Section 1000, State of Texas Access Reform Plus (STAR+PLUS) Managed Care

Revision 20-2; Effective October 1, 2020

1143.1.3 STAR+PLUS Personal Assistance Services (PAS) Practitioner’s Statement of Need (PSON)

Revision 20-2; Effective October 1, 2020

State plan personal assistance services (PAS) must be authorized according to 42 Code of Federal Regulations (CFR) §440.167. STAR+PLUS managed care organizations (MCOs) must authorize state plan PAS either in the service plan developed and approved by the MCO for all STAR+PLUS members or by requiring a practitioner’s statement of need (PSON). **Note**: See Uniform Managed Care Contract Section 8.1.13.2, STAR+PLUS MRSA Contract Section 8.1.13.2 and STAR+PLUS Expansion Contract Section 8.1.13.2. All STAR+PLUS members are considered members with special health care needs.

If the MCO chooses to require a PSON, the PSON may be requested under one or more of the following circumstances:

* at initial request;
* if original approval was based on temporary need;
* if the member experiences a significant change in condition, as defined by managed care contracts; or
* at reassessment.

A PSON cannot be required for PAS provided under the STAR+PLUS Home and Community Based Services (HCBS) program or Community First Choice (CFC).

Implementing a PSON process should not cause a delay in a prior authorization decision or in delivery of PAS that has been assessed as medically or functionally necessary. The PSON request must be initiated 90 days prior to the expiration of the authorization for PAS, if required upon reassessment. For a significant change in condition, the PSON must be initiated during the 21-day follow-up period for reassessment. The MCO must have a documented process in place for the steps that they will take to follow up with the practitioner to secure the PSON. This process should include the steps that will be taken to notify the member and service provider of the status, including outreach attempts by phone, in writing or in person. The MCO must accept a PSON signature that was gathered by the member or the member’s service provider.

**Authorization Extension and Outreach Efforts**

Previously authorized services must continue until a signed PSON is obtained. The MCO must have a process in place to extend the authorization to ensure the member has no gap in services while additional outreach efforts are being made by the MCO. The extended authorization period may not exceed 45 additional days. During the extended authorization period, the MCO must continue outreach to the practitioner and to offer the member the opportunity to change to a new practitioner. The MCO must communicate to the member and the member’s service provider the potential impact to PAS services if a signed PSON is not obtained. The MCO must document in the member’s record all outreach efforts and member education related to the PSON.

**Required Data Elements**

If the STAR+PLUS MCO chooses to require a PSON for STAR+PLUS PAS, the MCO must develop their own version of a PSON. The PSON must include the following separate data elements:

* Member name;
* Member identification (ID) number;
* Member date of birth (DOB);
* Certification that the member was evaluated by a practitioner in the last 12 months;
* If the practitioner certifies that they have evaluated the member in the last 12 months, additional certification that the member has a medical diagnosis resulting in one or more functional limitations, as indicated, or that the practitioner is unable to certify the member has a medical diagnosis resulting in one or more functional limitations;
* Notation of whether the medical diagnosis is resulting in a temporary need, along with the expected end date;
* All of the items listed in Parts III and IV on [Form 3052](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-3052-practitioners-statement-medical-need), Practitioner's Statement of Medical Need;
* Practitioner printed name;
* Practitioner address;
* Practitioner phone number;
* Practitioner license number;
* Signature of physician, nurse practitioner, advanced practice registered nurse or physician assistant; and
* Date form was signed.

The MCO also must provide the practitioner a copy of the completed [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide, when requested.

If the MCO has exhausted all efforts to obtain a PSON and intends to deny, limit, reduce, suspend, terminate or make any other adverse determination regarding a member’s services, the MCO must follow the procedures found in the *Uniform Managed Care Manual*, Chapter 3.21, Medicaid MCO’s Notices of Actions Required Critical Elements.