifier changes.

2200 General Billing Requirements

HCBS-AMH Providers shall be enrolled as a Medicaid provider and assigned a Medicaid provider type specific to the HCBS-AMH Program.

All HCBS-AMH services must be on and provided in accordance with the Active IRP, authorized by HHSC. All services require documentation to support that the service rendered meets needs-based criteria.

HCBS-AMH services are subject to retrospective review and recoupment if documentation does not support the service billed. HHSC may request required documentation at any time to verify reimbursed services are being provided in accordance with the requirements of the HCBS-AMH Program. (See 2800 Documentation of Service Provision).

Claims submitted to the Claims Administrator TMHP for people who receive services under the Long- term Services and Supports (LTSS), STAR+PLUS Home and Community Based Services Waiver, Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services Waiver (HCS), or Texas Home Living Waiver (TxHmL) are identified quarterly and payments are recouped.

The department supports the following principles:

- Persons are charged for services based on their ability to pay;
- Procedures for determining ability to pay are fair, equitable, and consistently implemented;
- Paying for services in accordance with his/her ability to pay reinforces the role of the person as a customer;
- Earned revenues are optimized; and
- The department is the payer of last resort.

2210 Verification of Medicaid Eligibility

A person must have Medicaid effective during the service period for which the provider submits Medicaid claims.

2300 Service Rates

2310 Rates Schedule

The published rates for HCBS-AMH are available on the [HHSC Rate Analysis for Long- Term Care Services, Adult Mental Health](#) website.

2320 Services with Requisition Fee

A requisition fee is the administrative portion of the service provision. The HCBS-AMH Provider bills for and retains the requisition fee associated with the provision of the following services:

- Transition Assistance Services (\$158.28 one-time fee per transitionevent)

2330 Cost Reporting

Costs reports must be completed and submitted to the Texas Health and Human Services Commission (HHSC) according to HHSC's rules and instructions.

- Providers may not include costs associated with non-reimbursable activities on a cost report.
- Providers may not code staff time associated with non-reimbursable activities on time studies used to set rates for HCBS-AMH services.
- The costs of the following activities may be included in the cost report although they are not reimbursable:
 - ▶ Staff travel time and cost of travel to provide the service at a location that is not owned or operated by, or under arrangement with the provider.
 - ▶ Quality assurance activities specific to the service.

2400 Service Authorization

Services provided without prior authorization are subject to non-payment. Services must be on the Active Individual Recovery Plan (IRP), approved by HHSC prior to the provision of HCBS-AMH services.

2500 Provider Qualifications

The HCBS-AMH Provider Agency is responsible for verifying that direct service provider meets minimum provider qualifications. To be a qualified direct service provider, a person must:

- Be 18 years of age or older;
- Be a staff member or contractor of the HCBS-AMH Provider;
- Be paid by the HCBS-AMH provider to provide the service;
- Not be disqualified to provide the particular service being claimed;
- Meet the minimum provider qualifications, credentials, and training requirements as outlined by HHSC in the HCBS-AMH Provider Manual;
- Not have been convicted of an offense listed under §250.006 of the Texas Health and Safety Code;
- Not be designated in either the Employee Misconduct Registry or the Nurse Aid Registry maintained by HHSC as having abused, neglected or exploited a person or misappropriated a person's property;
- Not be the person's spouse;
- Not be a relative (exception for Host Home/Companion Care, see Section 3150 Billable Host Home/Companion Care Activities and Services); and
- Not be a guardian or managing conservator for the person or otherwise legally responsible for the person.

2600 Location of Service Provision

Services must be provided as indicated in Section 3000 Service Specific Billing Guidelines and in accordance with the requirements outlined in this Section 2600 Location of Service Provision.

2610 Excluded Locations for Medicaid Services

Texas Medicaid must not be billed for HCBS-AMH services provided to a person who is a resident or inpatient of:

- Nursing facilities (for people not mandated by the Omnibus Budget Reconciliation Act [OBRA] of 1987);

- An ICF-ID;
- State-supported living centers;
- State MH facilities;
- Title XIX participating hospitals, including general medical hospitals;
- Private psychiatric hospitals;
- A Texas Medicaid-certified residence not already specified;
- An institution for mental diseases, such as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing the diagnosis, treatment, or care of people who have mental diseases, including medical attention, nursing care, and related services; or
- A jail or public institution.

2620 Home and Community Based Services

Approved Settings

Providers are responsible to assure that services are provided in HHSC approved settings and in accordance with Code of Federal Regulations 42 CFR §441.710 Home and Community Based Settings.

Home and community-based settings, including provider offices, must meet certain qualifications. These include:

- Integrated in and supports full access of persons receiving HCBS-AMH Services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as persons not enrolled in HCBS-AMH;
- The setting is selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the Individual
- Recovery Plan (IRP) and are based on the person's needs, preferences, and, for residential settings, resources available for room and board;
- Ensures person rights of privacy, dignity and respect, and freedom from coercion and restraint;

- Optimizes, but does not regiment, person initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and
- Facilitates person choice regarding services and supports, and who provides them.
- In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:
 1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the person receiving services, and the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
 2. Each person has privacy in their sleeping or living unit:
 - ◊ Units have entrance doors lockable by the person, with only appropriate staff having keys to doors.
 - ◊ Persons sharing units have a choice of roommates in that setting.
 - ◊ Persons have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 3. Persons have the freedom and support to control their own schedules and activities, and have access to food at any time.
 4. Persons are able to have visitors of their choosing at any time.
 5. The setting is physically accessible to the person.
 6. Any modification of the additional conditions specified in items 1 through 4 above, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
 - ◊ Identify a specific and individualized assessed need.
 - ◊ Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

- ◇ Document less intrusive methods of meeting the need that have been tried but did not work.
- ◇ Include a clear description of the condition that is directly proportionate to the specific assessed need.
- ◇ Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- ◇ Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- ◇ Include the informed consent of the person.
- ◇ Include an assurance that interventions and supports will cause no harm to the person.

Residential Settings include:

- Homes or apartments owned by the person consumer or their family;
- Homes or apartments leased by the person from non-HCBS providers sources;
- Homes owned or leased by an HCBS-AMH provider and certified by the State; or
- Assisted living facilities licensed by the State under 26 TAC Chapter 553 (relating to Licensing Standards for Assisted Living Facilities).

2630 Exceptions

Certain HCBS-AMH services are reimbursable by General Revenue (GR) when provided in an inpatient setting (See Section 3340 HCBS-AMH Medicaid Services Provided in the Hospital). Additionally, HCBS- AMH allows for the limited provision of Recovery Management, reimbursable by GR while the person is in Suspended Status or is transferring from another HCBS program (See 3331 Updating an IRP for Person in Suspended Status and 3350 Recovery Management Conversion Services).

The HCBS-AMH provider is responsible to accurately reflect the location of service provision through required documentation and submission of claims as required.

2700 Billable Units of Service

A service event:

- Is a discrete period of continuous time during which billable activity for one service is performed by one service provider;
- Consists of one or more billable activities; and
- Ends when the service provider stops performing billable activity or performs billable activity for a different service.

2710 15 Minute Unit of Service

The following services have a unit of service of 15 minutes:

- Recovery Management;
- Peer Support
- HCBS Psychosocial Rehabilitation Services (Individual and group); and
- Substance Use Disorder Service (individual)
- HCBS-AMH Pre-Engagement Service
- Supported Home Living
- Respite Care - In Home

All claims for reimbursement are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour. Payment will not be made for fractional units of service.

To calculate billing units, count the total number of billable minutes and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

Providers may use the following conversion table:

Time	Units
at least 8 minutes – but less than 23 minutes	1 unit
at least 23 minutes – but less than 38 minutes	2 units
at least 38 minutes – but less than 53 minutes	3 units
at least 53 minutes – but less than 1 hour, 8 minutes	4 units
at least 1 hour, 8 minutes – but less than 1 hour, 23 minutes	5 units
at least 1 hour, 23 minutes – but less than 1 hour, 38 minutes	6 units

Time	Units
at least 1 hour, 38 minutes – but less than 1 hour, 53 minutes	7 units
at least 1 hour, 53 minutes – but less than 2 hours, 8 minutes	8 units
at least 2 hours, 8 minutes – but less than 2 hours, 23 minutes	9 units
at least 2 hours, 23 minutes – but less than 2 hours, 38 minutes	10 units
at least 2 hours, 38 minutes – but less than 2 hours, 53 minutes	11 units
at least 2 hours, 53 minutes – but less than 3 hours, 8 minutes	12 units
at least 3 hours, 8 minutes – but less than 3 hours, 23 minutes	13 units
at least 3 hours, 23 minutes – but less than 3 hours, 38 minutes	14 units
at least 3 hours, 38 minutes – but less than 3 hours, 53 minutes	15 units
at least 3 hours, 53 minutes – but less than 4 hours, 8 minutes	16 units
at least 4 hours, 8 minutes – but less than 4 hours, 23 minutes	17 units
at least 4 hours, 23 minutes – but less than 4 hours, 38 minutes	18 units
at least 4 hours, 38 minutes – but less than 4 hours, 53 minutes	19 units
at least 4 hours, 53 minutes – but less than 5 hours, 8 minutes	20 units
at least 5 hours, 8 minutes – but less than 5 hours, 23 minutes	21 units
at least 5 hours, 23 minutes – but less than 5 hours, 38 minutes	22 units
at least 5 hours, 38 minutes – but less than 5 hours, 53 minutes	23 units
at least 5 hours, 53 minutes – but less than 6 hours, 8 minutes	24 units
at least 6 hours, 8 minutes – but less than 6 hours, 23 minutes	25 units
at least 6 hours, 23 minutes – but less than 6 hours, 38 minutes	26 units
at least 6 hours, 38 minutes – but less than 6 hours, 53 minutes	27 units
at least 6 hours, 53 minutes – but less than 7 hours, 8 minutes	28 units
at least 7 hours, 8 minutes – but less than 7 hours, 23 minutes	29 units
at least 7 hours, 23 minutes – but less than 7 hours, 38 minutes	30 units
at least 7 hours, 38 minutes – but less than 7 hours, 53 minutes	31 units
at least 7 hours, 53 minutes – but less than 8 hours, 8 minutes	32 units
at least 8 hours, 8 minutes – but less than 8 hours, 23 minutes	33 units
at least 8 hours, 23 minutes – but less than 8 hours, 38 minutes	34 units
at least 8 hours, 38 minutes – but less than 8 hours, 53 minutes	35 units
at least 8 hours, 53 minutes – but less than 9 hours, 8 minutes	36 units
at least 9 hours, 8 minutes – but less than 9 hours, 23 minutes	37 units
at least 9 hours, 23 minutes – but less than 9 hours, 38 minutes	38 units

Time	Units
at least 9 hours, 38 minutes – but less than 9 hours, 53 minutes	39 units
at least 9 hours, 53 minutes – but less than 10 hours, 8 minutes	40 units
at least 10 hours, 8 minutes – but less than 10 hours, 23 minutes	41 units
at least 10 hours, 23 minutes – but less than 10 hours, 38 minutes	42 units
at least 10 hours, 38 minutes – but less than 10 hours, 53 minutes	43 units
at least 10 hours, 53 minutes – but less than 11 hours, 8 minutes	44 units
at least 11 hours, 8 minutes – but less than 11 hours, 23 minutes	45 units
at least 11 hours, 23 minutes – but less than 11 hours, 38 minutes	46 units
at least 11 hours, 38 minutes – but less than 11 hours, 53 minutes	47 units
at least 11 hours, 53 minutes – but less than 12 hours, 8 minutes	48 units
at least 12 hours, 8 minutes – but less than 12 hours, 23 minutes	49 units
at least 12 hours, 23 minutes – but less than 12 hours, 38 minutes	50 units
at least 12 hours, 38 minutes – but less than 12 hours, 53 minutes	51 units
at least 12 hours, 53 minutes – but less than 13 hours, 8 minutes	52 units
at least 13 hours, 8 minutes – but less than 13 hours, 23 minutes	53 units
at least 13 hours, 23 minutes – but less than 13 hours, 38 minutes	54 units
at least 13 hours, 38 minutes – but less than 13 hours, 53 minutes	55 units
at least 13 hours, 53 minutes – but less than 14 hours, 8 minutes	56 units
at least 14 hours, 8 minutes – but less than 14 hours, 23 minutes	57 units
at least 14 hours, 23 minutes – but less than 14 hours, 38 minutes	58 units
at least 14 hours, 38 minutes – but less than 14 hours, 53 minutes	59 units
at least 14 hours, 53 minutes – but less than 15 hours, 8 minutes	60 units
at least 15 hours, 8 minutes – but less than 15 hours, 23 minutes	61 units
at least 15 hours, 23 minutes – but less than 15 hours, 38 minutes	62 units
at least 15 hours, 38 minutes – but less than 15 hours, 53 minutes	63 units
at least 15 hours, 53 minutes – but less than 16 hours, 8 minutes	64 units
at least 16 hours, 8 minutes – but less than 16 hours, 23 minutes	65 units
at least 16 hours, 23 minutes – but less than 16 hours, 38 minutes	66 units
at least 16 hours, 38 minutes – but less than 16 hours, 53 minutes	67 units
at least 16 hours, 53 minutes – but less than 17 hours, 8 minutes	68 units
at least 17 hours, 8 minutes – but less than 17 hours, 23 minutes	69 units
at least 17 hours, 23 minutes – but less than 17 hours, 38 minutes	70 units

Time	Units
at least 17 hours, 38 minutes – but less than 17 hours, 53 minutes	71 units
at least 17 hours, 53 minutes – but less than 18 hours, 8 minutes	72 units
at least 18 hours, 8 minutes – but less than 18 hours, 23 minutes	73 units
at least 18 hours, 23 minutes – but less than 18 hours, 38 minutes	74 units
at least 18 hours, 38 minutes – but less than 18 hours, 53 minutes	75 units
at least 18 hours, 53 minutes – but less than 19 hours, 8 minutes	76 units
at least 19 hours, 8 minutes – but less than 19 hours, 23 minutes	77 units
at least 19 hours, 23 minutes – but less than 19 hours, 38 minutes	78 units
at least 19 hours, 38 minutes – but less than 19 hours, 53 minutes	79 units
at least 19 hours, 53 minutes – but less than 20 hours, 8 minutes	80 units
at least 20 hours, 8 minutes – but less than 20 hours, 23 minutes	81 units
at least 20 hours, 23 minutes – but less than 20 hours, 38 minutes	82 units
at least 20 hours, 38 minutes – but less than 20 hours, 53 minutes	83 units
at least 20 hours, 53 minutes – but less than 21 hours, 8 minutes	84 units
at least 21 hours, 8 minutes – but less than 21 hours, 23 minutes	85 units
at least 21 hours, 23 minutes – but less than 21 hours, 38 minutes	86 units
at least 21 hours, 38 minutes – but less than 21 hours, 53 minutes	87 units
at least 21 hours, 53 minutes – but less than 22 hours, 8 minutes	88 units
at least 22 hours, 8 minutes – but less than 22 hours, 23 minutes	89 units
at least 22 hours, 23 minutes – but less than 22 hours, 38 minutes	90 units
at least 22 hours, 38 minutes – but less than 22 hours, 53 minutes	91 units
at least 22 hours, 53 minutes – but less than 23 hours, 8 minutes	92 units
at least 23 hours, 8 minutes – but less than 23 hours, 23 minutes	93 units
at least 23 hours, 23 minutes – but less than 23 hours, 38 minutes	94 units
at least 23 hours, 38 minutes – but less than 23 hours, 53 minutes	95 units
at least 23 hours, 53 minutes – but less than 24 hours, 8 minutes	96 units

2720 Hourly Unit of Service

The following services have a unit of service of an hour:

- Community Psychiatric Supports and Treatment;
- Employment Services;

- Nursing (RN and LVN); and
- Substance Use Disorder Services (Group)

All claims for reimbursement are based on the actual amount of billable time associated with the service. For those services for which the unit of service is an hour (1 unit = 60 minutes = one hour), partial units must be billed in tenths of an hour and rounded up or down to the nearest six-minute increment.

To calculate billing units, count the total number of billable minutes divide by 60 to convert to billable units of service. If the total billable minutes are not divisible by 60, the minutes are converted to partial units of service as follows:

Time	Units
0 to 3 minutes – but less than 4 minutes	0 unit
at least 4 minutes – but less than 10 minutes	.1 unit
at least 10 minutes – but less than 16 minutes	.2 unit
at least 16 minutes – but less than 22 minutes	.3 unit
at least 22 minutes – but less than 28 minutes	.4 unit
at least 28 minutes – but less than 34 minutes	.5 unit
at least 34 minutes – but less than 40 minutes	.6 unit
at least 40 minutes – but less than 46 minutes	.7 unit
at least 46 minutes – but less than 52 minutes	.8 unit
at least 52 minutes – but less than 58 minutes	.9 unit
at least 59 minutes – but less than 64 minutes	1 unit
at least 64 minutes – but less than 70 minutes	1.1 units
at least 70 minutes – but less than 76 minutes	1.2 units
at least 76 minutes – but less than 82 minutes	1.3 units
at least 82 minutes – but less than 88 minutes	1.4 units
at least 88 minutes – but less than 94 minutes	1.5 units

2730 Daily Unit of Service

For services with a daily unit of service, an HCBS-AMH Provider may only submit a claim for one unit of service per calendar day. The following services have a unit of service of one day:

- Respite (except for in-home
- Respite. See Section 2710);
- Assisted Living;
- Host Home/Companion Care; and
- Supervised Living.

2740 Other Units of Service (Event, Encounter, Mile, Meal)

The following services have units that cannot be associated with time. The applicable unit for each of the services below is outlined in the table.

Service	Units
Adaptive Aids	Dollar
Flexible Funds	Dollar
Home Delivered Meals	Meal
Minor Home Modifications	Dollar
Transition Assistance Services	Dollar
Transition Assistance Requisition Fee	One-Time Fee
Transportation	Mile
Recovery Management Conversion Services Fee	One-Time Fee
Recovery Management Transitional Fee (for first 3 months of	One-Time Fee
Recovery Management Transitional Day Rate (from 3 months and one day up to 6 months	Day Rate

2800 Documentation of Service Provision

All HCBS-AMH providers are responsible to maintain records that demonstrate services and items provided meet needs-based criteria; support reimbursement for service provision; and demonstrate compliance with HCBS-AMH requirements in the

Billing Guidelines and HCBS-AMH Provider Manual. The HCBS-AMH Provider shall maintain documentation of service provision for each invoiced amount within the person's clinical record. HHSC may access the HCBS-AMH clinical records at any time to compare invoiced amounts with documentation of service provision. An HCBS-AMH provider may document a service in any way that meets the requirements of HCBS- AMH Billing Guidelines including this section and section 3000 Service Specific Billing Requirements. HCBS-AMH Providers may be required to submit documentation of performed services (i.e. supporting documents). Upon request, the RMEs and Pas must make available to HHSC any documents, papers, and phone records that are directly pertinent to the goods or services being provided to participants in the HCBS-AMH Waiver program. Examples includes but are not limited to: invoices; service authorizations; sign-in sheets; insurance certificates; any documentation required under the entity's contract; and the HHSC Standard Procurement Terms and Conditions, and/or HCBS-AMH Waiver standards.

2810 General Documentation Requirements to Support Service Provision

A program provider must have written documentation that supports service provision. Documentation must:

- Be legible;
- Support the service claim;
- Include the following:
 - Original or electronic signature, including title, of the staff person who provided the service;
 - Name of the person who was provided the service;
 - Day, month and year the service was provided;
 - Type of service that was provided;
 - Begin and end time of the service;
 - Location where the service was provided;
 - A summary of the activities that occurred;
 - The modality of the service provision, e.g., individual, group;
 - Method of service provision, e.g., face to face, phone, or telehealth;
 - Verbal consent for telehealth services received attest the participant is in a private and safe place prior to service delivery;

- ▶ The training methods used, if applicable, e.g., instructions, modeling, role play, feedback; or repetition;
- ▶ Title of the curriculum used, if applicable;
- ▶ Treatment plan objective (s) that was/were/ the focus of the service;
- ▶ Progress or lack of progress in achieving treatment plan goals; and
- ▶ A Written Service Log and Written Summary Log, for each person in accordance with the following:
 - ◊ For assisted living, supervised living, supported home living, respite, nursing, employment assistance and supported employment, a written service log written by a direct service provider who delivered the service; and
 - ◊ For host home/companion care, a written service log or a written summary log by a service provider who delivered the service.

2820 Written Service Log

A written service log must:

- Be written after the service is provided and within 14 calendar days after the activity being documented is provided;
- Include the following:
 - ▶ A description or list of activities performed by the direct service provider and the person that evidences the performance of one or more of the billable activities for the particular service being claimed;
 - ▶ A brief description of the location of the service event such as the address or name of business; and
 - ▶ For services with a daily unit of service include a description or list of activities performed by the direct service provider and the person that evidences the performance of the billable activities for the particular service being claimed; and
- Include the signature and title of the direct service provider making the written service log.
- Be completed by the direct service provider providing the service.

2821 Unacceptable Content

The following are unacceptable as a description of the activities in a written service log or written summary log:

- Ditto marks;
- References to other written service logs or written summary logs using words or symbols;
- Non-specific statements such as "had a good day," "did ok," or "no problem today;"
- A statement or other information that is photocopied from other completed or partially completed written service logs or written summary logs; and
- A medication log.

2830 Written Summary Log

A Written Summary Log must:

- Be written after services have been provided and within 14 calendar days after the week being documented;
- Include information that identifies the person for whom the written summary log is made;
- Include a general description or list of activities performed during the calendar week in which the service was provided;
- Include a brief description of the location of the service event, such as address or name of the business; and
- Include the signature and title of the direct service provider making the written summary log.
- Be completed by the direct service provider providing the service.

2831 Unacceptable Content

The following are unacceptable as a description of the activities in a written service log or written summary log:

- Ditto marks;
- References to other written service logs or written summary logs using words or symbols;

- Non-specific statements such as "had a good day," "did ok," or "no problem today;"
- A statement or other information that is photocopied from other completed or partially completed written service logs or written summary logs; and
- A medication log.

2840 Proof of Residence

The HCBS-AMH Direct Provider Agency is responsible for verifying the direct service provider's location for the provision host home/companion care and respite care as indicated in the HCBS-AMH Billing Guidelines.

The following serves as proof of residence of host home/companion care service provider:

- Two documents from the following categories:
 - Driver's license or other government issued photo identification of the direct service provider;
 - Voter registration card of the direct service provider;
 - Lease agreement for the time period in question with the name of the direct service provider as the lessee or an occupant; or
 - Utility bill for the time period in question in the name of the direct service provider; or
- At its discretion, HHSC may accept other written documentation as proof of the location of the residence of a direct service provider of host home/companion care.

2900 Multiple Services

Providers may not claim Federal Financial Participation (Medicaid reimbursement) for more than one service delivered on the same day and at the same time to a person. As such HCBS-AMH services can only be provided concurrently as indicated below and as otherwise outlined in the HCBS-AMH Billing Guidelines:

- Grey Box with an asterisk in the chart below indicates the service is not allowable at the same time unless otherwise indicated in these HCBS-AMH Billing Guidelines;

- ▶ Non face-to-face activities of Supported Home Living are allowable at the same time as other HCBS-AMH services. Provision of Minor Home Modifications, Adaptive Aids, and Transition Assistance Services may occur concurrently with other HCBS-AMH services, unless otherwise prohibited (See 4102.1 Billable Supported Home Living Activities and Services);
- ▶ Nursing, Peer Support, and Recovery Management may be provided at the same time only for the development of the IRP;

The request for exception can be submitted with the IRP. To receive HHSC approval there must be a documented legitimate rationale of clinical need for more than one service to occur. Documentation must identify that the services being provided are non-duplicative.

Home and Community-Based Services-Adult Mental Health Billing Guidelines

Service	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.
1. Adaptive Aids	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Supported Home Health	Y	N	N	N	N	*	*	Y	Y	Y	N	*	*	N	*	Y	*
3. Supervised Living	Y	N	N	N	N	Y	Y	N	N	Y	Y	Y	Y	N	Y	Y	N
4. Host Home/Companion Care	Y	N	N	N	N	Y	Y	N	N	Y	Y	Y	Y	N	Y	Y	N
5. Assisted Living	Y	N	N	N	N	Y	Y	N	N	Y	Y	Y	Y	N	Y	Y	N
6. Community Psychiatric Supports and Treatment	Y	*	Y	Y	Y	N	N	Y	Y	N	N	N	N	Y	N	Y	N
7. Employment Services	Y	*	Y	Y	Y	N	N	Y	Y	N	N	N	N	Y	N	Y	N
8. Home Delivered Meals	Y	Y	N	N	N	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	N
9. Minor Home Modifications	Y	Y	N	N	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
10. Nursing	Y	Y	Y	Y	Y	N	N	Y	Y	N	*	*	N	Y	N	Y	N
11. Peer Support	Y	Y	Y	Y	Y	N	N	Y	Y	*	N	*	N	Y	N	Y	N
12. Recovery Management	Y	*	Y	Y	Y	N	N	Y	Y	*	*	N	N	Y	N	Y	Y
13. Psychosocial Rehab	Y	*	Y	Y	Y	N	N	Y	Y	N	N	N	N	Y	N	Y	N
14. Respite	Y	N	N	N	N	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	N
15. Substance Use Disorder Services	Y	*	Y	Y	Y	N	N	Y	Y	N	N	N	N	Y	N	Y	N
16. Transition Assistance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
17. Transportation	Y	*	N	N	N	N	N	N	Y	N	N	N	N	N	N	Y	N

Y – Corresponding services can occur simultaneously

N - Corresponding services cannot occur simultaneously

* - Corresponding services may occur simultaneously with pre-approval from HCBS- AMH
Column headers 1 – 17 refer to the services listed in row 1 -17

3000 Service Specific Billing Requirements

3100 Medicaid Billable Activities and Services

3110 Adaptive Aids

Adaptive Aids include devices, controls and appliances that enable persons to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live; allow the person to integrate more fully into the community; or to ensure the health, welfare and safety of the person. HCBS-AMH Adaptive aids include:

1. Vehicle adaptations or modifications:
2. May be made to a vehicle that is not owned by the provider and is the person's primary means of transportation
3. Vehicle adaptations or modifications do not include the following:
4. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the person;
5. Purchase or lease of a vehicle; and
6. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications.
7. Service animals and supplies (service animals and the associated costs for equipping, training and maintaining the health and safety of the animal):
 - ▶ Veterinary care (cost effectiveness of medical interventions outside of routine care necessary for the animal are to be determined on an individual basis);
 - ▶ Travel benefits associated with obtaining and training a dog; and Provision, maintenance, and replacement of items and supplies required for the animal to perform the tasks necessary to assist persons.
8. Environmental adaptations and aids for daily living such as:
 - ▶ Reachers;
 - ▶ Adapted utensils;
 - ▶ Certain types of lifts;
 - ▶ Pill keepers;

- ▶ Reminder devices;
- ▶ Signs;
- ▶ Calendars;
- ▶ Planners; and
- ▶ Storage devices.

3111 Non-billable Adaptive Aids Items and Services

The following are not billable to HCBS-AMH Adaptive Aids:

1. Adaptive aids and supplies that do not help the person or are not related to a goal on the person's IRP
2. General appliance (e.g., washer, dryer, stove, dishwasher or vacuum cleaner), without an approved exception by HHSC;
3. Swimming pool;
4. Hot tub;
5. Shoes not specifically designed for the person;
6. Automobile;
7. Toy, game or puzzle;
8. Recreational equipment;
9. Personal computer or software for purposes other than those specified in the IRP;
10. Medication, including a co-payment for a medication;
11. Daily hygiene products;
12. Rent;
13. Utilities (for example, gas, electric, cable or water);
14. Food;
15. Ordinary bedding supplies (for example, bedspread, pillow or sheet);
16. Exercise equipment;
17. Pager, including a monthly service fee;
18. Conventional telephone, including a cellular phone or a monthly service fee not directly related to an IRP goal;

- 19.Home security system, including a monthly service fee; and
- 20.Supplies assumed for use by paid direct service providers and considered a provider expense (e.g. gloves).

3112 Documentation

Receipt for the purchase of the Adaptive Aid is required.

An HCBS-AMH program provider must obtain the documentation described below before purchasing the adaptive aid:

1. An HCBS-AMH Provider must have written documentation to support a service claim for Adaptive Aids that:
 - ▶ Meets the requirements set forth in Section 2800 Documentation of Service Provision; and
 - ▶ The person or LAR agree that the recommended adaptive aid is necessary and should be purchased; and
2. For items over \$500 HCBS-AMH provider must:
 - ▶ Meet and ensure that the person meets needs-based criteria) (See 4101.7 Needs-Based Criteria); and
 - ▶ Document any discussion with the person or LAR about the recommended adaptive aid;
3. For items over \$500 for a person who is under 21 years of age, the program provider must obtain one of the following as proof of non-coverage by Medicaid:
 - ▶ Letter from Texas Medicaid Healthcare Partnership (TMHP) that includes:
 - ◇ Statement that the requested adaptive aid is denied under the Texas Medicaid Home Health Services or the Texas Health Steps programs; and
 - ◇ Reason for the denial, which must not be one of the following:
 - Medicare is the primary source of coverage;
 - Information submitted to TMHP to make payment was incomplete, missing, insufficient or incorrect;
 - Request was not made in a timely manner; or
 - Adaptive aid must be leased;

- ▶ Letter from TMHP stating that the adaptive aid is approved and the amount to be paid, which must be less than the cost of the requested adaptive aid; or
 - ▶ Provision from the current Texas Medicaid Providers Procedure Manual stating that the requested adaptive aid is not covered by the Texas Medicaid Home Health Services or the Texas Health Steps programs.
4. For items over \$500 for a person eligible for Medicare, a program provider must obtain one of the following for an HCBS-AMH adaptive aid:
- ▶ Letter from Cigna Government Services that includes:
 - ◊ Statement that the requested adaptive aid is denied under Medicare; and
 - ◊ Reason for the denial, which must not be one of the following:
 - Information submitted to Cigna Government Services to make payment was incomplete, missing, insufficient or incorrect;
 - The request was not made in a timely manner; or
 - The adaptive aid must be leased;
 - ▶ Letter from Cigna Government Services stating that the adaptive aid is approved and the amount to be paid, which must be less than the cost of the requested adaptive aid; or
 - ▶ Provision from the current Region C DMERC (Durable Medical Equipment Region C) DMEPOS (Durable Medical Equipment Prosthetics, Orthotics and Supplies) Supplier Manual stating that the requested adaptive aid is not covered by Medicare.

3113 Unacceptable Documentation

The following are examples of documentation that are not acceptable as proof of non- coverage:

- Statement from a Medicaid enrolled Durable Medical Equipment (DME) provider that the adaptive aid requested is not covered by the Texas Medicaid Home Health Services or the Texas Health Steps programs; and
- Statement from a Medicare DME provider that the adaptive aid requested is not covered by Medicare.

3114 Bids

Required Number of Bids

Comparable bids describe the adaptive aid and any associated items or modifications identified in the assessment required. An HCBS-AMH provider must obtain comparable bids for the requested adaptive aid from three vendors, except for the following items:

- Reachers;
- Adapted utensils;
- Pill keepers;
- Reminder devices;
- Storage devices;
- Eyeglasses;
- Hearing aids, batteries and repairs;
- Orthotic devices, orthopedic shoes and braces; or
- For an adaptive aid, other than one listed above, with written justification for obtaining less than three bids because the adaptive aid is available from a limited number of vendors.

3115 Required Content and Time Frame

A bid must:

- Be cost effective according to current market prices for the adaptive aid and be the lowest cost based on availability unless contraindicated by specific written justification for using a higher bid;
- State the total cost of the requested adaptive aid;
- Include the name, address and telephone number of the vendor, who may not be a relative of the person; and
- Be obtained within one year after the written recommendation required by 4101.7 Needs-Based Criteria is obtained.

3116 Request for Payment of Higher Bid

If an HCBS-AMH requests authorization for payment that is not based on the lowest bid, the program provider must have written justification for payment of a higher bid.

Examples of Justification That May Be Acceptable

The following are examples of justifications that support payment of a higher bid:

1. Higher bid is based on the inclusion of a longer warranty for the adaptive aid;
or
2. Higher bid is from a vendor that is more accessible to the person than another vendor.

3117 Proof of Ownership

If applicable, the HCBS-AMH provider must obtain proof that the person, person's family member or host home/companion care provider owns the vehicle for which a vehicle lift is requested.

3118 Approval of Annual Vendors

In lieu of obtaining bids an adaptive aid costing less than \$500 monthly, the HCBS-AMH provider must, obtain HHSC approval of annual vendor(s). An approval of an annual vendor by HHSC is only valid for a calendar year.

If HHSC approves an annual vendor to provide an adaptive aid, the HCBS-AMH provider must use the vendor to supply the adaptive aid to all persons of the program provider who need the adaptive aid.

To obtain approval of an annual vendor, a program provider must submit documentation outlined below:

- No sooner than November 1 of the year prior to the calendar year for which the request is being made; and
- No later than January 31 of such calendar year.

3119 Required Documentation for Annual Vendor

To obtain approval of an annual vendor, a program provider must submit the following written documentation to HHSC:

1. List of the adaptive aids to be provided by an annual vendor;
2. Documentation of the current price of each adaptive aid on the list from three vendors who are:
 - ▶ Durable Medical Equipment Home Health (DMEH) suppliers;
 - ▶ Medicare suppliers; and
 - ▶ Not relatives of the person;
3. Documentation identifying the vendor for whom the program provider seeks HHSC approval; and
4. Documentation that the cost of the majority of the adaptive aids to be provided by the identified vendor is the lowest of the three vendors.

31110 Needs-Based Criteria

Adaptive aids are limited to vehicle modifications, service animals and supplies, environmental adaptations, and aids for daily living, such as reachers, adapted utensils, certain types of lifts, pill keepers, reminder devices, signs, calendars, planners, and storage devices. Other items may be included if specifically required to realize a goal specified in the IRP and prior approved by HHSC.

31111 Items \$500 or Greater:

Individual items costing over \$500.00 must be recommended in writing by a licensed practitioner of the healing arts (Physician, Advanced Practice Registered Nurse, Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Marriage and Family Therapist) who is qualified to assess the person's need for the specific adaptive aid and be approved by HHSC.

The written recommendation must:

- Be based on a face-to-face evaluation of the person by the qualified direct service provider conducted not more than one year before the date of purchase of the adaptive aid;
- Include a description of and a recommendation for a specific adaptive aid and any associated items or modifications necessary to make the adaptive aid functional;
- Include a diagnosis that is related to the person's need for the adaptive aid;
- Include a description of the condition related to the diagnosis; and

- Include a description of the specific needs of the person, including information justifying needs-based criteria, if required, and how the adaptive aid will meet those needs (for example, the person needs to ambulate safely and independently from room to room and the use of a walker will allow him to do so).

31112 Limitations

Adaptive Aids are only provided to persons age 21 and over. All medically necessary adaptive aids for children under age 21 will be covered in the state plan pursuant to the early and periodic screening, diagnostic and treatment (EPSDT) benefit.

Adaptive aids are available only after benefits available through Medicare, other Medicaid benefits, or other third party resources have been documented as exhausted.

Except for a vehicle lift, a billable item must be the exclusive property of the person to whom it is provided.

The annual cap is \$10,000 per person, per year. Should a person require adaptive aids after the cost limit has been reached, the person must access other resources or alternate funding sources.

3120 Supported Home Living

Supported Home Living services include assisting residents in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources, and adaptive skills necessary to reside successfully in home and community-based settings. As needed, this service may also include assistance in promoting positive social interactions, as well as services to instruct persons in accessing and using community resources. These resources may include transportation, translation, and communication assistance related to the IRP goals and services to assist the person in shopping and other necessary activities of community and civic life, including self-advocacy. Finally, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included.

3121 Billable Supported Home Living Activities and Services

The only billable activities for Supported Home Living are:

1. Interacting face-to-face with a person to assist the person with activities of daily living including:
 - ▶ bathing,
 - ▶ dressing
 - ▶ personal hygiene;
 - ▶ eating;
 - ▶ meal planning and preparation; and
 - ▶ housekeeping.
2. Assisting the person with ambulation and mobility;
3. Reinforcement of any professional therapies provided to the person;
4. Assisting with the administration of the person's medication or to perform a task delegated by a registered nurse in accordance with rules of the Texas Board of Nursing at 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions) or the Texas Human Resources Code, §§161.091-161.093, as applicable;
5. Developing or improving skills that allow the person to live more independently; develop socially valued behaviors; and integrate into community activities; use natural supports and typical community services available to the public; and participate in leisure activities;
6. Securing transportation for the person;
7. Transporting the person, provided to persons in accordance with HCBS-AMH guidelines. Transportation is not billable for Rideshares; and
8. Performing one of the following activities that does not involve interacting face- to-face with a person:
 - ▶ shopping for the person;
 - ▶ planning or preparing meals for the person;
 - ▶ housekeeping for the person;
 - ▶ procuring or preparing the person's medication; or

- securing transportation for the person.

3122 Non-Billable Supported Home Living Activities and Services

Payments for Supported Home Living are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Supported home living is not billable for the sole activity of supervising the person's safety and security.

3123 Documentation

An HCBS-AMH Provider must have written documentation to support a service claim for Supported Home Living services that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

An HCBS-AMH Provider must comply with 1 TAC 354, Subchapter O, Electronic Visit Verification (EVV), to document the provision of supported home living. 1 TAC Chapter 354, Subchapter O requires an HCBS-AMH Provider to comply with the Electronic Visit Verification Provider Policy Handbook and other policies, including those located on the HHSC Electronic Visit Verification webpage

3124 Transportation as Supported Home Living Activity

A program provider must have written documentation to support a service claim for the supported home living activity of transporting a person. An HCBS-AMH Supported Home Living Provider may document such activity in any way that meets requirements. (see 8003 Documentation of Transportation as Part of HCBS-AMH Service). The written documentation must include:

- Name of the person who was being transported;
- Day, month and year the transportation was provided;
- Place of departure and destination for the person being transported;
- Transportation time;
- Begin and end time for each transportation time;
- Total minutes of each transportation time;

- For each "trip":
 - the number of passengers;
 - the number of direct service providers;
 - the resulting service time; and
 - the signature of the direct service provider transporting the person; and
- Any service times accumulated to make a unit of service for a service claim.
- Transportation is not billable for Rideshares.

3125 Needs-Based Criteria

Supported Home Living will be provided to meet the person's needs as determined by an individualized assessment performed in accordance HHSC. The services are coordinated within the context of the IRP which delineates how Supported Home Living Services are intended to achieve the identified goals.

3126 Limitations

Location

Supported Home Living services are supportive and health-related residential services provided to persons in settings licensed or certified by the State of Texas. Supported Home Living services are necessary, as specified in the person's IRP, to enable the person to remain integrated in the community and ensure the health, welfare, and safety of the person in accordance with 42 CFR

§441.710. Supported Home Living Services are provided in community-based residences and must meet federal HCBS Settings requirements.

Home and Community-Based Settings must:

- Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as persons not receiving Medicaid HCBS.
- Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting.

- Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
- Facilitate person choice regarding services and supports, and who provides them.

Supported Home Living services cannot be provided in or on the grounds of the following settings:

- Nursing facilities;
- Institutions for mental disease;
- Intermediate care facilities for persons with Intellectual or Developmental Disabilities;
- Inpatient hospitals; or
- Any other location that has qualities of an institutional setting.

3127 Submitting a Service Claim for a Person on a Visit with Family or Friend

If the person is on a family or friend visit outside of the provider's location, the provider may submit a service claim for up to 14 calendar days of the visit.

3128 Duplication of Services

Persons receiving adult foster care or Department of Family and Protective Services foster care services may not also receive Supported Home Living services.

A person may receive only one of the following services on the same day:

- Supported Home Living;
- Assisted Living;
- Supervised Living; or
- Host Home/Companion Care

Two entities may not be paid for providing the same service to the same person during the same time period.

This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

3130 Assisted Living

Assisted Living services include assisting residents in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources, and adaptive skills necessary to reside successfully in home and community-based settings. As needed, this service may also include assistance in promoting positive social interactions, as well as services to instruct persons in accessing and using community resources. These resources may include transportation, translation, and communication assistance related to the IRP goals and services to assist the person in shopping and other necessary activities of community and civic life, including self-advocacy. Finally, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included.

3131 Billable Assisted Living Activities and Services

Assisted Living Services has a daily rate and is inclusive of the following:

- 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.
- Interacting face-to-face with a person to assist the person with activities of daily living including:
 - ▶ bathing;
 - ▶ dressing;
 - ▶ personal hygiene;
 - ▶ eating;
 - ▶ meal planning and preparation; and
 - ▶ housekeeping
- Assisting the person with ambulation and mobility;
- Personal care, homemaker, and chore services;
- Reinforcement of specialized rehabilitative, habilitative or psychosocial therapies;

- Medication oversight; and
- Therapeutic, social, and recreational programming.

3132 Non-Billable Assisted Living Activities and Services

Payments for Assisted Living are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Separate payments will not be made for respite, home-delivered meals, or minor home modifications for persons who receive Assisted Living Services.

Nursing and skilled therapy services (except periodic nursing evaluations) are incidental, rather than integral to providing assisted living services. Payment will not be made for 24-hour skilled care.

Transportation is not billable for Rideshares.

3133 Documentation

An HCBS-AMH Provider must have written documentation to support a service claim for Assisted Living Services that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

3134 Needs-Based Criteria

Assisted Living will be provided to meet the person's needs as determined by an individualized assessment performed in accordance HHSC. The services are coordinated within the context of the IRP which delineates how Assisted Living Services are intended to achieve the identified goals.

3135 Limitations

Location

Assisted Living services are supportive and health-related residential services provided to persons in settings licensed by the State under 26 TAC Chapter 553 (relating to Licensing Standards for Assisted Living Facilities) and certified by the State of Texas. Assisted Living services are necessary, as specified in the person's IRP, to enable the person to remain integrated in the community and ensure the health, welfare, and safety of the person in accordance with 42 CFR §441.710. Assisted Living Services must also meet federal HCBS Settings requirements.

Home and Community-Based Settings must:

- Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as persons not receiving Medicaid HCBS.
- Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
- Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
- Facilitate person choice regarding services and supports, and who provides them

Assisted Living services cannot be provided in or on the grounds of the following settings:

- Nursing facilities;
- Institutions for mental disease;
- Intermediate care facilities for persons with Intellectual or Developmental Disabilities;
- Inpatient hospitals; or
- Any other location that has qualities of an institutional setting.

3136 Submitting a Service Claim for a Person on a Visit with Family or Friend

If the person is on a family or friend visit outside of the provider's location, the provider may submit a service claim for up to 14 calendar days of the visit.

3137 Duplication of Services

Persons receiving adult foster care or Department of Family and Protective Services foster care services may not also receive HCBS-AMH Assisted Living Services.

A person may receive only one of the following services on the same day:

- Supported Home Living;
- Assisted Living;
- Supervised Living; or
- Host Home/Companion Care.

Two entities may not be paid for providing the same service to the same person during the same time period.

This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

3140 Supervised Living

Supervised Living services include assisting residents in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources, and adaptive skills necessary to reside successfully in home and community-based settings. As needed, this service may also include assistance in promoting positive social interactions, as well as services to instruct persons in accessing and using community resources. These resources may include transportation, translation, and communication assistance related to the IRP goals and services to assist the person in shopping and other necessary activities of community and civic life, including self-advocacy. Finally, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included.

3141 Billable Supervised Living Activities and Services

Supervised Living Services has a daily rate and is inclusive of the following:

- Enabling social interaction and participation in leisure activities;
- Helping the person develop daily living and functional living skills;
- Providing persons with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks;
- Assistance with planning and preparing meals; transportation or assistance in securing transportation;

- Assistance with ambulation and mobility;
- Reinforcement of specialized rehabilitative, habilitative or psychosocial therapies;
- Transportation (Rideshares are not billable).; and
- Assistance with medications based upon the results of an RN assessment; the performance of tasks delegated by a RN in accordance with the Texas Board of Nursing rules as defined by 22 TAC Chapter 225; and supervision of the person's safety and security.

Supervised living provides residential assistance as needed by persons who live in residences in which the HCBS provider holds a property interest and that meet program certification standards. This service may be provided to persons in one of two modalities:

1. By providers who are not awake during normal sleep hours but are present in the residence and able to respond to the needs of persons during normal sleeping hours; or
2. By providers assigned on a shift schedule that includes at least one complete change of staff each day. Type and frequency of supervision is determined on a person basis based on the level of need for each person.

3142 Non-Billable Supervised Living Activities and Services

Payments for Supervised Living are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

A person may receive only one type of residential assistance (Host – home/Companion Care, Assisted Living, Supervised Living or Supported Home Living) at a time.

Transportation costs are included in the rate for the supervised living service for providing transportation to the participant and not provider staff. Transportation is not billable for Rideshares.

Separate payments will not be made for respite, personal assistance, home-delivered meals, minor home modifications, non-medical transportation, or transition assistance services for persons who receive HCBS-AMH Supervised Living Service in provider owned or operated settings.

3143 Documentation

An HCBS-AMH Provider must have written documentation to support a service claim for Supervised Living Services that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

3144 Needs-Based Criteria

Supervised Living will be provided to meet the person's needs as determined by an individualized assessment performed in accordance HHSC. The services are coordinated within the context of the IRP which delineates how Supervised Living Services are intended to achieve the identified goals.

3145 Limitations

Location

Supervised Living services are supportive and health-related residential services provided to persons in settings licensed or certified by the State of Texas. Supervised Living services are necessary, as specified in the person's IRP, to enable the person to remain integrated in the community and ensure the health, welfare, and safety of the person in accordance with 42 CFR

§441.710. Supervised Living Services can only be provided in settings certified by HHSC or in licensed assisted living facilities with no more than four (4) beds. Supervised Living Services must meet federal HCBS Settings requirements.

Home and Community-Based Settings must:

- Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as persons not receiving Medicaid HCBS.
- Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
- Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.

- Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
- Facilitate person choice regarding services and supports, and who provides them.

Supervised Living services cannot be provided in or on the grounds of the following settings:

- Nursing facilities;
- Institutions for mental disease;
- Intermediate care facilities for persons with Intellectual or Developmental Disabilities;
- Inpatient hospitals; or
- Any other location that has qualities of an institutional setting.

3146 Submitting a Service Claim for a Person on a Visit with Family or Friend

If the person is on a family or friend visit outside of the provider's location, the provider may submit a service claim for up to 14 calendar days of the visit.

3147 Duplication of Services

Persons receiving adult foster care or Department of Family and Protective Services foster care services may not also receive HCBS-AMH Supervised Living services.

A person may receive only one of the following services on the same day:

- Supported Home Living;
- Assisted Living;
- Supervised Living; or
- Host Home/Companion Care

Payment for Supervised Living services without authorization is prohibited.

Two entities may not be paid for providing the same service to the same person during the same time period.

This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

3150 Host Home/Companion Care

Host Home/Companion Care services include assisting residents in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources, and adaptive skills necessary to reside successfully in home and community-based settings. As needed, this service may also include assistance in promoting positive social interactions, as well as services to instruct persons in accessing and using community resources. These resources may include transportation, translation, and communication assistance related to the IRP goals and services to assist the person in shopping and other necessary activities of community and civic life, including self-advocacy. Finally, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included.

3151 Billable Host Home/Companion Care Activities and Services

Host Home/Companion Care has a daily rate and is inclusive of the following:
Enabling social interaction and participation in leisure activities;

- Helping the person develop daily living and functional living skills;
- Providing persons with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks;
- Assistance with planning and preparing meals; transportation or assistance in securing transportation;
- Assistance with ambulation and mobility;
- Reinforcement of cognitive training or specialized mental health therapies/activities
- Transportation (Rideshares are not billable).; and
- Assistance with medications based upon the results of an RN assessment; the performance of tasks delegated by a RN in accordance with the Texas Board of Nursing rules as defined by 22 TAC, Chapter 225; and supervision of the person's safety and security.

Host home/companion care is provided in a private residence meeting HCBS requirements by a host home or companion care provider who lives in the residence.

In a host home arrangement, the host home provider owns or leases the residence.

In a companion care arrangement, the residence may be owned or leased by the companion care provider or may be owned or leased by the person.

No more than three (3) HCBS-AMH persons may live in the host home/companion care arrangement. Host home/companion care is the only HCBS-AMH service that allows a relative to be the provider. A family member, court- appointed guardian, or LAR is eligible to provide Host Home/Companion Care if they meet the necessary provider requirements as outlined in the HCBS-AMH Provider Manual. For the purposes of the HCBS-AMH program, a person's spouse is not eligible to provide host/home companion care services to the person.

3152 Non-Billable Host Home/Companion Care Activities and Services

Payments for Host Home/Companion Care are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Separate payments will not be made for respite, home-delivered meals, or minor home modifications for persons who receive HCBS-AMH Host Home/Companion Care services.

If a family member or court- appointed guardian chooses to provide Host/Home Companion Care, the person may not receive HCBS-AMH Respite Services.

3153 Documentation

An HCBS-AMH Provider must have written documentation to support a service claim for Host Home/Companion Care that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

3154 Needs-Based Criteria

Host Home/Companion Care will be provided to meet the person's needs as determined by an individualized assessment performed in accordance HHSC. The

services are coordinated within the context of the IRP which delineates how Host Home/Companion Care Services are intended to achieve the identified goals.

3155 Limitations

Location

Host Home/Companion Care services are supportive and health-related residential services provided to persons in settings licensed or certified by the State of Texas. Host Home/Companion Care services are necessary, as specified in the person's IRP, to enable the person to remain integrated in the community and ensure the health, welfare, and safety of the person in accordance with 42 CFR §441.710. Host Home/Companion Care must meet federal HCBS Settings requirements.

Home and Community-Based Settings must:

- Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as persons not receiving Medicaid HCBS.
- Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
- Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
- Facilitate person choice regarding services and supports, and who provides them.

Host Home/Companion Care services cannot be provided in or on the grounds of the following settings:

- Nursing facilities;
- Institutions for mental disease;
- Intermediate care facilities for persons with Intellectual or Developmental Disabilities;

- Inpatient hospitals; or
- Any other location that has qualities of an institutional setting.

3156 Submitting a Service Claim for a Person on a Visit with Family or Friend

If the person is on a family or friend visit outside of the provider's location, the provider may submit a service claim for up to 14 calendar days of the visit.

3157 Duplication of Services

Persons receiving adult foster care or Department of Family and Protective Services foster care services may not also receive HCBS-AMH Host Home/Companion Care services.

A person may receive only one of the following services on the same day:

- Supported Home Living;
- Assisted Living;
- Supervised Living; or
- Host Home/Companion Care.

Two entities may not be paid for providing the same service to the same person during the same time period.

This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

3160 Community Psychiatric Supports and Treatment

Community Psychiatric Supports and Treatment (CPST) are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the person's IRP.

CPST is provided face-to-face with the person present; however, family or other persons significant to the person may also be involved. This service may include the following components:

- Assist the person and family members or other collaterals to identify strategies or treatment options associated with the person's mental illness

and/or substance use disorder, with the goal of minimizing the negative effects of symptoms, emotional disturbances, or associated environmental stressors which interfere with the person's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration;

- Provide person supportive counseling, solution-focused interventions, emotional and behavioral management support, and behavioral analysis with the person, with the goal of assisting the person with developing and implementing social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living;
- Facilitate participation in and utilization of strengths based planning and treatments which include assisting the person and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness and/or substance use disorder;
- Assist the person with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the person and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan, and/or seeking other supports to restore stability and functioning, as appropriate.

3161 Documentation

An HCBS-AMH Provider must have written documentation to support a service claim for Community Psychiatric Supports and Treatment that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

Additionally, the following documentation must be in the participant's IRP:

- A description of why this service is provided at the presenttime;
- A description of any existing psychosocial or environmentalproblems;
- A description of the current level of social and occupational oreducational functioning

- A description of the pertinent history that contains all of the following;
 - A chronological psychiatric, medical and substance use history with time frames of prior treatment and the outcomes of that treatment;
 - A social and family history; and
 - An educational and occupational history
- Clearly defined goals that indicate treatment can be successfully accomplished
- The expected number of sessions it will take to reach the discharge goals, and standards of practice for the client's diagnosis; and
- Identification of the client's aftercare needs that includes a plan for transition.

3162 Needs-Based Criteria

Needs-based criteria for these treatment services must be determined by a LPHA or physician who is acting within the scope of his/her professional license and applicable state law and furnished by or under the direction of a licensed practitioner to promote the maximum reduction of symptoms and/or restoration of a person to his/her best age-appropriate functional level. The LPHA or physician may conduct an assessment consistent with state law, regulation, and policy. If the determination of medical necessity for CPST requires additional assessment, this assessment may be conducted as part of the service up to one unit of the service.

This service is medically necessary if:

- The person has not achieved the goals necessary to conclude treatment, but the description of the person's progress indicates that continued service provision moves the person toward achieving the goals;
- The person has not achieved the goal necessary to conclude treatment and there is potential for serious regression or admission to a more intensive setting without continued provision of the service (requiring several months or longer of outpatient therapy); or
- The person's condition is one that includes long standing, pervasive symptoms or patterns of maladaptive behavior.

3163 Limitations

This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

CPST addresses specific person needs with evidence-based and evidence-informed psychotherapeutic practices designed specifically to meet those needs. Examples include, but are not limited to:

- Cognitive Behavioral Therapy (CBT);
- Cognitive Processing Therapy (CPT); and
- Dialectical Behavior Therapy (DBT).

Telehealth Delivery of Services Limitations

CPST services may be provided by synchronous telephone (audio-only) technology to persons with whom the treating provider has an existing clinical relationship as defined below, and, if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology. Providers must document in the participant's IRP the reason(s) why services were delivered by synchronous audiovisual or telephone (audio-only) technology.

Audio-visual or audio-only options are not to be used 100% of the time. All HCBS-AMH participants will receive at least one in-person visit during each IRP period for CPST services. HIPAA compliance remains the responsibility of the HCBS-AMH provider delivering the services. In order to ensure the privacy of individuals is respected, HCBS-AMH providers will be required to sign and submit an attestation form developed by HHSC that ensures they maintain telehealth service delivery in a private space. In addition, contracted providers will ensure, through verbal confirmation, each participant is in a private and safe space prior to telehealth delivery of CPST services.

Existing Clinical Relationship

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual CPST service by the CPST provider within the IRP period prior to the initial service delivered by synchronous telephone (audio-only) technology. The IRP period requirement for at least one in-person or synchronous audiovisual service of the same CPST service provider prior to the initial synchronous telephone (audio-only) service may not be waived.

3170 Employment Services

Employment services help people with severe mental illness work at regular jobs of their choosing and to achieve goals meaningful to them, such as increasing their economic security. Services must follow evidence-based or evidence-informed practices approved by HHSC. Employment services:

- Focus on the person's strengths and preferences;
- Promote recovery and wellness by enabling persons to engage in work which is meaningful to them and compensated at a level equal to or greater than persons without severe mental illness or other disabilities (competitive employment);
- Include systematic job development based on persons' interests, developing relationships with local employers by making systematic contacts.

3171 Supported Employment

Billable Supported Employment Activities and Services

The only billable activities for HCBS-AMH supported employment are:

1. Employment adaptations, supervision and training related to a person's disability;
2. Assisting the person with transportation needs which include:
3. developing the person's transportation plan;
 - ▶ training the person on how to travel to and from the job; and
 - ▶ securing transportation for or transporting a person, as necessary, to assist self-employment, work from home or perform in a work setting (Rideshares are not billable);
4. Participating in a service planning team meeting;
5. Orienting and training the person in work-related tasks;
6. Training or consulting with employers, coworkers or advocates to maximize natural supports;
7. Monitoring job performance;
8. Communicating with managers and supervisors to gather input and plan training;

9. Communicating with company personnel or support systems to ensure job retention;
10. Training in work-related tasks or behaviors to ensure job retention (for example, grooming or behavior management);
11. Setting up compensatory strategies;
12. Assisting the person to report earned income to the Social Security Administration and the Texas Health and Human Services Commission;
13. Assisting the person to develop a method for ongoing income reporting and for staying informed about the impact of the person's earnings on cash, Medicaid and other benefits;
14. Assisting the person to utilize work incentives to maintain needed benefits and continue to access needed supports and services;
15. Assisting the person with career advancement;
16. Assisting the person to develop assets and obtain self-sufficiency through work;
17. Training or consulting in work-related tasks or behaviors, such as support for advertising, marketing and sales;
18. Training or consulting with paid or natural supports (accountants, employees, etc.) who are supporting the person either short-term or long-term in managing the business;
19. Problem-solving related to company personnel or support systems necessary to run the business effectively and efficiently;
 - A. Assistance with bookkeeping, marketing and managing data or inventories;
 - B. Assisting the person with development of natural supports in the workplace;
 - C. Helping the person attend school and providing academic supports, when that is their preference;
 - D. Coordinating with employers or employees, coworkers and customers, as necessary;
 - E. Assisting persons in making informed decisions about whether to disclose their mental illness condition to employers and co-workers; and
 - F. Providing follow-along services for as long as the person needs and desires them to help the person maintain employment. Follow-along may

include periodic reminders of effective workplace practices and reinforcement of skills.

3172 Non-Billable Supported Employment Activities and Services

The following are examples of non-billable activities for HCBS-AMH supported employment:

1. Interaction with a person prior to the person's employment;
2. Time spent waiting to provide a service;
3. Any activity taking place in a sheltered work environment or other similar types of vocational services furnished in specialized facilities, or using Medicaid funds paid by DADS to the provider for incentive payments, subsidies or unrelated vocational training expenses;
4. Any activity that occurs before or after employment which is gained as a result of paying an employer to encourage the employer to hire a person;
5. Any activity that occurs before or after employment which is gained as a result of paying an employer for supervision, training, support and adaptations for a person that the employer typically makes available to other workers without disabilities filling similar positions in the business;
6. Paying the person as an incentive to participate in Supported Employment activities;
7. Paying the person for expenses associated with the start-up costs or operating expenses of a person's business;
8. Adaptations, assistance, and training used to meet an employer's responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act;
9. Training on a job specific task;
10. Seeking employment for a person;
11. Assisting a person in completing an application for employment; and
12. Prompting a person to perform a job task when such prompting is not related to a deficit caused by the mental illness.

3173 Employment Assistance

Billable Employment Activities and Services

Employment Assistance services consist of developing and implementing strategies for achieving the person's desired employment outcome, including more suitable employment for persons who are employed. Services are personalized, person-directed, and may include:

1. Identifying a person's employment preferences, job skills and requirements for a work setting and work conditions;
2. Locating prospective employers offering employment compatible with a person's identified preferences, skills and requirements;
3. Contacting a prospective employer on behalf of a person and negotiating the person's employment;
4. Assisting the person with transportation needs, which include:
 - ▶ developing the person's transportation plan;
 - ▶ training the person on how to travel to and from a job;
 - ▶ securing transportation for or transporting a person, as necessary, to assist the person to obtain a job (Rideshares are not billable); and
 - ▶ transporting the person to help the person locate paid employment in the community;
5. Participating in service planning team meetings, including those with the Department of Assistive and Rehabilitative Services or, for persons under age 22, with the person's school district;
6. Exploring options related to wages and employment outcomes (including self-employment outcomes);
7. Exploring the person's interests, capabilities, preferences and ongoing support needs;
8. Exploring the extended services and supports required at and away from the job site that will be necessary for employment success;
9. Observing the person's work skills and behaviors at home and in the community;
10. Touring current or potential work environments with the person;
11. Assisting the person to understand the impact of work activity on his/her services and financial supports;

12. Assisting the person to utilize work incentives to maintain needed benefits;
13. Collecting personal and professional reference information;
14. Assessing the person's learning style and needs for adaptive technology, accommodations and on-site supports;
15. Assessing the person's strengths, challenges and transferable skills from previous job placements;
16. Identifying the person's assets, strengths and abilities;
17. Identifying negotiable and non-negotiable employment conditions;
18. Identifying targeted job tasks the person can perform or potentially perform;
19. Identifying potential employers or self-employment options;
20. Training related to a person's assessed needs specific to his/her employment preferences, job skills and requirements for a work setting and work conditions;
21. Writing resumes and proposals to assist in placement;
22. Contacting employers and developing person jobs;
23. Performing a job analysis to determine if a potential job meets the person's interests, capabilities, preferences and ongoing support needs;
24. Assisting the person with job applications, pre-employment forms, practice interviews, and pre-employment testing or physicals;
25. Accompanying the person to interviews;
26. Negotiating aspects of the person's employment with prospective employers; and
27. Educating the employer about the Work Opportunity Tax Credit and other employer benefits.

For self-employment, services may additionally include:

1. Supporting the person in work-related tasks or behaviors, such as advertising, marketing, sales, accounting, and obtaining licenses and registrations;
2. Training or consulting with paid or natural supports (accountants, employees, etc.) who will be supporting the person either short-term or long-term in managing the business; and

3. Setting up services to address long-term supports that will be necessary to sustain the business.

3174 Non-Billable Employment Activities and Services

The following activities are not billable to HCBS-AMH Employment Assistance:

1. Non face-to-face activities;
2. Employment Assistance provided when a person is independently employed in the community, unless the IRP has identified outcomes for the person to find additional or more suitable employment;
3. Time spent waiting to provide a service;
4. Supervisory activities rendered as a normal part of the business setting;
5. Adaptions, assistance, and training used to meet an employer's responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act.
6. Supervision, training, support, and adaptations typically available to other non- disabled workers filling similar positions in the business;
7. Employment Assistance services accessed and/or funded through other sources at no cost to the HCBS-AMH provider. Examples include, but are not limited to, services provided to a person through the Texas Department of Assistive and Rehabilitative Services (DARS), the public school system, Medicaid Rehabilitative Services for Persons with Chronic Mental Illness, senior citizen centers, volunteer programs or other community-based sources;
8. Adaptations, assistance, and training used to meet an employer's responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act;
9. The use of Medicaid funds paid by HHSC to the provider for incentive payments, subsidies or unrelated vocational training expenses, such as paying an employer:
 - to encourage the employer to hire a person; or
 - for supervision, training, support and adaptations for a person that the employer typically makes available to other workers without disabilities filling similar positions in the business;

10. The use of Medicaid funds paid by HHSC to the provider for incentive payments, subsidies or unrelated vocational training expenses, such as paying the person:

- ▶ as an incentive to participate in Employment Assistance activities; or
- ▶ for expenses associated with the start-up costs or operating expenses of a person's business.

3175 Documentation

Documentation will be maintained in the person's clinical record for the provision of HCBS-AMH Employment Services for each encounter that describes that activities provided and, when appropriate, includes information pertaining to the person's progress toward goals and objectives.

An HCBS-AMH Provider must have written documentation to support a service claim for Employment Services that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision;
- d
- d

3176 Transportation as Employment Services Activity

A program provider must have written documentation to support a service claim for the employment service activity of transporting a person. An HCBS-AMH Employment Service Provider may document such activity in any way that meets requirements (see 8003 Documentation of Transportation as Part of HCBS-AMH Service). The written documentation must include:

- Name of the person who was being transported;
- Day, month and year the transportation was provided;
- Place of departure and destination for the person being transported;
- Transportation time;
- Begin and end time for each transportation time;
- Total minutes of each transportation time;
- For each "trip":
 - ▶ the number of passengers;

- the number of direct service providers;
- the resulting service time; and
- the signature of the direct service provider transporting the person; and
- Any service times accumulated to make a unit of service for a service claim.

3177 Needs-Based Criteria

Employment Services are personalized and extended as needed to assist the person attain and maintain meaningful work. Services are provided based on person preference and choice without exclusions based on readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, level of disability, or legal system involvement.

The services are coordinated within the context of the IRP which delineates how Employment Services are intended to achieve the identified goals.

3178 Limitations

Employment Services do not supplant existing resources; such any program funded under Section 110 of the Rehabilitation Act of 1973, relating to vocational rehabilitation services, or the Persons with Disabilities Education Act (20 U.S.C. 1401 et seq.), relating to special education programs available to the person.

Employment Services provide time-unlimited and personalized support for as long as the person wants and needs support.

Employment Services may not be provided on the same day and at the same time as services that contain elements integral to the delivery of Employment Services (e.g., rehabilitation).

Telehealth Delivery of Services Limitations

Employment services may be provided by synchronous telephone (audio-only) technology to persons with whom the treating provider has an existing clinical relationship as defined below, and, if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology. Providers must document in the participant's IRP the reason(s) why services were delivered by synchronous audiovisual or telephone (audio-only) technology.

Audio-visual or audio-only options are not to be used 100% of the time. All HCBS-AMH participants will receive at least one in-person visit during each IRP period for Employment services. HIPAA compliance remains the responsibility of the HCBS-AMH provider delivering the services. In order to ensure the privacy of individuals is respected, HCBS-AMH providers will be required to sign and submit an attestation form developed by HHSC that ensures they maintain telehealth service delivery in a private space. In addition, contracted providers will ensure, through verbal confirmation, each participant is in a private and safe space prior to telehealth delivery of Employment services.

Existing Clinical Relationship

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual Employment service by the Employment provider within the IRP period prior to the initial service delivered by synchronous telephone (audio-only) technology. The IRP period requirement for at least one in-person or synchronous audiovisual service of the same Employment service provider prior to the initial synchronous telephone (audio-only) service may not be waived.

3180 Home Delivered Meals

Home Delivered Meals services provide a nutritionally sound meal to persons. Each meal provides a minimum of one-third of the current recommended dietary allowance (RDA) for the person as adopted by the United States Department of Agriculture. The meal is delivered to the person's home. Home delivered meals do not constitute a full nutritional regimen.

The provider must be in compliance, during all stages of food service operation, with applicable federal, state and local regulations, codes, and licensor requirements relating to fire; health; sanitation; safety; building and other provisions relating to the public health, safety, and welfare of meal patrons.

Foods must be prepared, served, and transported:

- With the least possible manual contact;
- With suitable utensils; and
- On surfaces that have been cleaned, rinsed, and sanitized to prevent cross contamination prior to use.

Meals may be hot, cold, frozen, dried, or canned with a satisfactory storage life. Home delivered meals providers must be provided in-person delivery whereby a paid staff or volunteer delivers the meal to the individual's home.

3181 Documentation

The direct service provider must be able to demonstrate that menu standards are developed to sustain and improve a participant's health through the provision of safe and nutritious meals that are approved by a dietician.

An HCBS-AMH Provider must have written documentation to support a service claim for Home Delivered Meals that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

3182 Needs-Based Criteria

The services are coordinated within the context of the IRP. The person has met needs-based criteria for Home Delivered Meals if the person:

- Is unable to do meal preparation on a regular basis without assistance;
- Does not have access to alternate resources for the provision of the meal provided by this service; and
- Does not have natural supports available that are willing and able to provide meal preparation services.

3183 Limitations

HCBS-AMH home delivered meals may not be provided to persons who live in provider owned or operated settings.

The provision of home delivered meals does not provide a full nutritional regimen (i.e., 3 meals a day). Meal frequency:

- In areas where the frequency of serving meals five or more days per week is not feasible, home delivered meals providers have the ability to provide meals at less frequent intervals.
- For persons with an identified need for home delivered meals, who have a higher level of functioning as identified on the IRP, the provider may be authorized to provide frozen meals not to exceed 31 days' worth of meals.

3190 Minor Home Modifications

Minor home modifications are those physical adaptations to a person's home that are necessary to ensure the person's health, welfare, and safety, or that enable the person to function with greater independence in the home. In order to receive minor home modifications under this program, the person would require institutionalization without these adaptations.

Minor home modification may include:

1. Home accessibility adaptations (e.g. widening of doorways);
2. Modification of bathroom facilities;
3. Installation of ramps; or other minor modifications which are necessary to achieve a specific rehabilitative goal defined in the IRP and prior approved by HHSC; and
4. Repair and maintenance of a billable adaptation not covered by warranty.
5. Safety adaptations (alarm systems, alert systems, and other safety devices).

All minor home modifications are provided in accordance with applicable state or local building codes. The HCBS-AMH Comprehensive Provider agency must comply with the requirements for delivery of minor home modifications, which include requirements as to type of allowed modifications, time frames for completion, specifications for the modification, inspections of modifications, and follow-up on the completion of the modification.

3191 Non-Billable Minor Home Modifications Items and Services

The following are not billable to HCBS-AMH Minor Home Modifications:

1. Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the person (e.g. carpeting, roof repair, central air conditioning);
2. Adaptations that add to the total square footage of the home;
3. Minor home modifications made to residential settings that are leased, owned, or controlled by direct service providers;
4. Construction of new room, including installation of plumbing and electricity;
5. Fire sprinkler system;

6. Fire alarm system;
7. General appliance (e.g., washer, dryer, stove, dishwasher or vacuum cleaner), without an approved exception by HHSC;
8. Fence;
9. Carport;
10. Driveway;
11. Deck; and
12. Hot tub.

3192 Documentation

Receipt of purchase of the Minor Home Modification is required.

An HCBS-AMH Provider must obtain the documentation described below before purchasing the minor home modification.

1. An HCBS-AMH Provider must have written documentation to support a service claim for Minor Home Modifications that:
 - ▶ Meets the requirements set forth in Section 2800 Documentation of Service Provision; and
 - ▶ d
2. A person or LAR and HCBS-AMH Provider must:
 - ▶ Meet and consider the written recommendation by a qualified direct service provider (See 4109.4 Needs-Based Criteria);
 - ▶ Document any discussion about the recommended minor home modification;
 - ▶ Agree that the recommended minor home modification is necessary and should be purchased; and
 - ▶ Document the agreement in writing and sign the agreement.

3193 Bids

Required Number of Bids

Comparable bids describe the minor home modifications identified in the required assessment. An HCBS-AMH provider must obtain comparable bids for the requested minor home modifications from three vendors. The only exception is written

justification for obtaining less than three bids because the minor home modification is available from a limited number of vendors.

3194 Required Content and Time Frame

A bid must:

- Be cost effective according to current market prices for the minor home modification and be the lowest cost based on availability unless contraindicated by specific written justification for using a higher bid;
- State the total cost of the requested minor home modification;
- Include the name, address and telephone number of the vendor, who may not be a relative of the person;
- Include a complete description of the minor home modification and any associated installation specifications, as identified in the written assessment;
- Include a drawing or picture of both the existing and proposed floorplans;
- Include a statement that the minor home modification will be made in accordance with all applicable state and local building codes; and
- Be obtained within one year after the written recommendation required by 4109.4 Needs-Based Criteria is obtained.

3195 Request for Payment of Higher Bid

If an HCBS-AMH requests authorization for payment that is not based on the lowest bid, the program provider must have written justification for payment of a higher bid.

Examples of Justification That May Be Acceptable

The following is an example justification that supports payment of a higher bid:

- Higher bid is based on the inclusion of a longer warranty for the minor home modification.

3196 Needs-Based Criteria

The minor home modifications must be necessary to address specific functional limitations documented in the IRP and must be approved by HHSC.

3197 Items \$1000 or Greater:

Individual items costing over \$1000.00 must be recommended in writing by a direct service provider qualified to assess the person's need for the specific adaptive aid and be approved by HHSC.

The written recommendation must:

- Be based on a face-to-face evaluation of the person by the licensed professional conducted not more than one year before the date of purchase of the minor home modification;
- Include a description of and a recommendation for a minor home modification and any associated items or modifications necessary to make the minor home modification functional;
- Include a diagnosis that is related to the person's need for the minor home modification;
- Include a description of the condition related to the diagnosis; and
- Include a description of the specific needs of the person, including information justifying needs-based criteria, if required, and how the minor home modification will meet those needs.

3198 Limitations and Exclusions

There is an individual limit of \$7,500.00 per lifetime for minor home modifications. Once that maximum is reached, \$300 per IRP year/ person will be allowed for repair, replacement, or updating of existing modifications. Should a person require environmental modifications after the cost cap has been reached, the person/family must access other resources or alternate funding sources.

Claims may only be submitted for 3 minor home modifications per day.

31100 Nursing

Nursing services provide treatment and monitoring of health care procedures prescribed by a physician/medical practitioner, or as required by standards of professional practice or state law to be performed by licensed nursing personnel.

31101 Billable Nursing Services

Billable HCBS-AMH Nursing services must:

1. Be provided face-to-face with a person who has a medical need for registered nursing, including:
 - ▶ Preparation and administration of medication or treatment ordered by a physician, podiatrist or dentist;
 - ▶ Assistance or observation of administration of medication; and
 - ▶ Assessment of the person's health status, including conducting a focused assessment or an RN nursing assessment.
2. Be provided via tele health if not provided face-to-face with a person who has a medical need for registered nursing, including:
 - ▶ Observation of administration of medication;
 - ▶ Assessment of the person's health status, including conducting a focused assessment or an RN nursing assessment;
 - ▶ Verification of medications at the time they are received from the pharmacy by matching labels with the doctor's order and medication administration record sheet (MARS) for correct type and amount of medication, or additional times when there are documented medication errors or labs that show the person's therapeutic levels are abnormal;
 - ▶ Ensuring the accuracy of the type, amount and dosage instructions of medications at the time the person receives medication from the pharmacy.
3. Include researching medical information for a person who has a medical need for registered nursing, including reviewing documents to evaluate the quality and effectiveness of the medical treatment the person is receiving;
4. Include training the following persons how to perform nursing tasks or on a topic that is specific to a person's diagnosis, care and treatment:
 - ▶ Direct Service providers of host home/companion care, residential support, supervised living, supported home living, respite; or
 - ▶ A person other than a direct service provider who is involved in serving a person.
5. Include speaking with a pharmacist or representative of a health insurance provider, including the Social Security Administration, about a person's insurance benefits for medication if the RN justifies, in writing, the need for the registered nurse to perform the activity;
6. Include instructing, supervising or verifying the competency of an unlicensed person in the performance of a task delegated in accordance with rules of the

Texas Board of Nursing at 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions) or the Texas Human Resources Code, §§161.091-161.093, as applicable; or

7. Include participating in an Interdisciplinary team (IDT) meeting associated with the development of an IRP.

31102 Non-Billable Nursing Services

Non-billable activities include:

1. Activities not listed in 4110.1 Billable Nursing Services;
2. Transporting a person;
3. Waiting to perform a billable activity;
4. Waiting with a person at a medical appointment;
5. Making a medical appointment;
6. Instructing on general topics unrelated to a specific person;
7. Preparation for treatment or medication not associated with a face-to-face encounter with a person;
8. Storing, counting, reordering, refilling or delivering medication except as identified in 4110.1 Billable Nursing Services;
9. Documentation of service provision; and
10. Nursing activities performed without meeting needs-based criteria.

31103 RN

Services are those services that are within the scope of the Texas Nurse Practice Act and are provided by a registered nurse (RN) licensed to practice in the state. HCBS- AMH nursing services cover ongoing chronic conditions such as:

- Wound care;
- Medication administration (including training, monitoring, and evaluation of side effects); and
- Supervising delegated tasks.

31104 LVN

Services are those services that are within the scope of the Texas Nurse Practice Act and are provided by a licensed vocational nurse (LVN), under the supervision of an RN, licensed to practice in the state.

HCBS-AMH nursing services cover ongoing chronic conditions such as:

- Wound care;
- Medication administration (including training, monitoring, and evaluation of side effects); and
- Supervising delegated tasks.

31105 Documentation

The written documentation to support a service claim for the nursing service of registered nursing and licensed vocational nursing must:

- Be legible;
- Be written after the service is provided; and include:
 - Detailed description of activities performed by the direct service provider and the person that evidences the performance of one or more of the billable activities described in for the particular nursing service being claimed;
 - Description of the medical need for the activity performed during the service event;
 - Description of any unusual incident that occurs such as a seizure, illness or behavioral outburst, and any action taken by the registered nurse or licensed vocational nurse in response to the incident;
 - For any activity simultaneously performed by more than one registered nurse or more than one licensed vocational nurse, a written justification in the person's implementation plan for the use of more than one registered nurse or licensed vocational nurse;
 - Be supported by information that justifies the length of the service event, such as an explanation of why a billable activity took more time than typically required to complete; and

An HCBS-AMH Provider must comply with 1 TAC 354, Subchapter O, Electronic Visit Verification (EVV), to document the provision of RN and LVN services delivered in a

participant residence, Host Home or Companion Care setting, or Supported Home Living setting. 1 TAC Chapter 354, Subchapter O requires an HCBS-AMH Provider to comply with the Electronic Visit Verification Provider Policy Handbook and other policies, including those located on the HHSC Electronic Visit Verification webpage.

31106 Needs-Based Criteria

The services are coordinated within the context of the IRP which delineates how Nursing Services are intended to achieve the identified goals.

31107 Limitations

Nursing services are only provided to persons age 21 and over. All medically necessary nursing services for children under age 21 will be covered in the state plan pursuant to the early and periodic screening, diagnostic and treatment (EPSDT) benefit.

Nursing services are provided only after benefits available through Medicare, Medicaid, or other third party resources have been exhausted or are not applicable, including home health benefits.

Telehealth Delivery of Services Limitations

HCBS-AMH providers may deliver nursing care via telenursing if the nature of the care does not require in person contact. Direct care nursing services, such as wound care, blood draws, and essential (non-routine) blood pressure monitoring, should continue to be provided in person when indicated as appropriate. Telenursing is permitted under the Texas Nursing Practice Act and Texas Board of Nursing rules.

Nursing services may be provided by synchronous telephone (audio-only) technology to persons with whom the treating provider has an existing clinical relationship as defined below, and, if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology. Providers must document in the participant's IRP the reason(s) why services were delivered by synchronous audiovisual or telephone (audio-only) technology.

Audio-visual or audio-only options are not to be used 100% of the time. All HCBS-AMH participants will receive at least one in-person visit during each IRP period for Nursing services. HIPAA compliance remains the responsibility of the HCBS-AMH

provider delivering the services. In order to ensure the privacy of individuals is respected, HCBS-AMH providers will be required to sign and submit an attestation form developed by HHSC that ensures they maintain telehealth service delivery in a private space. In addition, contracted providers will ensure, through verbal confirmation, each participant is in a private and safe space prior to telehealth delivery of Nursing services.

Existing Clinical Relationship

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual Nursing service by the Nursing provider within the IRP period prior to the initial service delivered by synchronous telephone (audio-only) technology. The IRP period requirement for at least one in-person or synchronous audiovisual service of the same Nursing service provider prior to the initial synchronous telephone (audio-only) service may not be waived.

31110 Peer Support

Peer Support services are provided face-to-face by Certified Peer Specialists who are in recovery from mental illness and/or substance use disorders. Peer support specialists use their own experiences with mental illness, substance use disorder (SUD), and/or another co-occurring disorders (such as a chronic health condition), to help persons reach their recovery goals.

Peer Support Services Include:

1. Helping persons make new friends and begin to build alternative social networks;
2. Promoting coping skills;
3. Facilitating use of natural resources/supports;
4. Enhancing recovery-oriented attributes such as hope and self-efficacy;
5. Assisting the person with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery, including finding sober housing; making new friends, finding new uses of spare time, and improving one's job skills;
6. Providing assistance with issues that arise in connection with collateral problems such as having a criminal justice record or coexisting physical or mental challenges;

7. Helping persons navigate the formal treatment system, advocating for their access and gaining admittance, as well as facilitating discharge planning, typically in collaboration with treatment staff;
8. Encouraging participation in mutual aid groups in the community;
9. Facilitating participation in educational opportunities;
10. Developing linkages to resources that address specialized needs, such as agencies providing services related to HIV infection or AIDS, mental health disorders, chronic and acute health problems, parenting young children, and problems stemming from involvement with the criminal justice system; and
11. Participating in the development of the IRP.

31111 Documentation

An HCBS-AMH Provider must have written documentation to support a service claim for Peer Support Services that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

31112 Needs-Based Criteria

The services are coordinated within the context of the IRP which delineates how Peer Support Services are intended to achieve the identified goals.

31113 Limitations

Peer Support is available daily, limited to no more than four hours per day for a person. Peer services are not a substitute for or adjunct to other HCBS services such as HCBS Psychosocial Rehabilitation or Community Psychiatric Supports and Treatment.

Telehealth Delivery of Services Limitations

HCBS-AMH providers must refer to the [Texas Medicaid Provider Procedures Manual](#), Behavioral Health and Case Management Handbook Section 6, "Peer Specialist Services" for more information on Medicaid policies for telehealth delivery of Peer Support services.

31120 HCBS-AMH Recovery Management

Recovery Management includes services assisting beneficiaries in gaining access to needed Medicaid State Plan and HCBS-AMH services, as well as medical, social, educational, and other resources, regardless of funding source.

A recovery management reimbursable contact is:

- Provided by an authorized recovery manager;
- Face-to-face and telephone contact with the person and/or IDT; and
- Coordination of services to assist the person in gaining access to needed services

31121 Billable Recovery Management Activities and Services

The following activities are billable to HCBS-AMH Recovery Management:

1. Development of IRP using a person-centered recovery planning approach, in accordance with a HHSC approved model with a maximum of 8 units billed for an Initial IRP;
2. Monitoring the provision of services included in the IRP to ensure that the person's needs, preferences, health, and welfare are promoted;
3. Assisting the person identify and select direct service providers;
4. Facilitation of resolution, created with the person, to resolve issues that impede access to needed services;
5. Assisting the person identify and develop natural supports (family, friends, and other community members) and resources to promote the person's recovery;
6. Assisting the person with fair hearing requests upon request and when needed;
7. Assisting the person with retaining HCBS and Medicaid eligibility;
8. Educating and Informing the person about services, the person recovery planning process, recovery resources, rights, and responsibilities;
9. Monitoring health, welfare, and safety through regular contacts;
10. Responding to and assessing emergency situations and incidents and making needed referrals;

11. Monitoring the person's IRP, including progress towards goal.

31122 Non-Billable Recovery Management Activities and Services

The following activities do not constitute HCBS-AMH Recovery Management services, regardless of the funding source, and are not reimbursable under HCBS-AMH Recovery Management:

1. Performing any activity that does not directly assist a person in gaining or coordinating access to needed services, such as:
2. Merely accompanying a person to a social or recreational event or other entertainment or locations to conduct the person's personal affairs (e.g. shopping, interviewing for a job, visiting friends or relatives, getting a haircut, or finding housing); and
3. Merely helping the person with domestic or financial affairs, such as cleaning house or balancing a checkbook;
4. Performing an activity that is an integral and inseparable part of a service other than HCBS-AMH Recovery Management services;
5. Transporting the person, the person's LAR or primary caregiver;
6. Monitoring the person's general health status (when such information is not required to gain access or coordinate needed services);
7. Performing quality oversight of a direct service provider, such as determining provider compliance with rules or regulation;
8. Conducting utilization review or utilization management activities;
9. Conducting quality assurance activities;
10. Providing reporting as required by HHSC;
11. Travel time incurred by the recovery manager;
12. Services that constitute the administration of another program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, special education, and foster care;
13. Representative payee functions;

31123 Documentation

An HCBS-AMH Provider must have written documentation to support a service claim for recovery management that:

- meets the requirements set forth in Section 2800 Documentation of Service Provision; and

The recovery manager must document the following for all HCBS-AMH Recovery Management Services:

31124 Limitations

Case Load Limits

Service providers of Recovery Management (recovery managers) must follow the caseload limit requirements as outlined in the HCBS-AMH Provider Manual, unless the requirement is waived by HHSC.

Telehealth Delivery of Services Limitations

Recovery Management services may be provided by synchronous telephone (audio-only) technology to persons with whom the treating provider has an existing clinical relationship as defined below, and, if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology. Providers must document in the participant's IRP the reason(s) why services were delivered by synchronous audiovisual or telephone (audio-only) technology.

Audio-visual or audio-only options are not to be used 100% of the time. All HCBS-AMH participants will receive at least one in-person visit during each IRP period for Recovery Management services. HIPAA compliance remains the responsibility of the HCBS-AMH provider delivering the services. In order to ensure the privacy of individuals is respected, HCBS-AMH providers will be required to sign and submit an attestation form developed by HHSC that ensures they maintain telehealth service delivery in a private space. In addition, contracted providers will ensure, through verbal confirmation, each participant is in a private and safe space prior to telehealth delivery of Recovery Management services.

Existing Clinical Relationship

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual Recovery Management service by the Recovery Management provider within the IRP period prior to the initial service delivered by synchronous telephone (audio-only) technology. The IRP period requirement for at least one in-person or synchronous audiovisual service of the same Recovery

Management service provider prior to the initial synchronous telephone (audio-only) service may not be waived.

31125 Provider of Last Resort

When an HCBS-AMH Provider Agency also provides recovery management services as a provider of last resort, a clear separation of provider and recovery management functions must be present for the provision of HCBS-AMH Recovery Management.

The recovery manager must be administratively separate from other HCBS-AMH provider functions and any related utilization review units and functions.

31126 Duplication of Services

This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

31127 Location of Service

Recovery management activities for persons leaving institutions must be coordinated with, and must not duplicate, institutional discharge planning. This service may be provided up to 180 days in advance of anticipated movement to the community.

A claim for Recovery Management Transitional Fee may be submitted to HHSC for persons who are in the state hospital at time of enrollment. This is a one-time fee to cover service provision of recovery management and associated administrative costs up to 90 days past the enrollment date of the person. For 91-180 days Recovery Management Transitional Day Rate may be submitted to HHSC. Recovery management functions necessary to facilitate community transition may not be billed under Transition Assistance Services.

31130 HCBS Psychosocial Rehabilitation Services

HCBS Psychosocial Rehabilitation services are evidence-based or evidence-informed interventions which support the person's recovery by helping the person develop, refine and/or maintain the skills needed to function successfully in the community to the fullest extent possible.

Skills include, but are not limited to:

- Illness/Management Recovery;

- Self-care;
- Activities of daily living (ADL); and
- Instrumental activities of daily living (IADLs).

The modality(ies) used for the provision of HCBS Psychosocial Rehabilitation Services must be approved by HHSC. A variety of evidence-based practices may be used as appropriate to person needs, interests and goals.

All claims for reimbursement for HCBS Psychosocial Rehabilitation services are based on the actual amount of time the eligible person is engaged in face-to-face contact with a direct service provider. The billable units are person, group (15 continuous minutes). No reimbursement is available for partial units of service.

31131 Group HCBS-AMH Psychosocial Rehabilitation Services

The group services billable events refer to one service provided by one or more direct service staff to more than one person enrolled in HCBS-AMH. HCBS-AMH Psychosocial Rehabilitative Services may be provided in a group setting if identified as clinically appropriate by the IDT and in accordance with the approved IRP. Groups may consist of no more than 6 persons (excluding direct service providers).

31132 Documentation

An HCBS-AMH Provider must have written documentation to support a service claim for HCBS-AMH Psychosocial Rehabilitation services that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

31133 Needs-Based Criteria

Provision of HCBS-AMH Psychosocial Rehabilitation Services must be intended to achieve the identified goals or objectives as set forth in the person's IRP.

31134 Non-Billable HCBS Psychosocial Rehabilitation Activities and Services

The Department will not reimburse a provider of HCBS-AMH Psychosocial Rehabilitative Services for certain activities such as:

1. Medication-related services that are incidental to another service such as an office visit with a physician.
2. A medical evaluation, examination, or treatment that is otherwise reimbursable as a separate and distinct Medicaid-covered benefit.
3. Any activity that is not directly related to achieving the goals listed in the IRP. Examples of such activities include:
 - ▶ Merely accompanying a person to a social or recreational event or other entertainment or locations to conduct the person's personal affairs (e.g. shopping, interviewing for a job, visiting friends or relatives, getting a haircut, or finding housing);
 - ▶ Merely helping the person with domestic or financial affairs, such as cleaning house or balancing a checkbook; and
 - ▶ Having a casual conversation with a person about the person's interests or general well-being that is not related to service provision or identification of the person's needs.
4. Training in areas that are not generally recognized to address deficits caused by severe and persistent mental illness. Examples of such training areas include:
 - ▶ Cardiopulmonary resuscitation;
 - ▶ First aid;
 - ▶ Defensive driving; and
 - ▶ Recreational activities such as swimming, horseback riding, and piano lessons.
5. Educational services such as:
 - ▶ Remedial instruction and tutoring related to academics;
 - ▶ Preparation for taking a high school equivalency exam; and
 - ▶ Formal academic classes.
6. An activity provided as an integral and inseparable part of a service other than HCBS-AMH Psychosocial Rehabilitation Services. Examples of such activities include:
 - ▶ Pharmacological management by a physician;
 - ▶ Service incidental to a physician's visit;
 - ▶ Referral or medical consultation between medical personnel;

- Substance use disorder counseling;
- Development of a treatment plan for other services;
- Administration of an assessment for other services;
- Seeking employment for a person;
- Assisting a person in completing an application for employment; and
- Prompting a person to perform a job task when such prompting is not related to a deficit caused by the mental illness;
- Requesting a refill of a person's medication, filling a person's pillpack, unlocking a person's medication box, or obtaining or delivering a person's medication; and
- Any type of counseling or psychotherapy.

7. Administrative activities such as:

- Determination that a person meets needs-based criteria for HCBS-AMH Psychosocial Rehabilitation Services;
- Obtaining demographic information, information about the person's finances and benefits; and
- Completion of documentation.

8. Services provided in transit unless the specific skill being addressed is an identified deficit in accessing or using public transportation.

31135 Limitations

Telehealth Delivery of Services Limitations

HCBS Psychosocial Rehabilitation services may be provided by synchronous telephone (audio-only) technology to persons with whom the treating provider has an existing clinical relationship as defined below, and, if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology. Providers must document in the participant's IRP the reason(s) why services were delivered by synchronous audiovisual or telephone (audio-only) technology.

Audio-visual or audio-only options are not to be used 100% of the time. All HCBS-AMH participants will receive at least one in-person visit during each IRP period for

HCBS Psychosocial Rehabilitation services. HIPAA compliance remains the responsibility of the HCBS-AMH provider delivering the services. In order to ensure the privacy of individuals is respected, HCBS-AMH providers will be required to sign and submit an attestation form developed by HHSC that ensures they maintain telehealth service delivery in a private space. In addition, contracted providers will ensure, through verbal confirmation, each participant is in a private and safe space prior to telehealth delivery of HCBS Psychosocial Rehabilitation services.

Existing Clinical Relationship

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual HCBS Psychosocial Rehabilitation service by the HCBS Psychosocial Rehabilitation provider within the IRP period prior to the initial service delivered by synchronous telephone (audio-only) technology. The IRP period requirement for at least one in-person or synchronous audiovisual service of the same HCBS Psychosocial Rehabilitation service provider prior to the initial synchronous telephone (audio-only) service may not be waived.

31140 Respite Care

Respite is provided for the planned or emergency short-term relief for natural, unpaid caregivers. Respite is provided intermittently when the natural caregiver is temporarily unavailable to provide supports.

HCBS-AMH Respite has a 15 minute rate for in-home respite care and a daily rate for out-of-home respite care and is inclusive of the following:

- Personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks;
- Assistance with planning and preparing meals;
- Transportation or assistance in securing transportation. Transportation is not billable for Rideshares;
- Assistance with ambulation and mobility;
- Reinforcement of rehabilitation or specialized therapies;
- Assisting a person with administration of certain medications or with supervision of self-medication in accordance with the Texas Board of Nursing rules as defined the Texas Administrative Code;
- Supervision as needed to ensure the person's health and safety;
- Activities that facilitate the person's:

- ▶ inclusion in community activities;
- ▶ use of natural supports and typical community services available to all people;
- ▶ social interaction and participation in leisure activities; and
- ▶ development of socially valued behaviors and daily living and functional living skills.
- ▶ Respite is provided in the residence of the person or in other locations, including residences in which supervised living or residential support is provided or in a respite facility that meets HHSC requirements and afford an environment that ensures the health, safety, comfort, and welfare of the person;
- Transportation costs associated with the respite service, including transportation to and from the respite service site. Transportation is not billable for Rideshares.; and
- Room and board.

Other services indicated on the IRP may be provided during the period of respite, if they are not duplicative of or integral to services which can be reimbursable as respite or otherwise excluded by the HCBS-AMH Billing Guidelines.

31141 Non-Billable Respite Care Activities and Services

The following are not billable to HCBS-AMH Respite:

- Respite for persons receiving assisted living, supervised living, or host home/companion care in provider owned or operated settings, including host home/companion care, supervised living or assisted living;
- Respite for persons receiving Host/Home Companion Care from a family member or court- appointed guardian;
- Relief of paid caregivers and providers;
- Supplanting natural supports; and
- Room and board.

31142 Documentation

After the provision of any respite services, in which a relative is the direct service staff, the HCBS-AMH Provider must have the LAR sign the Respite Relative Provider Form indicating the date(s), time, and duration of the provision of the respite

services. The Respite Relative Provider Form will also include a statement as to the location of service provision (e.g., relative's home, HCBS-AMH recipient's home). The HCBS-AMH Provider must maintain the Respite Relative Provider Form in the HCBS- AMH participant's clinical record.

An HCBS-AMH Provider must have written documentation to support a service claim for HCBS-AMH Respite that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and
- Includes:

An HCBS-AMH Provider must comply with 1 TAC 354, Subchapter O, Electronic Visit Verification (EVV), to document the provision of supported home living. 1 TAC Chapter 354, Subchapter O requires an HCBS-AMH Provider to comply with the Electronic Visit Verification Provider Policy Handbook and other policies, including those located on the HHSC Electronic Visit Verification webpage.

31143 Needs-Based Criteria

The HCBS-AMH provider must ensure that respite is provided in accordance with the person's recovery plan.

Respite is provided for the planned or emergency short-term relief for natural, unpaid caregivers. Respite is provided intermittently when the natural caregiver is temporarily unavailable to provide supports due to non-routine circumstances.

31144 Limitations

Locations

In-home respite will be provided in the person's home or place of residence, or in the home of a family member or friend.

Out-of-home respite can be provided in the following locations:

- Adult foster care home;
- 24-hour residential habilitation home;
- Licensed assisted living facilities; and
- Licensed Nursing Facilities.

The number of persons in a respite setting shall be in accordance with associated licensure (if applicable) or other standards and account for the person needs of each person.

31145 Reimbursement Limitations

HCBS-AMH Respite is limited to 30 days annually of any combination of in-home or out-of-home respite.

31150 Substance Use Disorder Services

HCBS-AMH Substance Use Disorder (SUD) services are specialized to meet the needs of persons who have experienced extended institutional placement. HCBS-AMH SUD services may only be utilized when other state plan SUD services are exhausted or not appropriate (see 4331.5.2 Exhaustion of Non-HCBS State Plan SUD Benefits).

SUD services include:

- Assessment;
- Ambulatory group counseling; and
- Individual counseling.

Services shall:

- Follow evidence-based or evidence-informed treatment modalities approved by HHSC which may include:
 - motivational interviewing;
 - individual, group, and family counseling;
 - psycho-education;
 - medication management;
 - harm reduction;
 - and relapse-prevention;
- Assist the person in achieving specific recovery goals identified in the IRP and in preventing relapse; and
- Be provided using a team approach which integrates other HCBS-AMH services, such as peer support, as appropriate to the person's needs and preferences.

31151 Substance Use Disorder Assessment

An integrated assessment must be conducted to consider relevant past and current medical, psychiatric, and substance use information, including:

- Information from the person (and LAR on the person's behalf) regarding the person's strengths, needs, natural supports, responsiveness to previous treatment, as well as preferences for and objections to specific treatments;
- Needs and desire of the person for family member involvement in treatment and services if the person is an adult without an LAR; and
- Recommendations and conclusions regarding treatment needs and eligibility for services for persons.

A Substance Use Disorder Services assessment must be performed by a qualified credentialed counselor (QCC) (as defined by the HHSC licensure standard) to determine the severity of a client's SUD and identify their treatment needs.

Assessments are limited to once per episode of care of SUD.

Claims may not be submitted for more than one SUD Assessment per day.

31152 Group Substance Use Disorder Services

The group services billable events refer to one service provided by one or more direct service staff to more than one person enrolled in HCBS-AMH. Substance Use Disorder Services may be provided in a group setting if identified as clinically appropriate by the IDT and in accordance with the approved IRP. Groups may consist of no more than 6 persons (excluding direct service providers).

31153 Documentation

An HCBS-AMH Provider must have written documentation to support a service claim for Substance Use Disorder Services that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

SUD treatment plans will be developed with active participation of the person to specifically address and accommodate the person's needs, goals, and preferences and will support the overall HCBS-AMH IRP goals.

Written documentation of HCBS-AMH SUD must:

- For each patient encounter, document:
 - assessment,
 - clinical impression,
 - and diagnosis;
- Reason for encounter and relevant history; and

31154 Needs-Based Criteria

The services are coordinated within the context of the IRP which delineates how Substance Use Disorder Services are intended to achieve the identified goals.

31155 Limitations

Substance use disorder services are only provided to persons age 21 and over. All medically necessary substance use disorder services for children under age 21 will be covered in the state plan pursuant to the early and periodic screening, diagnostic and treatment (EPSDT) benefit.

Telehealth Delivery of Services Limitations

HCBS-AMH providers must refer to the [Texas Medicaid Provider Procedures Manual](#), Behavioral Health and Case Management Handbook Section 9, “Substance Use Disorder Services” for more information on the telehealth delivery of services. Important note: Chemical Dependency Treatment Facilities (CDTF) and Opioid Treatment Program (OTP) must comply with all applicable rules relating to telehealth services.

31156 Location of Services

Services may be provided in the person’s home or other community-based setting.

31157 Exhaustion of Non-HCBS State Plan SUD Benefits

Persons must exhaust other state plan SUD benefits before choosing the HCBS-AMH SUD benefit unless other state plan benefits are not appropriate to meet the person’s needs, limitations, and recovery goals as determined by the independent evaluation (e.g. severe cognitive or social functioning limitations, or a mental disability).

31158 Duplication of Services

This service may not be provided on the same day and at the same time as other state plan SUD services.

31160 Transition Assistance Services

Transition Assistance Services (TAS) pays set-up expenses for persons transitioning from institutions into community settings. Allowable expenses are those necessary to enable persons to establish basic households and may include:

1. Security deposits for leases on apartments or homes;
2. Essential household furnishings and expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bathlinens;
3. Set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water;
4. Services necessary for a person's health and welfare, such as pest eradication and one-time cleaning prior to occupancy; and
5. Activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge).

31161 Non-billable Transition Assistance Items and Services

The following are non-billable to HCBS-AMH Transition Assistance Services:

1. Room and board;
2. Monthly rental or mortgage expenses;
3. Food;
4. Regular utility charges;
5. Major household appliances;
6. Items that are intended for purely recreational purposes; and
7. Shared expenses, such as furniture and appliances, covered under provider owned or operated residential options.

31162 Documentation

Receipt of purchase of the TAS is required. The IRP must document that persons are unable to meet such expenses or the services cannot be obtained from other sources.

Documentation must include proof that the provider purchased the transition assistance services, and the date of purchase.

31163 Needs-Based Criteria

TAS are furnished only to the extent that the expense is reasonable and necessary, as determined through and clearly identified in the IRP.

Providers may only bill Medicaid for TAS on or after the date that the person is enrolled in the state plan benefit, on or after the date of discharge from the facility, and pursuant to the IRP.

31164 Limitations

There is a \$2,500 cost cap per participant for the transition event into their residence (including, but not limited, to supported home living and companion care arrangements). Persons transitioning to their own home (not a provider-owned or operated setting) have a need to purchase and arrange for essential household furnishings and expenses required to occupy and use a community domicile. These could include furniture, window coverings, food preparation items, and bed and bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water; and services necessary for a person's health and welfare, such as pest eradication and one-time cleaning prior to occupancy. These items are reflected in the cost cap.

There is a \$1,000 cap per participant for the transition event into a host home, supervised living or assisted living arrangement that reflects that while the person will need items to personalize their living space; other items such as furniture are provided by the residential setting.

31170 Transportation

All transportation funded by HCBS-AMH shall be billed in accordance with the Transportation service and the schedule of billable events for mileage. Transportation is provided to the person.

31171 Non-Billable Transportation Activities and Services

HCBS-AMH Providers and direct service staff may not bill for service time spent transporting a HCBS- AMH participant when the transportation is related to or a part of another HCBS-AMH service such as Supported Home Living or Employment Services. Transportation activities associated with Supported Home Living and Employment Services shall be billed in accordance with the requirements of those services, respectively.

Transportation provided to the person's LAR or primary caregiver is not billable. Transportation is not billable for Rideshares.

31172 Documentation

Transportation services are offered in accordance with the IRP. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Transportation should be provided if not doing so creates a barrier to full community integration for the person. This service does not duplicate transportation provided as part of other services or under the State Plan medical transportation benefit.

An HCBS-AMH Provider must have written documentation to support a service claim for HCBS-AMH Transportation Services that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

Documentation requirements for the provision Transportation include:

- Mileage log with Start and Stop Time;
- r.

See Transportation Log Template (Form 8002) for the documentation requirements of Transportation. The HCBS-AMH Provider must maintain Transportation Log or an alternative mileage log in the person's clinical record.

31173 Needs-Based Criteria

This service does not duplicate transportation provided as part of other services or under the State Plan medical transportation benefit. This service must be provided in support of the person's recovery goals as identified on the IRP.

31174 Limitations

Transportation services are only provided to persons age 21 and over. All medically necessary transportation services for children under age 21 will be covered in the state plan pursuant to the early and periodic screening, diagnostic and treatment (EPSDT) benefit.

There is a limit of \$2000 per person per year for this service.

3200 General Revenue Reimbursable Activities and Services

3210 HCBS-AMH Services Provided to Indigent Persons

Persons who are enrolled in HCBS-AMH who are indigent are eligible for the full HCBS-AMH service array. HCBS-AMH services provided to indigent persons are reimbursable through General Revenue. Billable and Non-billable activities, services, and items identified in 4100 Medicaid Billable Activities and Services apply.

3300 Non-Medicaid HCBS-AMH Services

3310 Flexible Funds

Requests for Flexible Funding for technology can be submitted using [Form 8202, HCBS-AMH and YES Waiver Program Request for Technology Funding](#). This funding is time limited and will expire no later than August 31, 2023. Reimbursement is for eligible devices intended to increase the availability of remote delivery for mental health services. Devices which must be purchased, owned by, and are the responsibility of the contract holder for HCBS-AMH services. Devices purchased within two (2) years of reimbursement must be returned to the HCBS-AMH program if a contract is terminated. Each type of purchase for technology must be reflected on the HCBS-AMH Encounter Invoice as described on the "Instructions" tab. Flexible Funds may be used in accordance with the following guidelines:

- Flexible funds are reserved for indigent persons, unless otherwise approved by HHSC.

- All services provided with Flex Funds must be identified on the IRP for review and prior-approval by HHSC.
- HHSC will review to ensure that the indicated service does not fall within the scope of the HCBS- AMH service array before approving.

The HCBS-AMH Direct Provider Agency will follow requirements and guidelines established by HCBS- AMH that exist regarding the use and reporting of Flexible Funds, including but not limited to the requirements and guidelines outlined within the HCBS-AMH Provider Manual.

3311 Documentation

Flexible Funding for technology is not documented on the IRP, this funding is specific for provider- owned devices. All other flexible funding Services shall be documented on the IRP.

HCBS-AMH Provider shall document good faith effort to secure funding for the service prior to requesting authorization of Flexible Funds.

An HCBS-AMH Provider must have written documentation to support a service claim for HCBS-AMH Flexible Funds that:

- Meets the requirements set forth in Section 2800 Documentation of Service Provision; and

3312 Needs-Based Criteria

All services provided with Flex Funds must be identified on the person's IRP, which delineates how Flexible Funds are intended to achieve the identified goals.

3313 Limitations

Flexible Funding for technology is time limited and will expire no later than August 31, 2023. Flexible Funds are only available for persons enrolled in HCBS-AMH who are indigent unless an exception is granted by HHSC for the unique circumstance where the service is clinically required and not attainable by any other resource available to the non-indigent person.

Flexible Funds used for purposes of monthly rental dues for persons residing in their own home or apartment is not to exceed 100% of the Fair Market Rent (FMR) values in the location of residence divided by the number of beds or residents

(whichever is greater) plus 30%. Refer to [Fair market Rents](#) at Office of Policy Development and Research website to determine FMR of the current year.

3320 HCBS-AMH Pre-Engagement Services

HCBS-AMH Pre-engagement services are provided by the referring entity completing referrals from the community to persons seeking enrollment as an HCBS-AMH participant. Services are provided to the individual or collateral, face-to-face or via telephone.

3321 Billable Pre-Engagement Activities and Services

The billable activities for Pre-Engagement are:

- Respond to inquiries from person's residing in the community about the HCBS- AMH program;
- Review of the MBOW 1915i report to identify potential HCBS-AMH participants;
- Schedule and perform initial program eligibility screening via inquiry phone line (if the person is not identified via MBOW report) and schedule initial assessment appointment
- Assist the person and/or LAR in completing HCBS-AMH Program Consent for Eligibility Determination and Enrollment Forms;
- Coordinate HCBS-AMH referral process for persons residing in the community via Provider Selection Form;
- Schedule and conduct the HCBS-AMH Uniform Assessment (UA) required for determining HCBS- AMH Program eligibility;
- Gathering or assisting the person in gathering documentation required to determine program eligibility;
- Assisting in obtaining the documents necessary for determining Medicaid eligibility;
- Assisting in submission of all Medicaid eligibility paperwork to System Agency for processing;
- Completing enrollment activities in accordance with the Manual to include but not limited to coordination with state hospital staff, criminal justice staff and emergency department staff;

- Assisting in completing the selection of the HCBS-AMH Provider Agency and Recovery Management Entity.

3322 Documentation

Supporting documentation includes a brief description of pre-engagement activities that occurred on the beginning date during the time indicated in the documentation. These dates and times should be totaled to determine the correct invoice amount.

The pre-engagement provider shall document the date of service as the date referral and enrollment activities begin. The time of service may reflect the cumulative total of units provided.

3323 Limitations

This service shall not be provided if Pre-Engagement service components are provided by as part of other services or under the State Plan.

Pre-engagement services shall be invoiced no more than one time per individual per submission of the HCBS-AMH Uniform Assessment. This may occur at time of initial referral, initial referral to the program after discharge from HCBS-AMH, and annual re-assessment.

HCBS-AMH Pre-engagement activities cannot be provided or reimbursed if the referring entity is providing and being reimbursed for another service by Medicaid, Medicare or alternative third party payer.

LMHA/LBHA shall maintain all encounter data sheets and invoices for all HCBS-AMH Pre-Engagement Services in the format requested by HHSC.

3330 Non-Medicaid Development of IRP

3331 Updating an IRP for Person in Suspended Status

If the person is placed on suspended status, Medicaid cannot be billed. However, it is the expectation that the recovery manager will continue to meet with the person at least monthly, if allowable by the non-home and community-based setting. HCBS-AMH Recovery Management is reimbursable by General Revenue under these circumstances. Documentation requirements for the provision of Recovery Management apply.

3340 HCBS-AMH Medicaid Services Provided in the Hospital

The HCBS-AMH Provider shall submit to HHSC, an encounter data report for any HCBS-AMH Service billing using the Encounter and Invoicing Template. The HCBS-AMH Provider must indicate on the invoice the location of the service encounter. The following services may be provided inside the state hospital but are not Medicaid billable while the person resides in the hospital. Therefore, they are only reimbursable by General Revenue:

- HCBS Psychosocial Rehabilitation services;
- Community Psychiatric Supports and Treatment;
- Peer support;
- Substance Use Disorder Services; and
- Recovery Management (See Limitations; Recovery Management Provided in the Hospital 4241.1).

3341 Limitations

Recovery Management Provided in the Hospital (Recovery Management Transitional Fee and Recovery Management Transitional Day Rate)

Recovery Management provided to the newly enrolled person in the State Hospital is billable to General Revenue as Recovery Management Transitional Fee or Recovery Management Transitional Day Rate. This may be assessed per person enrollment if the person is inside the state hospital at the time of enrollment. If the provider elects to submit a claim to HHSC for Recovery Management Transitional Fee or Recovery Management Transitional Day Rate, other claims for Recovery Management will not be reimbursed until the person is in the community.

3341.1 Recovery Management Transitional Fee

The Recovery Management Transitional Fee is a one- time fee that is paid to the Recovery Manager for the first three months of the provision of Recovery Management transitional services. The amount of this one- time Recovery Management Transitional Fee is not dependent on the person's length of stay during these three months of Recovery Management transitional services. The Recovery Management Transitional Fee rate is 1,842.87.

3341.2 Recovery Management Transitional Day rate

After a period of three months, Recovery Management transitional services will be paid at a day rate. The Recovery Manager is not eligible to bill for Recovery Management transitional services provided after the person's stay exceeds 180 days. The Recovery Management Transitional Day rate is \$19.28.

3350 HCBS-AMH Recovery Management Conversion Services

Recovery Management Conversion Services are provided to the following persons:

- a person who is enrolled in another HCBS program and decides to discontinue services in that program and enroll in HCBS-AMH
- a person who is residing in a nursing home

Recovery Management Conversion Services may be provided to the person but are not Medicaid billable; therefore, it is only reimbursable by General Revenue. This service is billable to General Revenue as Recovery Management Conversion Services Fee.

3351 Recovery Management Conversion Services Fee

The Recovery Management Conversion Services Fee is a one-time fee that is paid to the Recovery Manager for **one month** of Recovery Management Conversion services. The Recovery Management Conversion Services Fee rate is \$614.29.

3352 Recovery Management Conversion Service Preauthorization

In order to provide RM Conversion Services, the RM must obtain preauthorization. Preauthorization is approval by HCBS-AMH staff for coverage of recovery management conversion services prior to the person's enrollment into HCBS-AMH. RM services are the only services eligible for preauthorization. Preauthorization of RM conversion services will allow the RM to work with the person's HCBS team to ensure a smooth transition into the HCBS-AMH program.

The following information is necessary to consider when transitioning a person from a HCBS program into HCBS-AMH:

- RM will submit Preauthorization Request Form to HHSC for approval.

- After approval of preauthorization of services, an HCBS-AMH person will receive one month of conversion services.
- RM conversion services will begin the first of the month following approval by HCBS-AMH staff.
- Enrollment into HCBS-AMH will begin the first of the month following the month of conversion services.

The following steps must be taken when transitioning a person from a nursing facility:

- RM will submit Preauthorization Request Form to HHSC for approval.
- After approval of preauthorization of services, an HCBS-AMH person will receive one month of conversion services.
- RM conversion services will begin on the day conversion services are approved by HCBS-AMH staff.

3400 Non-Reimbursable/Non-Billable Activities

In addition to non-billable activities identified in section 4100 Medicaid Billable Activities and Services, the following activities do not constitute a Medicaid billable or GR reimbursable activity:

1. Travel if the direct service provider is not accompanied by a person;
2. Documentation of the service delivery (e.g. progress notes, completion of forms, and data entry);
3. Reviewing a person's clinical record;
4. Activities regarding a staff member's employment or contractor's association with the program provider (for example, attending conferences and participating in the performance evaluation of a staff member or contractor);
5. Activities regarding the preparation, submission, correction or verification of service claims;
6. Quality management activities;
7. Utilization management activities; and
8. Submission of required documents and reports to HHSC.

4000 Invoicing and Payment

- Payment will be made for only those services that are provided in accordance with the department's rules, guidelines, policy clarifications, and manuals.
- Payment will not be made to providers without a current and valid contract for HCBS-AMH services.
- Payment will not be made for services for which the documentation of that service does not include the original signature, including credentials, of the staff person who provided the service.
- Payment will not be made for services not authorized by HHSC on an active IRP.
- Payment will not be made for non-reimbursable activities.

4100 General Invoicing Information

HCBS-AMH Providers shall complete the HCBS-AMH Encounter Invoice Template available online at [HCBS-AMH Provider Portal website](#) under Rates tab to bill for HCBS-AMH service array services.

Referral entities shall complete the Pre-Engagement Encounter Invoice Template available online at [HCBS-AMH Provider Portal website](#) under Rates tab to bill for pre- engagement services.

4110 Submitting an Invoice

The provider shall submit the HCBS-AMH Invoicing Template to HHSC as follows:

- Invoices shall include all HCBS-AMH services provided during the timeperiod reflected in the invoice;
- The submission of invoice shall be submitted no later than 5:00pm (Central Standard Time)15 calendar days after the last day of each timeperiod;
- Invoices are due to HHSC by the 15th of each month for billing the previous month
- The Invoicing Template shall be submitted via HIPAA compliant encrypted email to the [Claims Processing Unit at MHContracts@hhsc.state.tx.us](#), with a copy to HHSC Accounts Payable at [HHSC AP@hhsc.state.tx.us](#) and HCBS-AMH Billing at [HCBS-AMH-Billing@hhsc.state.tx.us](#); and

- Upon Submission of B-13 and Invoice via email include the following details in the subject line of the electronic submission:
 - Contractor Name as it appears on your executed contract
 - Purchase Order Number
 - Contract Number as it appears on your executed contract
 - Program ID (MH/HCBS PA or MH/HCBS RM)
 - Month of service, year of service, and total invoice amount
- The HCBS-AMH Provider shall have prior approval by HHSC to submit the Invoicing Template through a method other than encrypted email.

4120 Time Periods for Service

The time periods for services are as follows:

- The 1st day of the month through the last day of the month.

4130 Service Claim Requirements

A provider must submit an electronic service claim that meets the following requirements. The claim must:

- Be for a service that is on an Active IRP (as defined in HCBS-AMH Provider Manual), authorized by HHSC;
- Be for a service provided during a period of time for which the person has an Active IRP;
- Be based on billable activity (See Section 3000 Service Specific Billing Requirements), for the particular service being claimed;
- Not be based on activity that is not billable, (See Section 4300 Non-Reimbursable/Non-Billable Activity);
- Must be based on activity performed by a qualified direct service provider (See Section 3500 Provider Qualifications);
- Be for a service provided to only one person;
- Be for a service provided on only one date;
- Be for the date the service was actually provided;
- Be for units of service determined in accordance with Section 3700 Billable Units of Service;

- Be supported by written documentation (See Section 2800 Documentation of Service Provision) for the particular service being claimed; and
- Be a clean claim and be submitted to the state Medicaid claims administrator no later than 12 months after the last day of the month in which the service was provided.

Match the EVV visit transaction, as required by 1 TAC §354.4009(a)(4) (relating to Requirements for Claims Submission and Approval), if the claim is for respite care services- in-home or supported home living – habilitative support.

4200 HHSC Review of Invoice

4210 General Invoice Review

HHSC will review the initial invoice within five (5) business days upon receipt to ensure all required information is provided and that the amount requested is within authorized limits of the most currently approved IRP. Any anomalies between the currently approved IRP and billing invoice will require HHSC staff to make additional inquiries until an error free invoice is received and approved. HCBS-AMH Providers shall be allowed 5 business days to return an error free invoice to HHSC for review. The HCBS- AMH Provider is responsible for making any necessary corrections determined by HHSC. The HHSC invoice review will include:

1. Verifying the person's eligibility for the HCBS-AMH Program services on the date of service delivery. HCBS-AMH services provided outside of HCBS-AMH Program eligibility will not be reimbursed;
2. Comparing the invoice to each HCBS-AMH participant's approved IRP. Services that are not on the approved IRP approved by HHSC will not be reimbursed; and
3. Verification that a current IRP was in place at the time of service delivery. Services provided on a date in which an Active IRP was not in place will not be reimbursed.

HHSC shall be allowed up to fifteen (15) business days to review a billing invoice submitted as a second attempt for payment and up to thirty (30) days to review a billing invoice submitted as a third attempt for payment.

4300 Payment

HHSC will review the invoices in relation to HCBS-AMH requirements and authorize payment through the state's accounting system. HHSC will submit data to HHSC for draw-down of the federal share.

The HCBS-AMH Provider will accept the current HCBS-AMH service reimbursement rate, found online at [TMHP Fee Schedule](#) or the rate as it may hereafter be amended, as payment in full for performance under the Provider Agreement. The HCBS-AMH Provider shall make no additional charge to the person, any member of the person's family or any other source, including a third-party payer, except as allowed by federal and state laws, rules, regulations and the Medicaid State Plan.

HHSC, on behalf of HHSC and Medicaid, will provide payment to an HCBS-AMH Provider in accordance with the terms of the Provider Agreement and the current HCBS-AMH reimbursement rate. Payment will be made to the HCBS-AMH Provider in accordance with standard State Comptroller's Office reimbursement practices and upon receipt of an error free and complete invoice, as determined by HHSC.

Please visit the State Comptroller's Office for additional information on Payment Services at [State Payee Payment Resources](#) website. Texas' "prompt payment law" establishes when some types of payments are due. The law says that payments for goods and services are due 30 days after the goods are provided, the services completed, or a correct invoice is received, whichever is later.

5000 Medicaid Billing

HCBS-AMH Providers shall be enrolled as a Medicaid provider and assigned a Medicaid provider type specific to the HCBS-AMH Program.

Claims must itemize charges by date of service to avoid a reduction of units per day. Services cannot exceed 24 hours or 96 units per day, per provider.

One direct service provider may not provide different services at the same time to the same person.

5100 Submitting Medicaid Claims

5110 Texas Medicaid & Healthcare Partnership

Texas Medicaid and Healthcare Partnership (TMHP) is the Medicaid claims administrator in Texas.

At the time of publication of these Billing Guidelines, HCBS-AMH Providers will not submit claims for reimbursement of HCBS-AMH services to TMHP. HCBS-AMH Providers will submit service encounters and invoices to HHSC for HCBS-AMH services and HHSC will pay claims for HCBS-AMH services directly to HCBS-AMH Providers (see Section 5000 Invoicing and Payment).

5200 Medicaid Effective Date

The Medicaid Effective Date is the date Medicaid benefits begin. HHSC establishes the Medicaid Effective Date:

- The Medicaid Effective Date will traditionally be dated back to the 1st of the month of the date of application. For example, if the financial application was signed on 6/17/10, the Medicaid Effective Date would be 6/1/10 once the financial determination was completed.
- The Medicaid Effective Date may be prior to or after the IRP Authorization date.
- Services will not be Medicaid reimbursable until Medicaid Effective Date.

5300 Non-HCBS State Plan Services

Medicaid providers of Non-HCBS State Plan Services shall submit claims for payment to TMHP, the appropriate Managed Care Organization (if applicable), or private insurance (if applicable). HHSC does not pay claims for Non-HCBS State Plan Services.

6000 Exclusions

6100 Room and Board

Payment of the cost of room and board is not included in the HCBS-AMH service array and is the responsibility of the person except when the person is receiving out-of- home respite services.

6200 Payor of Last Resort

6210 Medicaid Payor of Last Resort

Medicaid is the payor of last resort and any claims that may be covered under a private insurance or Medicare benefit shall be submitted for payment to the private insurance prior to submitting the claim to Medicaid (TMHP or Managed Care Organization).

6220 General Revenue Payor of Last Resort

The HCBS-AMH Provider must access all available funding sources before using HHSC general revenue funds to pay for a person's services. HCBS-AMH Providers are responsible for making reasonable efforts to collect payments from all available funding sources before accessing the department's funds to pay for services. Funding sources may include Medicaid, Medicare, third-party coverage, state and/or local governmental agency funds (e.g., crime victim's fund), Qualified Medicare Beneficiary (QMB) Program, indigent pharmaceutical programs, or a trust that provides for the person's healthcare and rehabilitative needs.

6230 Co-Payment of Person

Persons determined to be financially eligible for HCBS-AMH who are not Medicaid eligible and have income above 150% of the Federal Poverty Limit (FPL) may be required to share in the cost of HCBS- AMH Program services. This cost-sharing shall not exceed the Maximum Monthly Fee in accordance with the Maximum Monthly Fee Schedule outlined in 25 TAC Chapter 412, Subchapter C, Charges for Community Services, Rule §412.113. The [Monthly-Ability-To-Pay Fee Schedule](#) is available at [Texas HHS website](#) under Resources tab.

The co-payment must be paid by the person, LAR, or trustee directly to the HCBS-AMH Provider in accordance with the HHSC determination. The HCBS-AMH Provider is responsible to notify HHSC of all co-payments received by a person.

When calculating the co-payment amount for a person whose income exceeds 150% of the FPL, the following are counted towards the MMF:

- HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency charges for HCBS- AMH Services;
- Costs incurred for medical or remedial care that are necessary but are not subject to payment by Medicare, Medicaid, or any other third party, which include the costs of health insurance premiums, deductibles, and co-insurance; and
- The monthly account amount for services not covered by third-party coverage.

6231 Cost Sharing Limit

If the person has reached his/her annual cost-sharing limit (i.e., maximum out-of-pocket expense) as verified by the non-Medicare third-party coverage, then the

HCBS-AMH Provider shall not bill the person for the remainder of the state fiscal year.

6232 Statements

The HCBS-AMH Provider will send a statement to persons determined responsible for HCBS-AMH cost sharing, unless otherwise indicated. The statements shall include;

- Itemized list, at least by date and by type, of all services provided during the period;
- Standard charge for each service;
- Total charge for the period;
- Amount paid (or to be paid) by each funding source; and
- Amount to be paid by the person.

Unless requested otherwise, the HCBS-AMH Provider does not send statements to persons with a zero balance (i.e., the person does not currently owe any money).

Unless requested otherwise, the LMHA/LBHA does not send statements to persons (or parents) who have an inability to pay.

If the HCBS-AMH Provider makes a decision, based on a clinical determination that is documented and includes input from the persons' IDT, that being charged for services and receiving statements will result in a reduction in the functioning level of the person, refusal or rejection of the needed services, then the HCBS-AMH Provider will discontinue charging the person for services and stop sending statements. The clinical determination must be reassessed at least every three months. If the HCBS-AMH Provider decides to discontinue charging the person for services, then the IDT must develop and implement a plan to address the issues related to the person's functioning level or the or refusal or rejection of the needed services.

The HCBS-AMH Provider shall not refer a person to a debt collection agency for HCBS-AMH services without HHSC approval.

7000 Forms

7100 HCBS-AMH Invoice Template

The HCBS-AMH Billing and Pre-Engagement invoices are available online at [HCB-AMH Provider Portal](#) website.

7200 Transportation Log

This form shall be utilized for documentation of HCBS-AMH Transportation in accordance with the HCBS- AMH Billing Guidelines. The Transportation Log is available online at [HCB-AMH Provider Portal](#) website.

7300 Documentation of Transportation as Part of HCBS-AMH Service

This form shall be utilized for documentation of transportation associated with transporting a person as an integral part of another HBCS-AMH service as allowable (i.e. Employment Services and Supported Home Living). The Documentation of Transportation as Part of HCBS-AMH Service form is available online at [HCB-AMH Provider Portal](#) website.