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

Revision 18-2; Effective September 3, 2018

6100 Home and Community Based Services

Revision 18-2; Effective September 3, 2018

6110 Program Overview

Revision 18-2; Effective September 3, 2018

6111 Service Introduction

Revision 18-2; Effective September 3, 2018

The service array under the STAR+PLUS Home and Community Based Services (HCBS) program is designed to offer home and community based services as cost-effective alternatives to institutional care in Medicaid-certified nursing facilities. Eligible members receive services according to their specific needs, as defined by an assessment process, based on informed choice and through a person-centered process.

Agencies contracted with managed care organizations (MCOs) provide services to members living in their own homes, foster homes, assisted living facilities (ALFs) and other locations where service is needed. The services provided are identified on an individual service plan (ISP) and are authorized by the MCOs, as identified in [Section 6113](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-6000-sph-specific-starplus-waiver-services#6113), General Requirements for MCOs, and in accordance with the ISP.

6112 Service Locations for STAR+PLUS HCBS Program

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All services through the STAR+PLUS Home and Community Based Services (HCBS) program, except minor home modifications (MHMs), can be provided to members in locations of their choice. Nursing services, therapy services, adaptive aids (including dental) and medical supplies may be provided to a STAR+PLUS HCBS program member residing in an assisted living facility (ALF) contracted to provide STAR+PLUS HCBS program services. Per Title 42 of the Code of Federal Regulations (CFR), Subpart K, §441.530(a)(2), the following locations are excluded from STAR+PLUS HCBS program service locations, with the exception of out-of-home respite care:

* Nursing facilities (NFs);
* Psychiatric hospitals;
* Intermediate care facilities for individuals with intellectual disabilities (ICF/IID);
* Hospitals providing long-term care; and
* Locations that have the qualities of an institution.

6113 General Requirements for MCOs

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) must coordinate and ensure delivery and initiation of the array of services in accordance with [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1). Services include:

* personal assistance services (PAS);
* nursing services;
* physical therapy (PT);
* occupational therapy (OT);
* speech therapy (ST) services;
* cognitive rehabilitation therapy (CRT);
* adaptive aids;
* medical supplies;
* minor home modifications (MHMs);
* emergency response services (ERS);
* assisted living (AL);
* adult foster care (AFC);
* home-delivered meals;
* dental services;
* transition assistance services (TAS);
* respite care;
* employment assistance; and
* supported employment.

The MCO must identify, coordinate and when applicable, authorize available value added services, Medicare and other third-party resources (TPRs) before authorizing those services on the member's individual service plan (ISP).

6114 Service Plan

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) must authorize all services identified on the individual service plan (ISP). When sending an authorization to a provider, the MCO may send the following:

* [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1);
* [Form H1700-2](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-2-individual-service-plan-spw-pg-2), Individual Service Plan (Pg. 2);
* Form H1700-3, Nursing Service Plan;
* [Form H1700-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-a-rationale-hcbs-starplus-waiver-itemsservices), Rationale for STAR+PLUS HCBS Program Items/Services;
* [Form H1700-A1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-a1-certification-completiondelivery-hcbs-starplus-waiver-itemsservices), Certification of Completion/Delivery of STAR+PLUS HCBS Program Items/Services;
* [Form H1700-B](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-b-non-hcbs-starplus-waiver-services), Non-STAR+PLUS HCBS Program Services;
* [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;
* [Form H2060-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-a-addendum-form-h2060), Addendum to Form H2060;
* [Form H2060-B](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-b-needs-assessment-addendum), Needs Assessment Addendum,
* [Form H6516](https://hhs.texas.gov/laws-regulations/forms/6000-6999/form-h6516-community-first-choice-assessment), Community First Choice Assessment; or
* Other forms and assessments, as applicable.

The MCO must send any functional assessment documentation to the provider when requested. The MCO will post the signed Form H1700-2 to the XXXISP folder in TxMedCentral using the appropriate naming convention. All other forms are maintained in the member's file folder. If Form H1700-1 is electronic, the MCO will submit Form H1700-1 through the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Online Portal or TMHP Electronic Data Interchange.

The MCO registered nurse (RN) service coordinator or MCO contracted RN service coordinator and the member or authorized representative (AR) must sign Form H1700-2 prior to the start date of the ISP to certify the proposed ISP accurately reflects the needs of the member.

Verbal authorizations are permitted for ISP changes, as long as the name of the person who gave the verbal authorization and the date the verbal authorization was given, are included on the signature line. The proposed ISP should be presented to the member following development of the proposed ISP and the member should sign Form H1700-2 to indicate acceptance.

6115 Individual Agreement for Services

Revision 18-2; Effective September 3, 2018

Managed care organizations (MCOs) may choose to provide services through other pay arrangements with individuals awaiting determination of STAR+PLUS Home and Community Based Services (HCBS) program eligibility. MCOs will not be reimbursed by the state for services delivered prior to the determination of the STAR+PLUS HCBS program eligibility.

The provider cannot be held responsible for deficits or failure in areas not included in the provider’s portion of the member's individual service plan (ISP) when gratuitous care or care by other resources is being provided.

6116 Refusal to Serve Members

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If a provider refuses to serve a member, the reason the provider cannot adequately meet the needs of the member must be stated in writing to the member’s managed care organization (MCO). The reason for provider refusal must be related to the provider’s limitation and not previous experience with the member or discriminated against because of age, disability or gender, etc. The provider must work with the MCO to coordinate alternative provider agency arrangements. The MCO must coordinate the transfer of services on behalf of the member.

6117 Service Planning

Revision 18-2; Effective September 3, 2018

Services and care provided, as identified and authorized on [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1), must assist the member to attain or maintain the highest practicable physical, mental and psychosocial well-being.

Services provided are tailored to meet the member's goals and needs based upon her or his medical condition, mental and functional limitations, ability to self-manage and availability of family and other support.

The managed care organization (MCO) must assure the member's informed choice and convenience are incorporated into the planning and provision of the member's care by involved professionals. The service planning process must be person-centered and the individual service plan (ISP) must reflect the member’s goals, needs, strengths and preferences with regard to the manner of delivery of STAR+PLUS Home and Community Based Services (HCBS) program services. Members must be encouraged and allowed to play an active role in determining their ongoing plan of care (POC).

MCOs must recognize and support the member's right to a dignified existence, privacy and self-determination.

6118 Personal Assistance Services

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Personal assistance services (PAS) provide assistance to members in performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs) based on the member’s needs. Most members will receive PAS through Community First Choice (CFC), with the exception of members who are medical assistance only (MAO), or members who also require protective supervision. Protective supervision is not a benefit of CFC.

PAS includes assistance with the performance of ADLs and IADLs necessary to maintain the home as a clean, sanitary and safe environment. PAS is provided to the member, as authorized on [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1), or as delivered through CFC.

The state allows a member to select a relative or legal guardian, other than a legally responsible individual, to be the member's provider for this service if the relative or legal guardian meets the requirements for this type of service. Federal and state rules prohibit a spouse from being a paid PAS provider.

6118.1 Description of Personal Assistance Services

Revision 18-2; Effective September 3, 2018

* Personal assistance services (PAS) include, but are not limited to, the following:
	+ assisting with basic self-care tasks known as activities of daily living (ADLs). These include, but are not limited to, self-feeding, dressing, bathing, personal hygiene and grooming, transferring, and going to the toilet;
	+ assisting with instrumental activities of daily living (IADLs). These are activities that allow an individual to live independently in the community. These include, but are not limited to, cleaning and maintaining the house, preparing meals, shopping for groceries, and taking prescribed medications;
	+ providing extension of therapy services;
	+ providing assistance with ambulation and balance;
	+ assisting with medications that are normally self-administered;
	+ performing health maintenance activities, as defined by the Texas Board of Nursing;
	+ performing nursing tasks delegated and supervised by a registered nurse (RN), in accordance with the Texas Board of Nursing rules;
	+ escorting the member on trips to obtain medical diagnosis, treatment or both; and

.

* The managed care organization (MCO) must authorize and ensure the provision of PAS as identified on [Form H6516](https://hhs.texas.gov/laws-regulations/forms/6000-6999/form-h6516-community-first-choice-assessment), Community First Choice Assessment, or [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, [Form H2060-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-a-addendum-form-h2060), Addendum to Form H2060; and [Form H2060-B](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-b-needs-assessment-addendum), Needs Assessment Addendum, and authorize PAS, as applicable, to members living in their own homes or other community settings.
* Activities purchased under PAS are limited to the member’s personal space and solely for the member’s personal needs. The following examples of services not reimbursable under the STAR+PLUS Home and Community Based Services (HCBS) program are:
	+ taking care of household non-service related pets;
	+ ironing;
	+ moving furniture;
	+ cleaning windows; and
	+ performing yard work other than yard hazard removal.

Shopping

Shopping is intended for the purchase of groceries, medications, or other items that support the health, safety, and well-being of a member. This may be done by the attendant on behalf of the individual or the attendant may accompany the individual to assist with this task. Neither the provider nor the attendant can charge the member for transportation costs incurred in the performance of this task.

Ambulation

Ambulation is a personal care task that involves non-skilled assistance with walking or transferring while taking the usual precautions for safety (that is, standby assistance, gentle support of an elbow for balance or assuring balance of a walker). This does not involve nursing intervention. No special precautions are needed other than for safety measures.

To facilitate safe member ambulation or movement, the attendant may need to ensure safe pathways throughout the home for the member. Examples include those who use wheelchairs, walkers or crutches, or for members with visual impairment. The attendant care provider or member (or authorized representative (AR)) addresses this activity during orientation and on an ongoing basis for an attendant who provides services to a member needing assistance.

The member’s primary care provider (PCP) may request specific ambulation orders. If ambulation is authorized as a nursing task, the service coordinator must not authorize ambulation as a non-skilled task on Form H2060, Form H6516, and any addendums to Form H2060. Authorizing ambulation as a nursing task and at the same time as a non-skilled task is a duplication of services. When completing the functional assessment on Form H2060 and any addendums to Form H2060, the service coordinator must consider the member's need for ambulation. If it appears the member needs both skilled and non-skilled ambulation assistance, the service coordinator must document in the case record why and how the member requires both. The service coordinator can approve both if there is no duplication.

Escort

Escorting is for healthcare-related appointments and does not include the direct transportation of the member, or the receipt or exchange of health information by the attendant. Escort services may be provided for safety needs to enter or exit a building, or to remain safe during wait time while attending medical appointments. Transportation for Medicaid members to Medicaid appointments is available in every county through the Medical Transportation Program (MTP). Transportation is not included as an activity in the escort task.

Protective Supervision

The purpose of protective supervision is to assure the health and welfare of a member with a cognitive impairment, memory impairment or physical weakness. Protective supervision is authorized by the MCO and assures supervision of the member during instances in which the member’s informal support is unavailable.

Protective supervision is supervision only and does not include the delivery of personal care tasks. Protective supervision is appropriate when it is necessary to protect the member from injury due to her or his cognitive/memory impairment and/or physical weakness. If left unattended, for instance, the member may wander outside, turn on electrical appliances and burn herself or himself, or try to walk and then fall. Protective supervision is not routinely authorized for members who can safely live on their own, nor is it intended to provide 24-hour care. Protective supervision is not a benefit of CFC and can be on a member’s individual service plan (ISP), even if the member receives CFC.

Exercise

A member may request, or a physician may order, assistance with walking as a form of exercise. A member must be ambulatory for exercise to be an authorized PAS activity.

Therapy Extension

Licensed therapists may choose to instruct the PAS attendant on the proper way to assist the member in follow-up of therapy sessions. This assistance or support provides reinforcement of instruction and aids in the rehabilitative process. Therapy extension is documented on Form H2060-A.

6118.2 Personal Assistance Services Attendants

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Personal assistance services (PAS) are performed by personal care attendants who:

* are not themselves recipients of PAS;
* are employed by a managed care organization (MCO)-contracted provider or employed by the member or the employer of record under the Consumer Directed Services (CDS) Option;
* are not the spouses of members;
* perform all of the services available within their scope of competency;
* may serve as backup attendants to initiate services, prevent a break in service and provide ongoing service;
* are required to provide services that meet a member’s health and safety needs; and
* if applicable, meet additional eligibility requirements under the CDS option.

6200 Nursing Services

Revision 18-2; Effective September 3, 2018

Nursing services are services that are within the scope of the Texas Nursing Practice Act and are provided by a registered nurse (RN) (or licensed vocational nurse (LVN) under the supervision of an RN) licensed to practice in the state. In the Texas state plan, nursing services are provided only for acute conditions or exacerbations of chronic conditions lasting less than 60 days. Nursing services provided in the STAR+PLUS Home and Community Based Services (HCBS) program cover nursing tasks associated with ongoing chronic conditions such as medication administration and supervising delegated tasks. This broadens the scope of these services beyond extended state plan services. Extended state plan services are services provided which exceed benefits allowed under the state plan.

Nursing services purchased through the STAR+PLUS HCBS program can be skilled or specialized in nature and do not replace a member's acute care benefit. Nursing services are assessment, planning and interventions provided by a person licensed to engage in professional nursing or vocational nursing in Texas, or licensed in a state that has adopted the Nurse Licensure Compact. Proof of valid licensure can be verified by viewing the nurse's license at the Texas Board of Nursing website at <https://www.bon.texas.gov/>.

To assure quality of care for members in the STAR+PLUS HCBS program, the managed care organization (MCO) is responsible for coordinating services following a significant change in the member's condition. The MCO may become aware of a significant change in condition through interaction with members, family or an authorized representative (AR), and by performing interim assessments on current STAR+PLUS HCBS program members. The MCO is responsible for initiating appropriate services and supports to meet the care and well-being of the member on a timely basis.

6210 Settings

Revision 18-2; Effective September 3, 2018

Nursing services can be delivered in a member's own home or family home, in a personal care facility, assisted living facility (ALF) or an adult foster care (AFC) setting. Nursing services purchased through the STAR+PLUS Home and Community Based Services (HCBS) program may not be provided in the following settings as defined in 42 Code of Federal Regulations (CFR), §441.530(a)(2):

* Nursing facilities (NFs);
* Psychiatric hospitals;
* Intermediate care facilities for individuals with intellectual disabilities (ICF/IID);
* Hospitals providing long-term care; and
* Locations that have the qualities of an institution.

6220 Nursing Services to Meet Member Needs

Revision 18-2; Effective September 3, 2018

All STAR+PLUS Home and Community Based Services (HCBS) program members meet medical necessity (MN) and have a need for one or more nursing tasks, as described in Texas Administrative Code (TAC), Title 40, §19.2401. It is the responsibility of the managed care organization (MCO) service coordinator to identify and document in the individual service plan (ISP) or [Form H1700-B](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-b-non-hcbs-starplus-waiver-services%22%20%5Co%20%22Form%20H1700-B), Non-STAR+PLUS HCBS Program Services, how the member's nursing need(s) will be met.

The member's nursing needs may be met by direct or delegated nursing, health maintenance activity (HMA), informal support, or a combination, as described below:

* Direct nursing provided by a registered nurse (RN) or a licensed vocation nurse (LVN). This includes nursing services with a third-party resource (TPR) as the payer and nursing with the STAR+PLUS HCBS program as the payer.
* Delegation by an RN to an unlicensed assistive person (UAP), such as a personal attendant in accordance with Texas Board of Nursing rules, which may be delivered through Community First Choice (CFC) or the STAR+PLUS HCBS program.
* RN determination that a nursing task(s) is an HMA in accordance with Texas Board of Nursing rules. HMAs include performance of nursing tasks by a paid attendant and by informal support. For a member who chooses the provider or service responsibility option (SRO), the MCO service coordinator, in conjunction with the agency RN, makes the determination that a nursing task is an HMA.
* Informal support, such as unpaid family members, may be trained in the provision of nursing tasks to meet a member's needs. The MCO service coordinator must identify and document the tasks to be performed by the informal support on [Form H1700-B](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-b-non-hcbs-starplus-waiver-services) and the informal support must agree to perform the nursing tasks.

For information about delegation and HMAs, refer to TAC for Texas Board of Nursing, Title 22, Part 11, Chapters 224 and 225.

6230 Nursing Services in Assisted Living Facilities

Revision 18-2; Effective September 3, 2018

Assisted living facilities (ALFs) must have sufficient staff to assist with member medication regimens (Texas Administrative Code (TAC), Title 40, §92.41). Nursing for this task may be included on the individual service plan (ISP), depending on the member’s needs and the facility type. Licensed nurses who own an ALF or are employed by the facility may directly administer medication to members residing in ALFs, but are not required to do so. In ALFs, delegation of nursing tasks to facility attendants is not allowed by licensure. See [Section 7200](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7200), Assisted Living Services, [Section 7224](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7224), Personal Care 3, and [Section 7230](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7230), Other Services Available to Members.

If, because of licensure, an ALF does not provide nursing services, other facility employees may not deliver services other than personal assistance services (PAS) and administration of medications. If a resident needs additional services that are not available in the ALF, the managed care organization (MCO) must ensure the member’s needs are met. The MCO may do so through contract with a Home and Community Support Services Agency (HCSSA) or an independent health care provider.

PAS provided by the ALF include assistance with feeding, dressing, moving, bathing, or other personal needs or maintenance; or general supervision or oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence in the ALF; or assistance to a member to manage her or his personal life, regardless of whether a guardian has been appointed for the person.

6240 Nursing Services in Adult Foster Care Homes

Revision 18-2; Effective September 3, 2018

Based upon the assessment performed by the managed care organization (MCO) registered nurse (RN) service coordinator, the RN service coordinator determines a member’s classification level for adult foster care (AFC) services. MCOs must consider a need for limited or greater assistance with the performance of activities of daily living (ADLs) and behaviors that occur at least once a week in the assessment and determination, as well as other identified needs of the member. Nursing services may be purchased through the STAR+PLUS Home and Community Based Services (HCBS) program, depending on the member's assessed need and the AFC home classification. See [Section 7133](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7133) Classification Levels, for additional information.

6250 Specialized Nursing

Revision 18-2; Effective September 3, 2018

Specialized nursing services delivered by a registered nurse (RN) or licensed vocational nurse (LVN) are available through the STAR+PLUS Home and Community Based Services (HCBS) program. Specialized nursing services may be used when a member requires, as determined by a physician, daily skilled nursing to~~:~~

* cleanse, dress and suction a tracheostomy; or
* provide assistance with ventilator or respirator care.

6300 Therapy Services

Revision 18-2; Effective September 3, 2018

Therapy services provided through the STAR+PLUS Home and Community Based Services (HCBS) program are long-term services and do not replace a member’s acute care benefit. Therapy services include the evaluation, examination and treatment of physical, functional, cognitive, speech and hearing disorders and/or limitations. Therapy services include the full range of activities under the direction of a licensed therapist within the scope of her or his state licensure. Therapy services are provided directly by licensed therapists or by assistants under the supervision of licensed therapists in the member's home, or the member may receive the therapy in an outpatient center or clinic. If the therapy is provided outside the member's residence based on the member's choice, the member is responsible for providing her or his own transportation or accessing the Medicaid Medical Transportation Program (MTP).

If the therapy is provided outside the member's residence because of the convenience of the provider, the provider is responsible for providing the member's transportation. If a member resides in an adult foster care (AFC) or an assisted living (AL) setting and therapy is provided in an outpatient center or clinic (see [Section 6112](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-6000-sph-specific-starplus-waiver-services#6112), Service Locations for STAR+PLUS HCBS Program, the AL provider or AFC provider is responsible for arranging for transport or directly transporting the member.

Occupational therapy (OT), physical therapy (PT), speech therapy (ST) and cognitive rehabilitative therapy services are covered by the STAR+PLUS HCBS program only after the member has exhausted her or his therapy benefit under Medicare, Medicaid or other third-party resources (TPRs). Providers contracted with the managed care organization (MCO) must provide the OT, PT, ST and cognitive rehabilitation therapy (CRT) services as identified on the member's individual service plan (ISP). Individuals providing therapy services must be licensed in Texas in their profession or be licensed or certified as assistants and employed directly or through sub-contract or personal service agreements with a provider or through the Consumer Directed Services (CDS) Option.

PT is defined as specialized techniques for evaluation and treatment related to functions of the neuro-musculo-skeletal systems provided by a licensed physical therapist or a licensed PT assistant directly supervised by a licensed physical therapist. PT is the evaluation, examination and utilization of exercises, rehabilitative procedures, massage, manipulations and physical agents (such as mechanical devices, heat, cold, air, light, water, electricity and sound) in the aid of diagnosis or treatment.

OT consists of interventions and procedures to promote or enhance safety and performance in activities of daily living (ADLs), instrumental activities of daily living (IADLs), education, work, play, leisure and social participation. It is provided by a licensed occupational therapist or a certified OT assistant directly supervised by a licensed occupational therapist.

ST in the STAR+PLUS HCBS program is defined as evaluation and treatment of impairments, disorders or deficiencies related to an individual's speech and language. The scope of speech, hearing and language therapy services offered to STAR+PLUS HCBS program participants exceeds the state plan as the service in this context is available to adults. It is provided by a speech-language pathologist or a licensed associate in speech-language pathology under the direction of a licensed speech-language pathologist.

6310 Initiation of Assessment and Therapy

Revision 18-2; Effective September 3, 2018

Upon member request or recommendation from the nurse, primary care provider or service coordinator for a therapy assessment, the managed care organization (MCO) service coordinator must work with the member to select a provider for the assessment. The assessment must be submitted by the provider for the MCO to authorize service hours based on physician orders and medical necessity (MN) review. Any therapy for the management of a chronic condition must be included on the individual service plan (ISP).

6320 Responsibilities of Licensed Therapists in STAR+PLUS HCBS Program

Revision 18-2; Effective September 3, 2018

Responsibilities of the licensed therapists include, but are not limited to, the following:

* assessing the member's need for therapy, adaptive aids and minor home modifications (MHMs);
* delivering direct therapy as authorized in the individual service plan (ISP);
* supervising delivery of therapy rendered by the therapy assistant as authorized in the ISP;
* informing the physician and other team members of changes in the member's health status requiring a service plan change;
* training the member’s attendant or caregiver to extend therapeutic interventions;
* training the member to use adaptive aids; and
* participating in interdisciplinary team meetings, when appropriate and requested by the managed care organization (MCO).

6330 Cognitive Rehabilitation Therapy

Revision 18-2; Effective September 3, 2018

Cognitive rehabilitation therapy (CRT) is a service that assists a member in learning or relearning cognitive skills lost or altered as a result of damage to brain cells/chemistry in order to enable the member to compensate for the lost cognitive functions. Cognitive rehabilitation therapy is provided when determined to be medically necessary (MN) through an assessment conducted by an appropriate professional. Cognitive rehabilitation therapy is provided in accordance with the individual service plan (ISP) developed by the assessor, and includes reinforcing, strengthening or re-establishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Qualified providers include:

* Psychologists licensed under Texas Occupations Code Chapter 501;
* Speech and language pathologists licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401; or
* Occupational therapists licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

6400 Adaptive Aids and Medical Supplies

Revision 18-2; Effective September 3, 2018

Adaptive aids and medical supplies are specialized medical equipment and supplies, including devices, controls or appliances that enable members to increase their abilities to perform activities of daily living (ADLs), or to perceive, control or communicate with the environment in which they live. Adaptive aids and medical supplies are reimbursed with STAR+PLUS Home and Community Based Services (HCBS) program funds, when specified in the individual service plan (ISP), with the goal of providing individuals a safe alternative to nursing facility (NF) placement.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items; and durable and non-durable medical equipment not available under the Texas state plan, such as vehicle modifications, service animals and supplies, environmental adaptations, aids for daily living, reachers, adapted utensils and certain types of lifts.

The annual cost limit of this service is $10,000 per ISP year. The managed care organization (MCO) may exceed the $10,000 cost limit; however, the MCO must not include any costs over the $10,000 on any cost reports, claims, encounters or financial statistical reports.

The state allows a member to select a relative or legal guardian, other than a legally responsible individual, to be the member's provider for this service if the relative or legal guardian meets the requirements for this type of service.

Adaptive aids and medical supplies are limited to the most cost-effective items that:

* meet the member's needs;
* directly aid the member to avoid premature NF placement; and
* provide NF residents an opportunity to return to the community.

6410 List of Adaptive Aids and Medical Supplies

 Revision 18-2; Effective September 3, 2018

Adaptive aids and medical supplies are covered by the STAR+PLUS Home and Community Based Services (HCBS) program only after the member has exhausted state plan benefits and any third-party resources (TPRs), including product warranties or Medicare and Medicaid home health the member is eligible to receive. Adaptive aids, including repair and maintenance (to include batteries) not covered by the warranty, consist of but are not limited to following:

If a vehicle modification costs $1,000 or more and the vehicle has been driven more than 75,000 miles or is over four years old, the managed care organization (MCO) contracted provider must:

* obtain a written evaluation by an experienced mechanic to ensure the sound mechanical condition of all major components of the vehicle;
* document the experience of the mechanic doing the evaluation; and
* include the actual cost of the written evaluation as part of the invoice cost not to exceed $150.
* lifts:
	+ wheelchair porch lifts;
	+ hydraulic, manual or other electronic lifts;
	+ stairway lifts;
	+ bathtub seat lifts;
	+ ceiling lifts with tracks;
	+ transfer bench;
* mobility aids, including batteries and chargers:
	+ manual or electric wheelchairs and necessary accessories;
	+ customized wheelchair with documentation of cost effectiveness;
	+ three- or four-wheel scooters;
	+ mobility bases for customized chairs;
	+ braces, crutches, walkers and canes;
	+ forearm platform attachments for walkers and motorized/electric wheelchairs;
	+ prescribed prosthetic devices;
	+ prescribed orthotic devices, orthopedic shoes and other prescribed footwear, including diabetic shoes if the member does not have Medicare and there is a documented medical need and a physician order for the shoes;
	+ diabetic slippers or socks;
	+ prescribed exercise equipment and therapy aids;
	+ portable ramps;
* respiratory aids:
	+ ventilators or respirators;
	+ back-up generators;
	+ oxygen containers or concentrators, and related supplies;
	+ continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP) machines, including headgear;
	+ nebulizers;
	+ portable air purifiers and filters for a member with chronic respiratory diagnosis such as asthma, Chronic Obstructive Pulmonary Disease (COPD), bronchitis or emphysema;
	+ suction pumps;
	+ incentive spirometers and peak flow meters;
* positioning devices:
	+ standing boards, frames and customized seating systems;
	+ electric or manual hospital beds, tilt frame beds and necessary accessories;
	+ hospital beds, including electric controls, manual cranks or other items related to the use of the bed (Medicare/Medicaid can cover hospital beds, specialty mattresses and specialty hospital bed sheets for skin breakdown);
	+ replacement mattresses;
	+ egg crate mattresses, sheepskin and other medically related padding;
	+ wheelchair cushions;
	+ elbow, knee and heel protectors and hand rolls for positioning;
	+ arm slings, arm braces and wrist splints;
	+ abdominal binders;
	+ trapeze bars;
* communication aids (including repair, maintenance and batteries):
	+ augmentative communication devices:
		- direct selection communicators;
		- alphanumeric communicators;
		- scanning communicators;
		- encoding communicators;
		- speaker and cordless telephones for persons who cannot use conventional telephones;
	+ speech amplifiers, aids and assistive devices;
	+ interpreters;
* control switches or pneumatic switches and devices:
	+ sip and puff controls;
	+ adaptive switches or devices;
* environmental control units:
	+ locks;
	+ electronic devices;
	+ voice-activated, light-activated and motion-activated devices;
* medically necessary (MN) durable medical equipment not covered in the state plan for the Texas Medicaid Program;
* temporary lease or rental of medically necessary durable medical equipment to allow for repair, purchase, replacement of essential equipment or temporary usage of the equipment;
* payment of premium deductibles and co-insurance (for items covered under the STAR+PLUS HCBS program), including rentals for Medicare or TPRs, if not covered under the Qualified Medicare Beneficiary or the Medicaid Qualified Medicare Beneficiary programs;
* modifications or additions to primary transportation vehicles:
	+ van lifts;
	+ driving controls:
		- brake or accelerator hand controls;
		- dimmer relays or switches;
		- horn buttons;
		- wrist supports;
		- hand extensions;
		- left-foot gas pedals;
		- right turn levers;
		- gear shift levers;
		- steering spinners;
	+ MN air conditioning unit prescribed by a physician for individuals with respiratory or cardiac problems or people who can't regulate temperature;
	+ removal or placement of seats to accommodate a wheelchair;
	+ installation, adjustments or placement of mirrors to overcome visual obstruction of wheelchair in vehicle;
	+ raising the roof of the vehicle, lowering the floor or modifying the suspension of the vehicle to accommodate an individual riding in a wheelchair;
	+ installation of frames, carriers, lifts for transporting mobility aids;
	+ installation of trailer hitches for trailers used to transport wheelchairs or scooters;
		- **Note**: If the adaptive aid is a vehicle modification, the program provider must obtain written approval from the vehicle’s owner before making the modification. The owner must sign and date the approval. The MCO must maintain documentation that the contracted provider ensured the specifications for a vehicle modification included information on the vehicle to be modified, including:the year and model of the vehicle;
		- a determination that the vehicle is the member’s primary vehicle;
		- proof of ownership of the vehicle;
		- current state inspection and registration for the vehicle;
		- any required state insurance for the vehicle;
		- mileage of the vehicle;
		- an itemized list of parts and accessories, including prices;
		- an itemized list of required labor, including labor charges; and
		- warranty coverage.
* sensory adaptations:
	+ corrective lenses including eyeglasses not covered by the state plan;
	+ hearing aids not covered by the state plan;
	+ auditory adaptations to mobility devices; and
* adaptive equipment for activities of daily living (ADLs):
	+ assistive devices:
		- reachers;
		- stabilizing devices;
		- weighted equipment;
		- holders;
		- feeding devices, including:
		- electric self-feeders;
		- food processors and blenders – only for members with muscular weakness in upper body or who lack manual dexterity and are unable to use manual conventional kitchen appliances;
	+ variations of everyday utensils:
		- shaped, bent, built-up utensils;
		- long-handled equipment;
		- addition of friction covering;
		- coated feeding equipment;
	+ medication reminder systems, including those for the visually disabled;
	+ walking belts and physical fitness aids;
	+ specially adapted kitchen appliances;
	+ toilet seat reducer rings unless member resides in an assisted living facility (ALF);
	+ bedside commodes;
	+ hand-held shower sprays unless member resides in an ALF;
	+ shower chairs unless member resides in ALF/residential care facility;
	+ electric razors;
	+ electric toothbrushes;
	+ water piks;
	+ service animals and maintenance including veterinary expenses;
	+ over-bed tray tables unless member resides in an ALF;
	+ safety devices, such as:
		- safety padding;
		- helmets;
		- elbow and knee pads;
		- visual alert systems;
	+ medically necessary heating and cooling equipment for members with respiratory or cardiac problems, people who cannot regulate temperature or people who have conditions affected by temperature;
	+ one window or portable air conditioner, including wiring, for a member’s main living area, such as a bedroom;
	+ medical supplies necessary for therapeutic or diagnostic benefits for:
		- tracheostomy care;
		- decubitus care;
		- ostomy care;
		- pulmonary, respirator/ventilator care; and
		- catheterization.

Other types of supplies include:

* incontinence supplies, including diapers, disposable or washable bed pads, briefs, protective liners, pull ups, wipes, moisture protective mattress covers, moisture barrier cream, regular or antiseptic wipes (if a medical need is documented), sheets, towels and washcloths (if MN);
* nutritional supplements;
* enteral feeding formulas and supplies;
* mouth swabs and toothettes;
* diabetic supplies (strips, lancelets and syringes);
* Transcutaneous Electrical Nerve Stimulation (TENS) units/supplies/repairs;
* stethoscopes, blood pressure monitors and thermometers for home use;
* blood glucose monitors;
* medical alert bracelets;
* sharps or biohazard containers;
* anti-embolism hose/stockings, such as thromboembolic disease hose; and
* approved enemas, if not available through the Medicaid state plan or other TPRs.

Other

Necessary items related to hospital beds could include electric controls, manual cranks or other items related to the use of the bed. Medicare/Medicaid can cover hospital beds and specialty mattresses. Specialty sheets, such as hospital bed sheets, may be covered.

The STAR+PLUS HCBS program will pay for a Geri-chair if the member is alert, oriented and able to remove the tray table without assistance and as desired. Otherwise, the Geri-chair is considered a restraint and the STAR+PLUS HCBS program does not pay for restraints.

Gloves

Gloves may be purchased through the STAR+PLUS HCBS program for family or caregiver use in the care of a member with incontinence, or if the member has an active infectious disease that is transmitted via body fluids. Examples of active infectious diseases that qualify are Methicillin-resistant Staphylococcus aureus (MRSA) and hepatitis. Gloves may be purchased for family or caregiver use to provide wound care to protect the member. Documentation by the MCO-contracted provider must support the need of gloves to be left at the residence and for family or caregiver use only. If the member has other conditions requiring frequent use of gloves, the MCO nurse must give her or his approval.

Adaptive Aid Exclusions

The following are examples of items that may not be purchased using STAR+PLUS HCBS program funds. These items include, but are not limited to:

* hot water heater;
* combination heater, light and exhaust fan;
* heating and cooling system filters;
* non-adapted appliances, such as refrigerators, stoves, dryers, washing machines and vacuum cleaners;
* water filtration systems;
* central air conditioning and heating;
* multiple air conditioning units to cover an individual's residence;
* non-adapted home furnishings to include (except as allowed through Transition Assistance Services (TAS) or Supplemental Transition Support):
	+ cooking utensils;
	+ non-hospital bed mattresses and springs, including Adjustamatic, Craftmatic, Tempur-Pedic®, Posturepedic and Sleep Number® beds;
	+ pillows (excluding neck pillows and support wedge pillows);
* electrical heating elements (heating pads, electric blankets);
* recreational items, equipment and supplies including:
	+ bicycles and tricycles (2, 3 or 4 wheels);
	+ helmets for recreational purposes;
	+ trampolines;
	+ swing sets;
	+ bowling and fishing gear;
	+ karaoke machines;
	+ entertainment systems;
	+ off-road recreational vehicles;
* memberships to gyms, spas, health clubs or other exercise facilities;
* communication items, including:
	+ telephones (standard, cordless or cellular);
	+ pagers;
	+ pre-paid minute cards;
	+ monthly service fees;
* computers for the following justifications:
	+ educational purposes;
	+ self-improvement/employment purposes;
	+ improvement of general computer skills;
	+ internet and email access;
	+ games and fun/craft activities;
* office equipment and supplies to include:
	+ fax machines;
	+ printers/copiers;
	+ scanners;
	+ internet and email services;

**Note:** An individual accessing the Consumer Directed Services (CDS) option may purchase office equipment and supplies through the CDS budget.

* gloves for universal precautions, or gloves that are used by MCO contracted provider, an adult foster care (AFC) provider or any contracted provider staff;
* personal items for ADLs, such as hygiene products including soap, waterless soap, toothbrush, toothpaste, deodorant, powder, shampoo, lotions (except moisture barrier products), feminine products (except when documented for use as an incontinence supply), manual razors, washcloths, towels, bibs and first-aid supplies;
* clothing items;
* food;
* bottled water (for drinking and cooking);
* nutritional drinks and products, such as Carnation Instant Breakfast, V-8 Juice, Slim Fast, fruit juices, flavored water, vitamin enhanced water, nutrition and protein bars, breakfast cereals;
* vitamins, minerals and herbal supplements and over-the-counter drugs;
* title, license and registration for trailers or vehicles;
* wheelchairs and scooters for the purpose of facilitating participation in recreational activities and sports;
* vehicle repairs, as part of normal maintenance; repairs are part of normal vehicle maintenance and cannot be covered. Installation of heavy-duty shocks as required by a lift installation may be included as part of the vehicle modification. trailers (including taxes) for transporting wheelchairs or scooters;
* experimental medical treatment and therapies, such as equestrian therapy; and
* installation of gas or propane lines.

## 6420 Approval of Adaptive Aids and Medical Supplies

Revision 18-2; Effective September 3, 2018

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-spw-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 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-hcbs-starplus-waiver-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 notification of the denial of the specific item following the requirements outlined in the [*Uniform Managed Care Manual (link is external)*](http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/), 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 sends an adverse determination notice 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 sends the adverse determination notice 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 service plan to exceed the annual cost limit, the nurse may authorize it 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.

6421 Lift Chair Approvals

Revision 18-2; Effective September 3, 2018

Lift chairs may be authorized as adaptive aids as part of the STAR+PLUS Home and Community Based Services (HCBS) program service array. Use the following procedures if attempting to purchase the lift chair using Medicare funding.

Once the managed care organization (MCO) determines a lift chair may be needed or is requested by the member, the MCO assesses the member to determine if the member meets **all** of the following criteria required for Medicare to pay for the lift mechanism:

* The member must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
* The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the member's condition.
* The member must be completely incapable of standing up from any chair in her or his home. Once standing, the member must have the ability to ambulate with or without assistance.

Member Does Not Meet All Criteria

If the member does not meet **all** of the Medicare criteria, the MCO completes [Form H1700-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-a-rationale-hcbs-starplus-waiver-itemsservices), Rationale for STAR+PLUS HCBS Program Items/Services. The MCO should state the following on Form H1700-A, Section 4, "Lift Chair: Plus Mechanism." Along with Form H1700-A, the MCO must obtain a:

* prescription or statement signed by the physician certifying the need for the lift chair, specifically stating the member has difficulty or is incapable of getting up from a chair; and
* statement by the physician or provider specifically stating that once standing, the member has the ability to ambulate or transfer with or without assistance.

The MCO approves the cost of the lift chair plus the mechanism if the request meets **all** criteria and the above documentation is received.

Member Meets All Criteria

If the MCO determines the member meets **all** of the criteria for Medicare to pay for the lift mechanism, the MCO:

* approves the cost of the lift chair minus the mechanism;
* authorizes the durable medical equipment provider to deliver the lift chair and bill Medicare for the mechanism; and
* must document that Medicare is covering the mechanism.

If a request for a lift chair minus the mechanism is approved by the MCO, but the provider later requests additional funds for the mechanism denied by Medicare, the MCO may approve the request if it meets all STAR+PLUS HCBS program criteria. To avoid billing issues, the effective date of the change to add the funds for the lift mechanism must be the same as the effective date of the first change completed to approve the lift chair minus the mechanism.

## 6430 Effects of Changing MCOs on Adaptive Aids Procurements

Revision 18-2; Effective September 3, 2018

If a member changes to another managed care organization (MCO) while an adaptive aid is on order or in the process of being delivered, the MCO which authorized the service is responsible for payment and delivery of the adaptive aid.

6440 Temporary Lease and Equipment Rental

Revision 18-2; Effective September 3, 2018

Rental of equipment allows for repair, purchase or replacement of the equipment, or temporary usage of the equipment. The length of time for rental of equipment must be based on the individual circumstances of the member. If the medical professional and/or the member is not certain the medical equipment will be useful, the equipment should be rented for a trial or short-term period before purchasing the equipment.

The cost of renting equipment versus purchasing equipment may be explored, if you are currently renting the equipment. Rentals can be more cost-effective than direct purchase of an item. The expected duration of the use of equipment may be considered in the decision to rent or purchase. It may be more cost-effective, after renting for a period of time, to purchase the equipment instead of continuing to rent.

If the member prefers to buy the rented equipment, the managed care organization (MCO) must document the equipment functions properly and is appropriate for the member, so STAR+PLUS Home and Community Based Services (HCBS) program funds may be expended.

6450 Time Frames for Purchase and Delivery of Adaptive Aids and Medical Supplies

Revision 18-2; Effective September 3, 2018

6451 Time Frames for Adaptive Aids

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) must purchase and ensure delivery of any adaptive aid within **14 business days** of being authorized (except for vehicle modifications) to purchase the adaptive aid, counting from either the effective date of the individual service plan (ISP) form or the date the form is received, whichever is later. If delivery is not possible in **14 business days**, the MCO must document the reason for the delay.

The MCO must notify the member and document notification of any delay, with a new proposed date for delivery. The notification must be provided on or before the **14th business day** following authorization. If the delivery does not occur by the new proposed date, the MCO must document any further delays, as well as document member notification, until the adaptive aids are delivered. The MCO must authorize a vehicle modification on the effective date of the member’s ISP. The MCO must work with the provider and member to ensure the vehicle modification takes place as expeditiously as possible.

6452 Time Frames for Medical Supplies

Revision 18-2; Effective September 3, 2018

Medical supplies are expected to be delivered to the member within **five business days** after the member begins to receive STAR+PLUS Home and Community Based Service (HCBS) program services. The provider must deliver medical supplies within **five business days** from the start date on the individual service plan (ISP). The member’s current supply of these items should be considered. For example, if the member has a supply of diapers that is expected to last for one month, the diapers authorized on the ISP do not need to be delivered immediately.

If the provider cannot ensure delivery of a medical supply within **five business days** due to unusual or special supply needs or availability, the provider must submit [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, to the managed care organization (MCO) before the fifth day explaining why the medical supply cannot be delivered within the required time frame and including a new proposed date for the delivery.

If there is an existing supply of medical supplies on the service initiation date, the MCO must write "existing supply of needed medical supplies on hand" in the progress notes as verification that supplies were available to the member and did not require delivery at this time.

Stockpiling of medical supplies must not occur. Supplies, such as incontinence and wound care supplies not covered through Medicaid Home Health and needed on an ongoing basis, should be delivered so there is no more than a three-month supply in the member's home at a time.

6460 Co-Insurance and Deductibles

Revision 18-2; Effective September 3, 2018

Reimbursement for the cost of co-insurance for the purchase or rental of adaptive aids or the purchase of medical supplies reimbursed by Medicare or private health insurance is available if the following conditions are met:

* the member does not have coverage under the Qualified Medicare Beneficiary (QMB) or the Medicaid Qualified Medicare Beneficiary (MQMB) programs;
* the adaptive aid or medical supply is listed in the service definition of this handbook or has been prior authorized by managed care organization (MCO) management; and
* documentation submitted supports the necessity of the item(s) for the individual's disability or medical condition.

Reimbursement for the co-insurance amount to Medicare or private health insurance for therapy services or the rental of any adaptive aids is a cost-effective way to utilize third-party resources (TPRs). The cost of any co-insurance payment must be billed under adaptive aids.

For instances in which a member is not covered under the QMB or MQMB programs and cannot pay her or his premium deductible under a TPR for items covered under the STAR+PLUS Home and Community Based Services (HCBS) program, the deductible can be listed under adaptive aids on [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1), for payment.

6470 Bulk Purchase of Medical Supplies

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) may choose to buy medical supplies in bulk. The cost of storing supplies can be reported on the annual cost report as an allowable expense. The medical supply is billed at the unit rate based on the invoice cost of the bulk purchase divided by the number of units purchased.

6500 Dental Services

Revision 18-2; Effective September 3, 2018

Dental services are those services provided by a dentist to preserve teeth and meet the medical needs of the member. Dental services must be provided by a dentist licensed by the State Board of Dental Examiners and enrolled as a Medicaid provider with Texas Medicaid & Healthcare Partnership (TMHP). The managed care organization (MCO) service coordinator arranges the needed dental services for STAR+PLUS Home and Community Based Services (HCBS) program members with licensed and enrolled dentists.

The MCO must discuss with the STAR+PLUS HCBS program member any available resources to cover the expense of dental services and consider those resources before authorizing dental services through STAR+PLUS HCBS program. If dental services are on the individual service plan (ISP), the MCO must authorize and coordinate a referral to a dental provider within 90 days of request by the member, unless there is documentation that the member requested a later date.

6510 Allowable Dental Services

Revision 18-2; Effective September 3, 2018

Allowable dental services include:

* emergency dental treatment procedures necessary to control bleeding, relieve pain and eliminate acute infection;
* preventative procedures required to prevent the imminent loss of teeth;
* treatment of injuries to the teeth or supporting structures;
* dentures and the cost of fitting and preparing for dentures, including extractions, molds, etc.; and
* routine and preventative dental treatment.

The managed care organization (MCO) must ensure dental requests meet the criteria for allowable services before authorizing services, except in an emergency situation. Dental services are provided by STAR+PLUS Home and Community Based Services (HCBS) program when no other financial resource for such services is available and when all other available resources, with the exception of value-added services (VAS). VAS are not required to be used prior to waiver services. VAS vary by MCO.

The state allows a member to select a relative or legal guardian, other than a spouse, to be the member's provider for this service if the relative or legal guardian meets the requirements to provide this type of service. Payments for dental services are not made for cosmetic dentistry.

The annual cost limit of this service is $5,000 per individual service plan (ISP) year. The $5,000 cap may be waived by the MCO upon request of the member only when the services of an oral surgeon are required.

6520 Documentation of Dental Services by a Dentist

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) or its contractor must ensure all requests for dental treatments include documentation by a professional dentist of the need for dental services. A dentist must determine the medical necessity (MN) for dental treatment and submit a detailed treatment plan to the MCO to document the MN and all specific dental procedures to be completed. The dentist may not bill the STAR+PLUS Home and Community Based Services (HCBS) program member for the remainder of the cost over the approved amount.

[Form H1700-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-a-rationale-hcbs-starplus-waiver-itemsservices), Rationale for STAR+PLUS HCBS Program Items/Services, must be completed by the MCO to document the medical need for requested STAR+PLUS HCBS program items or services. MN for dental services is completed by the dental professional, as described above. Form H1700-A may be submitted in lieu the process described above, if the information is sufficient to describe the medical need for the dental services.

##  6530 Time Frames for Initiation of Dental Services

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) must work with the member to identify a dental provider or contracted provider no later than the first day of the member’s individual service plan (ISP). No later than the first day of the member’s ISP, the MCO must review the dental treatment plan. The MCO must send an authorization to the dentist within seven days of receipt of the dental treatment plan. Services must be initiated within 90 days of treatment plan development unless the member or dentist has a documented preference for a later initiation date. Value-added services (VAS) are not required to be used prior to using the STAR+PLUS HCBS program dental benefit.

6600 Minor Home Modifications

Revision 18-2; Effective September 3, 2018

Minor home modifications (MHMs) are those physical adaptations to a member’s home, required by the service plan, that are necessary to ensure the member's health, welfare and safety, or that enable the member to function with greater independence in the home. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the member’s welfare. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit.

All services are provided in accordance with applicable state or local building codes. Modifications are not made to settings that are leased, owned or controlled by providers contracted with the managed care organization (MCO). The state allows a member to select a relative or legal guardian, other than a spouse, to be the member’s provider for this service if the relative or legal guardian meets the requirements to provide this type of service.

6610 Responsibilities Pertaining to Minor Home Modifications

Revision 16-1; Effective March 1, 2016

In order to ensure cost-effectiveness in the purchase of minor home modifications (MHMs), the managed care organization (MCO) must:

* determine and document the needs and preferences of the member for the MHM; and
* document the necessity for the MHM.

The MCOs have their own policies and procedures in regards to bidding, awarding contracts, doing inspections and completing MHMs.

6620 List of Minor Home Modifications

Revision 18-2; Effective September 3, 2018

The following minor home modifications include the installation, maintenance and repair of approved items not covered by warranty:

* Purchase of wheelchair ramps;
	+ protective awnings over ramps;
* Modifications or additions for accessible bathroom facilities;
	+ wheelchair accessible showers;
	+ sink modifications;
	+ bathtub modifications;
	+ toilet modifications;
	+ water faucet controls;
	+ floor urinal and bidet adaptations;
	+ plumbing modifications and additions to existing structures necessary for accessibility adaptations;
	+ turnaround space modifications;
* Modifications or additions for accessible kitchen facilities;
	+ sink modifications;
	+ sink cut-outs;
	+ turnaround space modifications;
	+ water faucet controls;
	+ plumbing modifications or additions to existing structures necessary for accessibility adaptations;
	+ worktable/work surface adjustments or additions;
	+ cabinet adjustments or additions;
* Specialized accessibility/safety adaptations or additions, including repair and maintenance;
	+ door widening;
	+ electrical wiring;
	+ grab bars and handrails;
	+ automatic door openers, doorbells, door scopes, and adaptive wall switches;
	+ fire safety adaptations and alarms;
	+ medically necessary air filtering devices;
	+ light alarms, doorbells for the hearing and visually impaired;
	+ floor leveling, only when the installation of a ramp is not possible;
	+ vinyl flooring or industrial grade carpet necessary to ensure the safety of the member, prevent falling, improve mobility, and adapt a living space occupied by an individual who is unable to safely use existing floor surface;
	+ medically necessary steam cleaning of walls, carpet, support equipment and upholstery;
	+ widening or enlargement of garage and/or carport to accommodate primary transportation vehicle and to allow persons using wheelchairs to enter and exit their vehicles safely;
	+ installation of sidewalk for access from non-connected garage and/or driveway to residence, when existing surface condition is a safety hazard for the person with a disability;
	+ porch or patio leveling, only when the installation of a ramp is not possible;
	+ safety glass, safety alarms, security door locks, fire safety approved window locks and security window screens; for example, for persons with severe behavioral problems;
	+ security fencing for residence, for those persons with cognitive impairment or persons whose safety would be compromised if they wandered;
	+ protective padding and corner guards for walls for members with impaired vision and mobility;
	+ recessed lighting with mesh covering and metal dome light covers to compensate for violent aggressive behavior; for example, for persons with autism or mental illness;
	+ noise abatement renovations to provide increased sound proofing; for example, for persons with autism or mental illness;
	+ door replacement for accessibility only;
	+ motion sensory lighting;
	+ intercom systems for individuals with impaired mobility; and
	+ lever door handles.

Ramps may be installed for improved mobility for use with scooters, walkers, canes, etc., or for members with impaired ambulation, as well as for wheelchair mobility. In some instances and according to supporting documentation, multiple modifications may be needed for accessibility and mobility, such as ramps and hand rails for members with impaired ambulation. There is no limit to the number of wheelchair ramps that can be authorized, provided the total cost does not exceed the cost limit, but documentation must support the justification for additional ramps as related to medical need or health and safety of the member.

Carbon monoxide detectors cannot be purchased under STAR+PLUS Home and Community Based Services (HCBS) program as a "fire safety adaptation and alarm."

Requests for items (or repair of items) or service calls that are considered routine home maintenance and upkeep cannot be approved.

Items that cannot be approved by the service coordinator include:

* carpeting (other than industrial grade);
* newly constructed carports, porches, patios, garages, porticos or decks;
* electric fences;
* landscaping and yard work or supplies;
* roof repair or replacement;
* gutters;
* leaky faucet repair;
* elevators;
* house painting;
* electrical upgrades and/or electrical outlets, unless needed to power adapted equipment or a safety hazard exists;
* air duct cleaning and maintenance; and
* pest exterminations.

Heating and cooling equipment may be approved as an adaptive aid. Installation of approved heating and cooling equipment is included in the cost of the adaptive aid. Support platforms are frequently used to provide support for cooling equipment installed in home windows. The support platforms attach in a clamp-like manner without fasteners. The cost and installation of support platforms are considered as an adaptive aid. The installation of heating and cooling equipment may require modification of the home (for example, additional wiring or widening of the windows). The modification of the home must be authorized as a minor home modification (MHM).

Flooring applications, including vinyl and industrial carpet, may not be authorized for adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the member.

6630 Home Modification Service Cost Lifetime Limit

Revision 18-2; Effective September 3, 2018

There is a lifetime limit of $7,500 per member for this service and $300 yearly for repairs. Once the $7,500 cost limit is reached, only $300 per year per member, excluding associated fees, will be allowed for repairs, replacement or additional modifications. The managed care organization (MCO) is responsible for obtaining cost-effective modifications authorized on the member's individual service plan (ISP). The MCO may exceed the cost limit, however the MCO must not include any costs over the lifetime limit on any cost reports, claims, encounters or financial statistical reports.

If a member changes MCOs, the losing MCO must provide documentation to the gaining MCO related to any minor home modification expenditures. See Uniform Managed Care Terms and Conditions (UMCC), Section 5.06, Span of Coverage, for payment responsibilities.

6640 Landlord Approval for Minor Home Modifications

Revision 16-1; Effective March 1, 2016

When the member has a landlord or when the owner of the home is not the member, written approval prior to the initiation of any requested modification must be obtained.

6700 Employment Services

Revision 18-2; Effective September 3, 2018

6710 Employment Assistance

Revision 18-2; Effective September 3, 2018

Employment assistance is provided to a member to help the member locate paid employment in the community and includes:

* identifying a member's employment preferences, job skills and requirements for a work setting and work conditions;
* locating prospective employers offering employment compatible with a member's identified preferences, skills and requirements; and
* contacting a prospective employer on behalf of a member and negotiating the member’s employment.

In the state of Texas, this service is not available to members receiving waiver services under a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the member's record that the service is not available to the member under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

An employment assistance service provider’s credentials must satisfy one of these options:

Option 1:

* a bachelor's degree in rehabilitation, business, marketing or a related human services field; and
* six months of documented experience providing services to people with disabilities in a professional or personal setting.

Option 2:

* an associate's degree in rehabilitation, business, marketing or a related human services field; and
* one year of documented experience providing services to people with disabilities in a professional or personal setting.

Option 3:

* a high school diploma or GED; and
* two years of documented experience providing services to people with disabilities in a professional or personal setting.

6720 Supported Employment

Revision 18-2; Effective September 3, 2018

Supported employment is assistance provided, in order to sustain competitive employment, to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported employment includes adaptations, supervision, training related to a member's assessed needs and earning at least minimum wage (if not self-employed). In the state of Texas, this service is not available to members receiving waiver services under a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the member's record that the service is not available to the member under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

A supported employment service provider’s credentials must satisfy one of these options:

Option 1:

* a bachelor's degree in rehabilitation, business, marketing or a related human services field; and
* six months of documented experience providing services to people with disabilities in a professional or personal setting.

Option 2:

* an associate's degree in rehabilitation, business, marketing or a related human services field; and
* one year of documented experience providing services to people with disabilities in a professional or personal setting.

Option 3:

* a high school diploma or State of Texas Certificate of High School Equivalency; and
* two years of documented experience providing services to people with disabilities in a professional or a personal setting.