**Section 6000, Specific STAR+PLUS HCBS Program Services**

Revision 20-2; Effective October 1, 2020

**6420 Approval of Adaptive Aids and Medical Supplies**

Revision 20-2; Effective October 1, 2020

In the initial pre-enrollment assessment and at reassessment, the managed care organization (MCO) service coordinator identifies the basic needs of the member for adaptive aids and STAR+PLUS Home and Community Based Services (HCBS) program medical supplies along with the estimated costs on [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-1), Individual Service Plan (Pg. 1). The MCO must provide documentation supporting the medical need for all adaptive aids and medical supplies. The documentation must be provided by the member’s ordering, referring or prescribing provider. This can be a physician, physician assistant, nurse practitioner, registered nurse (RN), physical therapist, occupational therapist or speech pathologist. The service coordinator must use [Form H1700-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-a-rationale-starplus-hcbs-program-itemsservices), Rationale for STAR+PLUS HCBS Program Items/Services, to document medical need and the rationale for purchasing the item(s).

Adaptive aids and medical supplies are approved for purchase as a STAR+PLUS HCBS program service by the MCO only if the documentation supports the requested item(s) as being necessary and related to the member's disability or medical condition.

The MCO determines if the documentation submitted is adequate and makes the decision as to whether an adaptive aid or medical supply is needed and related to the member's condition. The MCO makes the final decision if the purchase is necessary and will be authorized on the individual service plan (ISP). The acute care benefit for any equipment or medical supplies must be expended before STAR+PLUS HCBS program benefits may be used.

If the member's request for a particular adaptive aid or medical supply is denied, the member must receive written notice of action of the denial of the specific item following the requirements outlined in the [*Uniform Managed Care Manual*](https://hhs.texas.gov/services/health/medicaid-chip/provider-information/contracts-manuals/texas-medicaid-chip-uniform-managed-care-manual), Chapter 3.21.

If the member requests an item the MCO deems is not medically necessary or related to the member's disability or medical condition, the MCO must send a notice of action to the member.

For situations in which the member requests an adaptive aid or medical supply, and the item(s) are documented by the nurse or other medical professional to be medically necessary, the MCO has the option of approving the item(s). If not approved, the MCO must send a notice of action to the member.

The member may appeal the denial by filing an appeal with the MCO. The member does not receive the adaptive aid or medical supply unless the denial is reversed. If the denial is reversed, the item is added to the ISP. The cost of the item is reflected in the ISP in effect at the time of the appeal.

Service plans should be individualized to the member. All items must be related to the member's disability or medical condition and used to support or increase level of independence.

If the provider cannot deliver the adaptive aids by the appropriate time frames, the provider must notify the MCO via [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, and include the reasons the adaptive aid will be late. The MCO reviews the information to determine if the reason given for the delay is adequate or if additional intervention is necessary. It may be necessary for the MCO to discuss the reasons for the delayed delivery with the member and provider staff.

If the adaptive aid requested will not be delivered in the current ISP, the item must be transferred to the new ISP. If the authorization on the new ISP causes the ISP to exceed the annual cost limit, the nurse may authorize the service using the date the item was ordered by the provider as the date of service delivery and the provider may bill against the previous ISP.